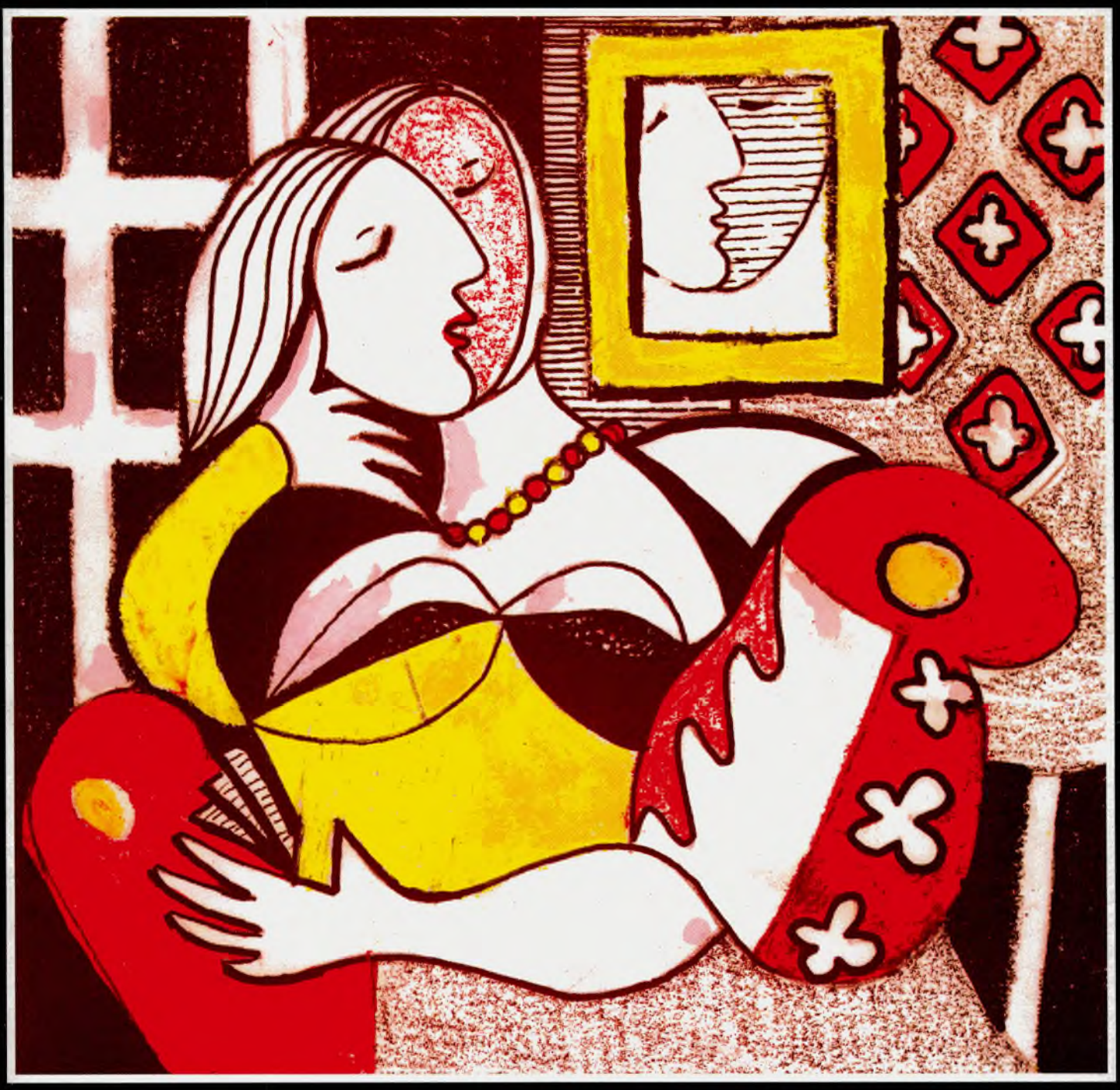
REFLECTIONS:

NARRATIVES of PROFESSIONAL HELPING



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Volume 7 **Winter 2001** **Number 1**

Special Issue:
Psychotherapy and Mental Health Practice: Stories of Growth and Change

Guest Editor: John A. Kayser, Ph.D., Graduate School of Social Work, University of Denver

The cover design was inspired by a painting by Pablo Picasso entitled "Woman with a Book" (1930). The painting was created in the "Cubist" style, a major European art movement in the early part of the 20th Century. The painting depicts a woman reclining on a sofa couch. The artist deconstructs the image of the woman into multiple views of the same person, suggesting the unfolding multiple perspectives of the human experience.

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Introduction To The Special Issue On Psychotherapy And Mental Health Practice: Stories Of Growth And Change

John A. Kayser, Ph.D., Special Issue Editor

A great deal of confusion, conflict, and (let's be honest) outright antipathy exists in the helping disciplines about the proper role or place of psychotherapy and mental health practice among the array of theories, intervention frameworks, and methods available to practitioners. Psychiatry, once a leader in mental health theory and practice, has essentially abandoned the psychotherapy field in favor of biopsychiatry, medication consults, and diagnostic taxonomies. (It is a measure of how much things have changed when directors of psychiatric training now debate whether carrying psychotherapy cases should have any role in the training of residents and fellows.) In social work, newer frameworks never miss an opportunity to pin the "deficit model" tail on the donkey of traditional psychotherapy practice. In the field of psychology, it is neuropsychology, rather than clinical or counseling psychology, which is in ascendance. As a result, as one of the contributors to this special issue has written elsewhere, "Psychotherapy is a lumbering dinosaur, whose relevance to the post-modern world is like that of God to an atheist, or Oz to Zeus" (Lyon, 2000, p. 67).

No wonder the general public is ever more wary and skeptical about mental health treatment when the helping professions themselves are so uncertain and/or antagonistic to the whole endeavor. Nonetheless, there appears to be an increasing demand for mental health treatment by both insured and uninsured consumers. Paradoxically, however, many professionals already have left their psychotherapy practices. Whether the leaving is due to managed care constraints, cumbersome agency bureaucracies, daunting paperwork, burnout, or diminished professional rewards, it is clear that there are increasingly large holes in the availability of seasoned therapists, experienced clinical supervisors, and knowledgeable clinical educators. As traditional mental health disciplines and experienced professionals depart the scene, the door has remained open for newer practitioners, often having less training and—perhaps—less commitment to ethical care, who are more than eager to take their place. It remains an open question as to whether these developments ultimately will prove beneficial or harmful to mental health consumers and their families, and to society at large.

This special issue of ***Reflections*** is not intended to be the last stand of the Jurassic era psychotherapists, dying under the massive impact of the killer comet called managed care. Rather, it aims to peer through the clouds of ambivalence, which have enveloped the professions' perceptions of mental health practice, by capturing three types of narratives: those of clients, of practitioners, and of service organizations and/or clinical programs. It is the intersections of these three types of stories that are of particular interest. Read on multiple

levels, these stories help illuminate the rich diversity of thought and work actually occurring in the field today, which may help liberate clinical practice from the negative stereotypes and distorted perspectives under which it currently labors.

Several important emphases in the special issue narratives are worth noting. First, the stories told here are by interdisciplinary contributors—from child and family development, clinical psychology, school psychology, and social work, respectively. Second, the stories are set in diverse practice settings (i.e., public and private) and at differing levels of intervention (i.e., micro to macro). Third, there is a distinct emphasis on collaboration (e.g., between client and therapist, supervisor and supervisee, student and educator, and university, community, and organizational stakeholders).

Clients' stories—the accounts of their struggles, strengths, and impetus for growth—are prominently featured in most of the narratives in this special issue. They take center stage, however, in the narrative by Thomas Roberts, a child and family development educator and therapist. Roberts gives us an account of his work with a self-styled "professional mental health client," and the discovery of the therapeutic value of making mistakes. In addition, the poems and reflections of Tiffany Bucknam provide the voice of one who has been not only a client but also a service provider and (now) a social work student.

Another group of narratives in the special issue are the stories of the professionals providing services, as well as the stories of educators and supervisors involved in the training of mental health professionals. While rarely shared with clients or students except in moments of self-disclosure, these educator and practitioner stories also are important. For example, Carolyn Saari, a well known clinical social work educator and author, traces the linkages between her personal and professional development in social work and the development of a conceptual framework regarding the role of the environment and social justice concerns in psychotherapy practice. Nancy Decker, a clinical social worker, offers a story about the evolution of her understanding of gender roles and how that has shaped her development as a therapist treating couples and men. In addition, there are two articles on clinical supervision, one by Jeff Rothstein, a clinical social work educator and supervisor, and another by Colleen Attoma-Mathews, a recent social work graduate, which provide overlapping perspectives regarding the role clinical supervision plays in the practitioner's development, and its resulting impact on the parallel process work with clients. Further, the co-authored article on resilience by Mark Lyon, a school psychology educator, and Catherine Cohn, a school social worker, describes their focus on client strengths and resilient capacities and the mutual collaboration between, on the one hand, student practitioner and faculty member in the classroom, and on the other hand, the student practitioner and the child and family receiving services.

Two narrative articles address the helping systems themselves. School psychology educator, Gloria Miller, and school social worker, Connie Clifton, describe their personal and professional collaboration in developing an alliance between a school district, a university, and a low income community in developing an innovative prevention program for kids—who are considered (wisely) as being "at-promise," rather than being labeled only as "at-risk." This article pointedly reminds us that mental health practice is not confined to the 45 or 50-minute psychotherapy hour. Social work

educator, John Kayser, clinical psychologist, Judith Silver, and school psychology educator, Mark Lyon, share their case and cause advocacy work on behalf of a variety of client systems, involving, respectively, interventions in a managed care organization, a junior high school, and an urban school district.

The goals of this special issue, therefore, will be accomplished if these narrative articles help readers: (a) understand the change process from multiple viewpoints—clients, therapists, supervisors, educators, and communities; (b) appreciate the organizational and social policy context within which psychotherapy and mental health practice takes place; (c) identify some of the social justice and cultural dimensions occurring in the delivery of mental health services; (d) understand the impact of the therapist's discipline, education, and training on the process of therapy; and (e) understand the management of personal and professional issues by therapists, including their strategies for self-care and self-renewal.

Finally, on a personal note, I would like to thank all of the contributors to this special issue, who have worked diligently with me over the past twelve months in developing their manuscripts, to the peer reviewers for their timely reviews and helpful suggestions, and to the past and present editors of ***Reflections*** for the opportunities to be involved in this unique journal.

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Call for Narratives

SPECIAL ISSUE:

CONFLICT IN THE MIDDLE EAST

This special issue focuses on the long-standing tensions, struggles, and violence affecting Israel, the Palestinians and their Arab neighbors. **Reflections** seeks to give voice to all sides in pursuit of a deeper understanding of the pain as well as the hope for some resolution of the seemingly intractable issues that remain unresolved in this region.

NARRATIVES:

- ❑ Accounts by members of the helping professions about their work and experience in this region
- ❑ Narratives of those with family members in the region who have been directly affected by the conflict
- ❑ Narratives from visitors to the region who have had experiences they wish to share

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Manuscripts due by June 30, 2001

Psychotherapy: Potential Agent for Social Reform?

By Carolyn Saari, School of Social Work, Loyola University, Chicago. Professor Saari has written numerous articles and two books on clinical social work theory and practice.

This narrative is the account of the author's search for a way of conceptualizing the relationship between the person and the environment in psychotherapy. She was initially motivated to become a professional social worker by exposure to social injustice, particularly the experience of adolescent years living in Montgomery, Alabama, during the bus strike. Later, however, as she became fascinated by theories of mental illness, this search has had very personal meanings for her as well as importance for clinical social work.

One of clinical social work's strengths is the recognition that in order to be helpful to a client, both the client and the client's environment must be taken into consideration. This is one piece of the "practice wisdom" that is passed on through supervision, through informal relationships with senior practitioners, and through beginning textbooks. Most clinical social workers know that the person-situation configuration perspective is critical in treatment, but there is little that anchors this perspective in a theory that also offers guidance for intervention methods. There are theories about the environment, but these usually do not help the practitioner individualize the client. There are theories that deal with individuals, but these usually are intrapsychic, or at best interpersonal, and usually do not take the non-human environment seriously. We have, therefore, been stuck in thinking of the inner world and the external world of the person as two different entities without the ability to show how the two interrelate. This conceptual problem has been troubling me for a long time.

The practice of psychotherapy was not what I was initially intending to do in social work. I wanted to change the world. I first encountered the world's unfairness at age eight when spending time at my father's business, located in a slum area in Manchester, New Hampshire, shortly after WWII. The textile factories that had been the main industry in Manchester had moved south where labor was cheaper, leaving local workers without their customary means of supporting themselves and finding many of them destitute. Patricia, the girl I considered my best friend, lived in the building above my father's business, and we ordinarily played in the paved loading area behind the building. Once, however, she took me to the apartment where she lived with her mother and her three sisters. The hallway was unlit and I was frightened at not being able to see where I was going, although she seemed unconcerned about this. The apartment had one room in which most of the space was taken up by the double bed where she, her divorced mother, and the baby slept. A mattress slid out from under the bed at night and the two middle girls slept there. A small stove and refrigerator with overhead cabinets were at one end of the room. The bathroom was a closet-sized space curtained off from the kitchen. I knew already from my middle-class parents that I would be expected to go to college and that Patricia would be lucky if she were able to finish high school. She and I shared many interests at the time, but our lives were and would continue to be entirely different.

Not long after that time, my father's business dictated that we move to the south ourselves—first to Atlanta, Georgia, and then to Montgomery, Alabama. It was in Montgomery that I learned about public welfare and professional social workers through a neighbor who, as a volunteer, had become the liaison between the local welfare office and the women's groups of the local Council of Churches. When a welfare worker had a family with special needs the department could not meet, the worker would call this neighbor who would then find a women's group that could supply whatever was required. This neighbor's particular interest was in convincing the women's groups to give through the welfare office, thereby allowing for client confidentiality and preventing the family from having to feel shamed by needing help. She also wanted to convey to her women's clubs that the poor had needs all year long, not just at Thanksgiving and Christmas. As a young, idealistic adolescent, I thought this woman wonderful, and she took me with her on some of her visits to the welfare office where I became familiar with their services and problems. I wanted to make society a place where equal opportunities could be made available to all, and I knew well that this was not the case. For example, one of the black women we had employed as a maid had a college degree but, nevertheless, could not get more desirable work.

I was in 10th grade in Montgomery when in 1955 Rosa Parks refused to give up her seat and the bus strike began. As Yankees who believed in integration but who had not been politically active, my parents found it increasingly necessary to take a public stance in regard to some of the events that ensued. There were, for example, attempts to ruin selected "colored" businesses by stopping deliveries from white wholesalers; threats and sometimes actual violence against blacks and whites who were seen in public with blacks; and, worst of all, the bombing of five black churches. Increasingly, as the community became polarized on black/white relationships, my family became known as "damn Yankee n---- lovers" and were called such once even in a church service. Damn Yankee n---- lovers were particularly despicable because such people failed to understand that the intellectually and creatively limited (so not quite human) blacks really needed the protection of benevolent southern whites and, when not stirred up by outside agitators, lived quite happily within the traditionally segregated southern culture.

No one in my family was physically hurt, though there were threats, harassing telephone calls, and once a rock was hurled through a window as my father gave Christmas presents to the children of his black employees, striking the face of a toddler and barely missing her eye. Vicious leaflets from the White Citizen's Council were left in our mailbox, clearly and frighteningly placed there in person rather than having been sent through the mail. After my father refused to contribute to a fund being collected to defend the men who had bombed the black churches, our telephone would begin ringing at about 2:00 AM and continue to do so until about 4:00 AM for a period of about two weeks.

Living in fear is a terrible thing, and although I wanted to dedicate my life to being an activist, I also began to question whether I would be able to cope with this as a career. Tired of the stress that continued even after the bus strike was settled, I gladly went north to college. I hoped that in the north I would find others who were similarly dedicated to social reform. How-

ever, I became disillusioned at finding that the northern whites involved in the civil rights movement were commonly uninterested in the serious issues needing resolution in order to create a society in which blacks and whites could get along. Some northerners seemed content to point fingers at southerners, thereby making themselves feel righteous. The option of being some sort of activist seemed even less attractive.

I had never known anyone who was "mentally ill" and thought that what little I knew about psychoanalytic theory—the Oedipus complex—was "nuts." I had, however, heard about medical social work, and it made sense to me that when there was illness, people would understandably have additional needs. In the summer between my sophomore and junior years in college, I signed up for an internship program in New York City that gave college students an experience in social work with the hope of recruiting them. I was assigned to the Methodist Hospital in Brooklyn and had a supervisor who was wonderfully supportive and who made sure that I had a wide variety of experiences. I was hooked.

It was at the Methodist Hospital that I first encountered a psychiatric patient. I was offered the opportunity to sit in on an interview conducted by a psychiatrist in the outpatient clinic. The patient was a middle-aged woman who told the psychiatrist in graphic detail how her husband, trying to kill her, had disabled the brakes in her car. The psychiatrist calmly suggested that she admit herself to the state hospital and, much to my surprise, she consented without protest. When the interview was over, I asked the psychiatrist how he had known that the husband was not trying to kill her. The psychiatrist, patiently but somewhat patronizingly, explained to me that this woman had been in the state hospital many times and knew that when she came to the clinic this was what would be done. I was less than fully convinced, but also not concerned about it because I was not interested in dealing with psychiatric patients anyway. Yet I continued to wonder how the psychiatrist could have so little concern with the patient's real environment.

After college I worked for a year with the American Red Cross doing medical social work in a military hospital and then went to the Simmons College School of Social Work, choosing this school because I understood it to be a national leader in training people for medical settings. When I got there, however, I found that they were no longer putting much emphasis on medical settings and instead were focusing on psychiatric work. I dutifully listened to psychoanalytic concepts in classes with the attitude that I would learn "whatever was necessary" for the degree I needed, even though I thought much of this ridiculous. I continued to think of myself as a medical social worker.

In the early 1960s, social work students were not allowed to choose where they would do their field placements, and I have always thought that my second -year assignment to the one setting that the overwhelming majority of the students wanted was an attempt to dissuade me from medical social work. I was given the Day Hospital at the Massachusetts Mental Health Center, then widely known for its pioneering effort in this program. Once there, I was amazed—living examples of

the theories I had eschewed were walking down the hallways!

I had been told by my much beloved supervisor at Mass. Mental that the best way for a psychiatric social worker to begin her career was to work at a family service agency for a few years to gain confidence in her own skill before moving to a mental health setting. So, following graduation, I took a job at Family Service of Philadelphia, which was regarded as a leader in the field. I loved my work, but it was the middle 1960s and "casework was dead." In the midst of the Great Society programs, experts in social reform were declaring that psychotherapy was simply adjusting people to a sick society. I knew instinctively that this was not what I was doing, but did not know how to argue my case—after all, I could hardly claim that society was not sick. Even as I got more confidence in my own treatment skills and my fascination with the complexity of the inner lives of my clients grew, I worried that I had abandoned my first and more altruistic original purpose, sometimes feeling quite guilty about this.

After a little over four and one-half years in Philadelphia, I thought that I had gotten as much as I could from a family service agency and it was time to move on to a psychiatric setting. I went, therefore, to the Yale Psychiatric Institute (YPI) in New Haven, Connecticut. At that time the YPI was a small, long-term, in-patient hospital for severely ill adolescents where social workers did family therapy and participated in the milieu therapy program. This was a very expensive facility with a staff-to-patient ratio of 5 to 1, and most of the families were well off financially—not exactly the group I had set out to help. They were, however, in tremendous and obvious pain and I found it rewarding to work with so many other staff who were unselfishly dedicated to helping patients who usually had been labeled "untreatable" elsewhere. At least I had found a place where others were as idealistic as I was. Nevertheless, I did sometimes suffer from by now familiar pangs of guilt.

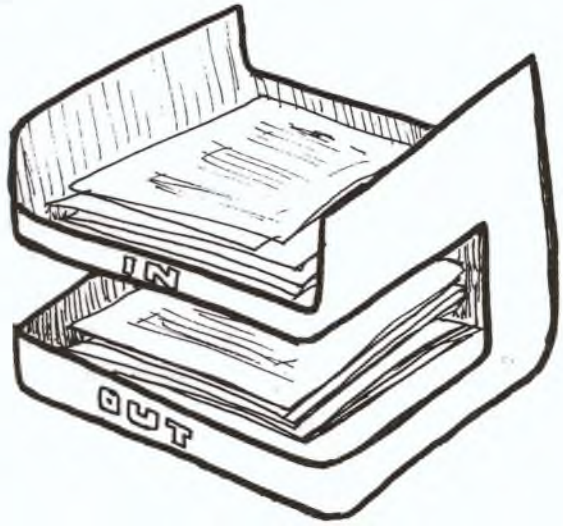
I often told myself that my purpose for being at Yale was that I was learning. If I needed to work with the rich in order to learn what it was that the poor ought to be getting, then I would have to do that. And learn I did! Separation-individuation theory was just coming out, and the YPI was a dynamic example of its applicability to schizophrenic adolescents and their families. I sat in on courses for the advanced residents and learned more about Piaget's cognitive theories, about the work of Sullivanians and other interpersonal analysts who specialized in the seriously ill, about the importance of language and symbolization in treatment, about the importance of the milieu in the treatment of the severely mentally ill, and, best of all, about Hans W. Loewald's work. I was, however, acquiring mental indigestion. I was working, on average, about 60 hours a week, and I had no time to devote to a full exploration of the ideas to which I was being exposed. I wanted to be able to gain command of them.

After two years at YPI, I left to work on a doctorate at the Smith School for Social Work with an agreement that if there was a position, I would return when I had completed the program. I always intended to return, knowing that after I had been able to study more, I would still need to have experience in the clinical application of the theories if I expected to understand them fully. I thought I would ultimately want to teach in a graduate social work program but did not want to do that until I really had something substantial to offer students. Many friends advised me to switch professions (since social work was moving away from clinical emphasis) and to get a doctorate in psychology. Even though I really

could not have articulated exactly what I wanted to get from a social work program, I did know that I could not give up my concerns about social injustice. The doctoral program involved a number of stresses, but fortunately my dissertation advisor was supportive of my interests and very facilitative in my attempts to articulate ideas. I was not, however, sure that I had learned anything more about social justice issues and these seemed to have taken something of a back seat.

When I returned to Yale, I had changed—I was now quite confident about my mastery of important theories and no longer so quiet about what I thought or so reticent to state my opinions in meetings. The YPI had changed as well, however, and there were new stresses. There was a new state law, intended to curb the growth of health care cost, which meant that the YPI could no longer make a profit that was passed on to the Department of Psychiatry through which it was administered. Since it was no longer a money-making facility, there were concerns about whether YPI should be closed. More significant, at least for me, there was the first real wave of women coming through the residency program, creating additional stress in this bastion of masculinity. Having female residents was wonderful as far as I was concerned, and I became good friends with most of them. I was also getting the clinical experience I had wanted to help me refine my ideas. After three years of administrative change with considerable accompanying chaos, I was told by a new administrator that I was to be moved to another part of the Department of Psychiatry. I did not, he told me, understand how much I was intimidating the residents. He was right; I did not. Since most of the female residents were personal friends, I knew that he meant the male residents and some of the male members of the new regime. I had gotten the clinical experience I wanted, so declined a transfer to another part of Yale. I also had gotten a personal taste of how sexism operates.

I moved to social work education, becoming the Associate Dean of the School for Social Work at Smith but did not find that much administration to be fulfilling, so after three years I moved again, this time to the School of Social Work at Loyola University Chicago where I have been for the last 20 years. My responsibilities at Loyola included planning and directing a new clinical doctoral program, but, more importantly for me, gave me time to think and write. Soon I would resign from directing the doctoral program, once more finding administration less than fully satisfying, and would concentrate more on the writing. I was, of course, also able to include concerns about social justice into the courses I taught and hoped that I was conveying to students the importance of a commitment to the underprivileged and oppressed in the world around them.



In retrospect, it is easy for me to see that my writing was always working on the problem of the environment and issues of social injustice—even though I was not always conscious of this. (Or is it that I have now rewritten my autobiographical narrative?) The problem, I somehow knew, could not be solved unless therapeutic effectiveness could be understood differently. My first paper written after moving to Chicago dealt with the issue of "reality" in psychotherapy using a constructivist frame.

In this, I presented case material involving a woman who had been unable to adjust to a new environment and who much later needed to return to the southern town of her childhood in order to experience herself as real. Later, this paper would become part of my first book, *Clinical Social Work Treatment: How Does It Work?* (Saari, 1986). That book ended with an answer:

> Treatment works though the construction of a therapeutic concordance {a culture created in the interaction between the therapist and the client} within which the client and the clinician, in their working alliance, practice and refine reality-processing skills, which the client later can utilize in cultures external to the concordance itself. (p. 213)

Since culture is defined as a meaning system, this could be seen as existing both inside the client and outside in the society.

Introducing the idea of culture as an important feature of treatment was a beginning, but did not solve the problem. My second book, *The Creation of Meaning in Clinical Social Work* (Saari, 1991), dealt with the problem of adaptation as the treatment goal. After all, adaptation presupposed an environment, and for social work that would have to mean the currently existing social environment—a very conservative proposition. In this second book, I posited that people should have as much freedom to live their own lives as they could reasonably have, but choices could be limited in two different ways. First, options might not be available because the society limited them to only certain groups or classes, and for this *social action beyond psychotherapy would be necessary*. Second, however, options might not be available because the individual could not recognize them due to an underdevelopment of imagination and creativity. It was the second problem that could be addressed through psychotherapy. I had taken another step—but the larger social justice problem was still not solved.

In the second book, I did discuss Katherine Nelson's (1985, 1989) idea that children may first create a picture of their cultural surround and only subsequently create a sense of who they are in relationship to that environment. It was an intriguing thought, but at that time I was unable to take this to its logical conclusion. I had not yet understood Foucault's (see Chambon, Irving & Epstein, 1999) philosophy, which criticizes the concept of repression as the manner in which oppression works and instead indicates that in our current societies, oppression works through the ways in which human subjectivity itself is created. Yes. Patricia (my childhood best friend) had not found the hallway frightening because in both her internal world and her external world hallways were unlighted and unclean and people lived crammed into tiny, one-room apartments. Southern whites of the 1950's expected that African Americans should be perfectly happy in a culture that kept blacks in subservient roles. Worse, blacks in the south often expected this to be the case as well. By the 1970's, I and the female residents at Yale had expected that we ought to be able to be as vocal and as assertive as our male colleagues, and this was experienced as intimidating by many of the men whose understanding of an expectable environment did not include "castrating women."

When oppression operates through the creation of a subjectivity, psychotherapy can indeed serve the punishing and disciplining functions that Foucault and others have ascribed to it. It does not, however, *have* to do that. Instead, psychotherapy can fight oppression and create freedom through the intersubjective, client-therapist creation of awareness of more choices than the client's original culture seemed to allow.

Such change will invariably be slow, but then social changes through attempts to reform social policy and through activist confrontations also have been slow.

I am currently involved in writing a third book that will say human beings first gain an understanding of what happens in the world around them. Only after an image of the expectable world is created does the person create an identity for herself, and that identity will be based on personal experiences within the immediate environment. Since common injustices seem a perfectly natural part of the world as it "has always been," the personal identity will likely also mean that oppression is both expected and, in some manner, deserved. It takes a creative individual to imagine a world different from the social environment in which he or she has been socialized. Psychotherapy can be used to reinforce oppression and social injustice, but it does not have to do so. It can also help individuals, families, and small groups to find ways of transcending the environments into which they have been socialized and thereby help them find ways to deal with injustices.
I do not know whether any of my career efforts have really helped to change very much, but at least I no longer have to suffer from pangs of guilt over having abandoned my original purpose. I like to think that there are many ways of working for social reform: some of them involving social action; some involving direct practice; and even some that involve contributing to our understanding of how best to think about the conditions under which humans can realize more of their potential.

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Therapeutic Use of the Unpredictable: When Mistakes Lead to Therapeutic Change

By Thomas W. Roberts, Chair, Department of Child and Family Development at San Diego State University.

This narrative is a reflection on mistakes that occur in therapy and how they can enhance therapeutic change. Mistakes are viewed in a broader context of human relationships in which persons participate free of scripts. The need for the therapist to be a person *as the first priority in the therapist-client relationship is contrasted with playing the role of* therapist. *The author recounts an incident that occurred early in his career when he was in training to be a therapist. He discusses how he dealt with a mistake during a therapy session openly, honestly, and outside the confines of expected therapeutic intervention.*

Over the past 25 years as a therapist, I have treated most types of psychological problems with varying degrees of success. As I reflect on my experiences, it intrigues me that some of the most successful and interesting outcomes could not have been predicted at the outset. In fact, the change mechanism that occurs in individuals and families in therapy is too complex to clearly define. As a supervisor I would like to package it and give it to my students. Unfortunately, this is not so easily done.

This article is a reflection about an ignored portion of this change dynamic that I have noticed in therapy, namely mistakes made by the therapist. I believe that Carl Whitaker (Whitaker & Keith, 1981) was right when he said that therapists should guard their impotence like it was their most valued possession. By this I think he meant to guard one's discomfort and feeling of inadequacy. To paraphrase him, I would say, "Guard your mistakes like they are your most valued possessions." Mistakes make therapists human, and I have come to realize that being a person first and a therapist second is the proper hierarchy of these two roles. When being a therapist is considered the first priority, one has only to get it right. The mechanisms of being a therapist take over as one learns techniques and appropriate responses to client statements. Change is dependent on the therapist making correct responses and "therapeutic" interventions. The therapist must succeed where others in the natural social environment have failed.

On the other hand, when the person of the therapist is emphasized as Whitaker (Whitaker & Keith, 1981) suggested, one is concerned more with being an individual in a particular relationship. A person makes mistakes honestly and, hopefully, learns from them. This trial and error manner of relating occurs in our most intimate relationships. Yet, as therapists, we are overcome with fright when mistakes occur in therapy sessions.

I am not suggesting that there is no need to learn techniques, or that the therapist need not learn how to phrase comments to respond to a person in a psychotic rage. Rather, I am stating that much of what happens to change people occurs in the realm of real human interactions and emotions in which one, including the therapist, may be ill prepared to handle according to set techniques or deliberate manipulation.

The belief that mistakes may provide opportunities for change in therapy began early in my career when I was in supervised training as part of my Ph.D. program. My internship site was a large community mental health center in an inner city area of a large metropolitan area. The center's client population was mixed, with about 60 percent African American, 30 percent white, and the remainder of various Asian groups, mainly Cambodian.

The center provided many services for a wide range of clients. Many of the clients needed follow-up services after being hospitalized at the state mental hospital. A small percentage of clients were considered "growth" because they were not diagnosed with a psychotic process. These clients were having problems with relationships or adjustments to life situations. Therapists generally competed for these cases because they could used a wider range of therapeutic techniques. In general, more experienced therapists were assigned the growth clients. My observation from the standpoint of being an intern was that a therapist's reputation as an effective therapist depended to some extent on how many growth clients he or she had.

The community mental health services in the state initially were set up as aftercare programs for hospitalized clients. As these aftercare centers grew, a new philosophy was developed in the state's Department of Human Resources. This philosophy was that persons improve when they are treated in the least restrictive manner. The concept of treating clients in their "natural environments" emerged. Hospitalization was to be used as short-term treatment and the community mental health center was designated to be the long-term treatment facility. Consequently, this dual role of following up on the chronic population and providing front-line services for persons with family or adjustment type disorders generally meant that therapists were overworked and had huge caseloads.

This change in philosophy at the state level occurred a few years before I began my internship and the system had not fully adjusted to it. The number of clients in the mental hospital was dwindling while the number of clients in the community system kept increasing. At the time, I questioned the commitment of some of the old-timers (i.e., therapists who had been in the system prior to the change) who had worked with chronic clients for many years. They seemed burned out and lacking energy. Now I realize what overwork and few rewards can do to morale.

I believe that many of the chronic clients recognized that they were not the "prized" clients at the center, though this was never discussed openly. I wonder now if some of the clients' acting out episodes may have been partly a response to feeling neglected. Many of the clients were seen in monthly medication groups for the purpose of maintaining them on medication, but little or no other therapy was done with them.

When I was a student, my approach to therapy was to consider every client unique and capable of improving his/her life. My undergraduate major in philosophy and the influence of existential thinkers greatly influenced this approach to therapy. I believed then, and still do, that life circumstances, especially failures, can be the greatest opportunity for new and different behavior. I saw this first hand in some of my most chronic clients. They would tell of the most horrendous experiences that led to new and different life situations. For example, stories of dread and doom always contain the sparks of newness.

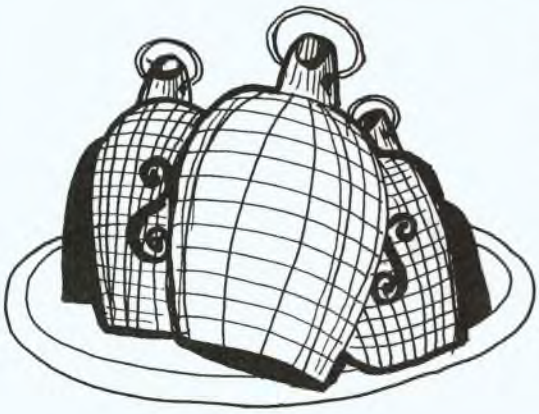
A concomitant theme as a student was that I tried to work with clients with as few presuppositions as possible. Over the years I've had to work to keep from having presuppositions and expectations linked to diagnoses. I believe that this is as much a danger for the seasoned therapists as it was

for many of the full-time therapists in the mental health center. Seeing the possibilities rather than the limitations is an ongoing challenge in therapy.

The incident that I referred to above occurred while completing my dissertation in child and family development with an emphasis in marriage and family therapy and completing my intern hours required for graduation. It was a particularly difficult time for me because I was working full-time during the day and writing my dissertation in the evening. My wife, who also worked full-time, had recently given birth to our first child. To complicate things even more, the baby had difficulty sleeping through the night. Frequently, I was exhausted and sleepy during sessions, particularly in the afternoon.

My main objective in my internship was to have enough clients to meet the requirement for graduation. I frequently would ask for more cases with little concern about the client's diagnosis. As a result, I was assigned a number of medication maintenance cases that the regular therapists considered non-therapy cases, cases that were not considered "growth." One of these cases was "Larry Hutton." (His name and other identifying information have been changed to preserve confidentiality.)

The entire mental health staff had worked with Larry at some point during his long and successful *career* as a mental client. I use the word successful in the sense that he managed to never improve despite the various services provided. He knew the game of therapy very well. Haley's (1973) belief that symptoms are very powerful is well illustrated in this case. Larry knew how therapists would react to everything he did, and like his relationship with his parents, he seemed to enjoy his manic episodes as a way to manipulate the system again.



I have to admit that for the first appointment I had not reviewed his chart because of working in a few extra clients. Ten minutes before my appointment with Larry, his last therapist gave me a quick summary. Larry was 43 years old, the youngest of three children. He still lived at home with his elderly parents, both retired and in their mid-seventies. He was considered extremely intelligent and had held high-ranking executive jobs for short periods of time. At present, he was working for the IRS as a filing clerk and during the heavy tax season, he worked for H & R Block preparing tax returns.

Larry was diagnosed manic depressive and was taking the medication Lithium. While always more or less in a manic state, he was able to avoid hospitalizations as long as he took his medication. Periodically, he would stop taking his medication and have a manic episode. His manic episodes were likely to involve the police and require several months in the hospital.

Some of the most noted manic episodes were briefly described. Once he came for his appointment with Head and Shoulders shampoo rubbed in such quantity on his head and shoulders that he looked like a Halloween goblin. Another time he went to the Kentucky Derby and while there convinced the hotel bellboy that he was Howard Cosell's assistant. Gaining entrance to Cosell's room, Larry proceeded to have a party, running up a room service tab of $300. Another time while his parents were out of town, he washed the kitchen dishes on the kitchen floor using a garden hose and household ammonia.

The most recent episode began when he stopped taking his medicine. About two weeks later at 3:00 PM in the afternoon he decided to mow the grass in the yard with

no clothes on. His house was on the corner of a busy boulevard and many passersby, both in cars and walking on the sidewalk, reported to the police that a man was mowing his grass in the nude. The police knew him because of many past contacts and took him directly to the mental hospital. It was after this episode and the discharge from the hospital that he was coming in for treatment.

While Larry had been a client at the center for years and lived with his parents, his parents had never been involved in therapy. According to Larry's former therapist, his parents would call him on the phone but refused to come in with him. They believed that Larry was sick and there was nothing anyone could do except keep him on medication. Larry was compared unfavorably with an older, successful brother who was a tax attorney.

Larry's episodes tended to parallel a family problem or circumstance. When his father had bypass heart surgery, Larry stopped taking his medication and was hospitalized at the state mental hospital in a manic state before his father was released. His relationship with his parents was up and down. They would give him double messages about his living at home. At times they would demand that he get his own apartment, but then they expected him to do needed jobs, such as painting the house or mowing the grass. Since he had his own suite with a kitchenette in his parents' home, he would sometimes isolate himself for weeks without any contact with them. Although he had this ambivalent relationship with them and sometimes threatened to move out, he never did. He described both parents as "feeble" and needing him to be there.

When he appeared in the doorway of my office for this first appointment, he looked like an overgrown boy. He had on khaki pants and a short-sleeved shirt. His rounded face, ruddy complexion, and white curly hair made him look like a giant stuffed doll. As I greeted him for his appointment he smiled very freely and said as he handed me a business card, "So you're the lucky one who gets me this time." I'm sure he knew that I was new and inexperienced and he would actually enjoy making my life exciting.

The business card stated only:

> LARRY HUTTON
>
> Professional Mental Health Patient

He talked very rapidly, laughing frequently, and changed subjects every other sentence. Attempts to structure the monologues led to his retelling them rather than offering explanations. After 30 minutes of working very hard to structure him with little success, my mind began to wander as I realized how tired I was. I had worked until 2:00 AM on my dissertation and the baby woke me at 4:15 AM, and I never got back to sleep. As my eyes got heavier and heavier, I noticed that the time was 3:35 PM.

Suddenly, I was startled by my own loud snore. Larry, who had been talking nonstop said, "Were you asleep?" I looked at the clock and noticed that it was 3:55 PM. My whole life as a therapist more or less flashed in front of me. I thought, "I will lose this job and not finish my Ph.D. How can I ever justify sleeping during a therapy session?" I felt the hot rush of blood to my face, and I was uncertain what to do next. I thought that if I admitted to sleeping it would be like admitting that I was a complete and total failure. Then, another line of thought entered my mind. I can't lie; I'll tell the truth. Surely he must understand that I'm overworked and have a small baby that doesn't sleep through the night. So suddenly without any more thoughts, I heard

myself replying, "Yes, I believe I did fall off to sleep."

Jumping to his feet, he went into a rage and yelled, "I pay good money for you to sleep? I won't put up with this! I can't believe that you have the nerve to sit there and sleep while I'm spilling my guts. I'm not going to pay for this session. In fact, I want another therapist." And then as an afterthought he said, "By the way, how long were you asleep?"

Looking at the clock again, I said, "I'd say about 20 minutes."

"You mean to tell me that you slept one half of our therapy time?"

"I'm afraid so."

"I want another therapist!"

"OK. You must be very disappointed in me."

"Disappointed?! Pissappointed! This has never happened to me in 20 years of mental health treatment."

"Well, sometimes novelty can be very meaningful."

Something seemed to just take over. I no longer was worried about what I was saying or felt the least bit defensive about what had occurred. The words just seemed to flow out of my mouth. Maybe this reaction is akin to what happens in an emergency when you just react and have little time to think about what you are doing. Later, you may have little or no recollection of how you reacted, but it was the right thing to do. Or, maybe I had stumbled onto something that I read later in a book by Minuchin (1974) that you need to learn about how to do therapy and then forget it when you are in a session. The therapist must learn to listen to his or her intuitions about how to intervene rather than follow a prescribed course.

"Well, the only meaning I see here is that you slept through our session."

"I'd like to share some thoughts I have about it if you're willing to do so."

"Why should I? What could I possibly learn?"

"You have every right to feel this way, but can I ask you just one question?"

"Well, I don't know. You had the opportunity before, but you were asleep!"

"OK, it's your call, but I think this question is very interesting."

"I'm really upset about this and I'm not going to let this drop!"

"So can I ask the question or not?"

"OK, just one question and that's all!"

"If you can answer this question, you can walk out of the room and demand another therapist. You can stand in the hallway and yell in a loud voice: 'Tom Roberts fell asleep during my therapy session' or anything you want to do, but if you can't answer this question, you will sit down and we'll continue talking about it. Agreed?"

"Yeah, I'd like to see this. Agreed."

"The question is: how could you continue to talk with me for 20 minutes while I'm sleeping and not know it?"

A puzzled look came on his face. He rubbed his chin, scratched his curly hair, smiled, and said in a boyish, teasing manner, "Well, I don't know, but it still doesn't justify your sleeping."

"So you really can't answer that question."

"No, I can't," he said as he slowly took a seat.

What happened next was just short of a miracle given the circumstances. Larry took a seat and the anger disappeared. I admitted that I had trouble staying awake because of getting no sleep the night before. I also suggested that he didn't seem to need me to pay attention because he talked nonstop. I explained that I lost interest in

the conversation because he could talk without needing me to respond. The idea that he could talk to a sleeping person for 20 minutes without knowing it intrigued him and became a metaphor for later treatment with him. I believe in the 30 minutes that followed he saw himself differently. He saw why coworkers avoided him and why he had difficulty sustaining relationships. We made a contract where I was to act as if I were sleeping and he had to talk slowly and pause enough to catch me napping. During subsequent sessions, I would close my eyes and he would ask me to repeat back what he was saying.

Larry was actually on my caseload for about seven years because I continued at the center for a few years after I completed my degree. During this time, he had no remissions and established his own residence. He got rid of his mental health professional patient cards and tried to find power in being sane instead. His father had a stroke and he moved back home to help his mother until his father died. We both had many cautions about this, but he did not regress. He developed a few friendships, but was still working on establishing and maintaining long-term intimate relationships when our therapeutic relationship ended when I moved out of state.

While I have seen many clients over the years since this incident, and had other situations that did not exactly go by the books, I can say that I learned more from this situation than any other I recall. First, I learned that you can use almost anything that happens between you and a client therapeutically. Therapy is primarily a relationship between people and when something occurs between the participants, the possibility of change is increased. I believe that a therapeutic change occurred with Larry because I reacted to him as a person first and didn't hide behind the therapist role. I reacted the same way I would have to my wife if the same situation had occurred. The question I asked Larry about not knowing that I was sleeping wasn't thought out, nor did I expect a certain outcome. I was simply curious how this could happen. I knew that had the situation been reversed and he fell asleep on me I would be aware that he was sleeping the moment he dozed off. The question for me was, "How could he not know this?"

His experience as a client contrasted somewhat with my inexperience as a therapist. Perhaps this inexperience helped in that I did not know the game well enough to play my part well. Not knowing the game of therapy freed me to relate to Larry in an open manner. I believe it also gave him the freedom to relate to me honestly as well. Even his anger seemed appropriate and I think I would have felt the same way had I been him. As the game of therapy changed to a discussion of two individuals attempting to understand something that happened between them, a more spontaneous interaction emerged.

Second, I learned that the therapist should not be afraid to push on the client. Therapy does not take place in a closed cloister in which there is only protection of the client. To grow, clients need to be challenged. The therapy room should be a microcosm of the real world in which there are real happenings. A therapist should not be afraid to interact with a client in the same manner that he or she interacts with significant others in his or her life.

Over the years I have noticed the work of colleagues and acquaintances who do therapy. I have much more concern about "nice" therapists who want all interactions to be kind and non-intrusive than I do about therapists who use confrontation. I am, of course, not suggesting that therapists abandon developing empathy. But I do believe that we have to let our clients know that we are real people with the same

emotions that they have and that we sometimes make mistakes and sometimes don't have answers. I believe that a good therapist is never too nice to be human.

Third, the therapeutic moment in which change occurs can happen at the time one least expects it. I certainly did not expect to have a therapeutic triumph after falling asleep in a session, but it happened. I certainly would never supervise students by suggesting that they sleep during the therapy session, but I would certainly tell students to never be afraid of what is happening in the present between them and the client.

I am reminded of a similar situation that occurred during supervision with a student. I was behind a one-way mirror observing a student conducting a therapy session with a single mother and her three children. The family had been referred by the department of family and child services because the 16-year-old son had been physically abusive to his twin 12-year-old sisters. The mother was functioning as one of the children rather than as the parent. Consequently, no household chores were being completed and there was total chaos. The 16-year-old son was attempting to take charge of the family, but didn't know how to do it. He attempted to spank the sisters for not following through on doing chores. In the session, everyone was talking at once. There was no order and the student/therapist was floundering. About halfway through the session, I buzzed the room and asked him to step out for a conference. I suggested that he lend support to the mother to reestablish her at the top of the family hierarchy and to free the son from assuming this responsibility. While I didn't tell the student how to establish order, I suggested that he set up some rules in order for the family to communicate with each more effectively. I thought it was much better for the student to think about this and decide how to address it from his own perspective than to tell him what to do.

When the student re-entered the room, the same dysfunctional communication patterns emerged. Again, there was no order and everyone was talking at the same time. After about 10 minutes, I was ready to buzz the room again for a second conference, when the student/therapist jumped to his feet and yelled in a very loud and intimidating voice, "Shut up!" You could have heard a pin drop. They all became very attentive and he pointed out how irritated he had become listening to them and not being able to structure them. He looked at the mother and said that there needed to be some rules to guide their interaction. In this way he engaged the mother to take some authority in the family. Putting the mother at the top of the hierarchy was built on in subsequent sessions, and over a short time the mother was helped to set consequences for the children and assume a parental role. While I would not endorse a therapist yelling at a family, I believe this intervention was successful because the student/therapist communicated in kind with the family. They were so used to yelling at each other that they didn't know how to respond to his genteel attempts to establish order.

Fourth, when you make mistakes in therapy always be truthful. The fact that I was truthful may have been the main catalyst in working through this situation. The temptation for therapists, sometimes, is to take the high road in the sense that we know more than the client. I believe that this posture creates a hierarchy that robs the client of his or her dignity.

If I had taken the high road by focusing on Larry's anger and his losing control, he would have been very comfortable with this arrangement because he had been put in this place so many times before. He would have demanded another therapist, who would have to deal with his anger, and the

escalation would have lasted until he found himself back in a mental hospital. Fully acknowledging the mistake and addressing his lack of knowledge of how he could talk to a sleeping person allowed both of us to grow.

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Gender Battles I Have Known and Loved: The Evolution of My Development as a Therapist Treating Men and Couples

By Nancy Decker, LCSW, Colorado Family Center. The author has held medical, psychiatric, and administrative social work positions in private and public health care organizations in the Denver area.

This narrative is a reflection on the cognitive and emotional process through which therapists attempt to develop empathy and understanding with clients in treatment. Developing empathy when clients and therapist differ significantly in terms of their cultural characteristics, such as gender, often presents particular challenges and opportunities in the course of treatment. These challenges and opportunities are examined in the context of the interrelationship between one female therapist's own personal and professional development.

"Being a woman is a terribly difficult task since it consists principally in dealing with men." Joseph Conrad

A more relevant paraphrase to the above quote might be: ***"Being a psychotherapist is a terribly difficult task since it consists principally in dealing with persons of gender."*** Over the course of a long career as a clinical social worker, I have had many opportunities to work with a variety of adult clients—individuals, couples, families, and groups—as they struggle with painful relationship issues related to sexuality, emancipation, marriage, work, divorce, custody, and life. This work has led me to think about and experience the process of empathy—both its strengths and limitations—in new ways. Most recently, I have reflected about my understanding of the gender roles of the men and women clients I see in treatment. This narrative attempts to describe both the *inner process* of the therapist as well as the *external interactions* with clients regarding gender issues and conflicts. It also describes the evolution, which has occurred over the years, of my own personal and professional journey in understanding these issues.

A Cognitive and Affective Exercise in Empathy Development

Sometimes I try to think about what it would be like to be a man. I consider what it would be like to be taller, to have more muscle density, to shave my face, or, alternatively, to have "stuff" growing from it. I try to imagine what it would be like to feel sadness and believe I should not weep but only flex a muscle in my jaw. I wonder what would it be like to feel the burden, deep within my being, of whether my children had food and clothes and to be constantly worried about being adequate. I'd be scared, and I might not even know it; I certainly couldn't say so if I did. I would have to compete about everything. I'd have to protect my turf or territory. I wonder whether I would be energized or exhausted by that constant effort.

I think about the song from the PBS children's television program *Mr. Roger's Neighborhood*, about "...some bodies being fancy on the inside and some on the outside." If I were a man, I guess I would focus on "fancy on the outside," like the two fiftyish men I once saw outside a newborn nursery. As they watched a *moments*-old newborn baby boy being diapered, one commented to the other, "He's sure going to make the girls happy some day." As a man, I wouldn't (or couldn't) ask for directions, and I'd be the one expected to lift heavy things and climb on ladders. As a man, I'd live in a culture that both sanctions male violence and prepares men to be sent to war, as psychiatrist Joan Shapiro (1992) has written. If I had been a man in military service, espe-

cially in wartime, I might be full of unspoken, unutterable sadness, confusion, and anger.

Mostly, though, I just try to imagine about how I would think and feel if I were a man. And, of course, there really is no way I can. Empathy can take one only so far.

Steps in my Personal and Professional Journey

These imaginings come from my work in providing "relationship" or couples therapy as well as individual psychotherapy with men. They are also part of my own maturation, or as I like to think of it, "trying to figure out some of the mysteries of the strange planet on which I live—which, by the way, is neither Mars nor Venus." The steps in my evolutionary journey, as seen from the vantage point of today, were uneven and not always forward moving:

1. In the earliest stage of my development, I had little conscious awareness (read clueless) of the implications of gender differences. All I knew was that there were some of each and they were different but co-existed, kind of like cats and dogs. I expected to be treated the same as anyone else, and assumed men and women were pretty much the same in how they viewed themselves in the world. In other words, if I thought about it at all, I thought more about differences among *individuals* than between *genders*. I think I wasn't a very good couples therapist during these years; in fact, part of this stage took place during my young adulthood before graduate education in social work.

2. Gradually, a different stage emerged through which I became more aware that men have been in charge of many significant aspects of my life (read power). For example, I was surprised to discover in the workplace how women can be disenfranchised by the flow of information controlled by male superiors. You know the drill—memos not received (or sent, for that matter), information not shared, input not solicited, decisions made unilaterally, feedback not accepted, and accountability conveniently on holiday. I once showed the administrator of a small psychiatric hospital a memo I'd written. The memo was notification of the layoff of a social worker on my staff. I'd begun the memo with "I'm saddened to tell you, etc." The administrator responded, "I wouldn't say 'saddened.'" In my thoughts I came back with, "I not only *would* say saddened, I *did* say it, and what's wrong with you that you don't feel sad about taking away someone's work!" Then I wondered to myself why I had shown it to the administrator at all, since it certainly wasn't his approval I was seeking. During this period, I'm not sure exactly how my practice was affected. These were the first occasions upon which I began to *think* of such matters. I began to chafe from this kind of treatment, on my own behalf and that of other women.

3. From this awareness, I developed a moderately assertive feminist bent (read polarized). During this stage, I once acidly commented to a revered male colleague, "All men are fascists—present company excluded!" This outburst was driven both by personal issues (an unraveling marriage) and professional issues (the need to fight the oppressive tactics in an agency headed by an exploitative man of questionable ethics).

At this professional juncture, I would not have been terribly empathic toward male clients. Fortunately, my work then was primarily administrative, so the harm I might have perpetrated was limited. It was, however, the period when I first became aware of the *mother bristle*, a concept I will elaborate later in this narrative. For now, I define it as the reaction of men to their perception of being treated by a woman in a controlling, maternal manner.

I experienced this reaction in a conversation with a staff member (man) and a psychiatric colleague (also a man), who had been having trouble with his knee. We stood talking, and at the end of the conversation, I commented to the psychiatrist that one of his shoes was untied. Immediately, the two men began talking, for my benefit, about how they "just didn't know how they managed to get dressed in the morning without someone (a woman) to direct them." I joked back, "Okay, go ahead and fall on your gimpy knee." Something similar happened with a later group of colleagues, two women and a man. This time we talked about what had happened and identified how different the message sent was from that received. The women perceived themselves as trying to be considerate and helpful. The male point of view was, "I'm able to take care of these things by myself." Although not clinical examples *per se,* these experiences become miniature laboratories in which male-female communication and interactions can be taken apart, understood, and applied to clinical interactions.

4. Most recently, I have been gentling my view of the other 50% of the world's population (read more tolerant and curious). It has been during this time that many of the ideas discussed here have emerged. I'm trying to become more accepting of many aspects of life as I grow older. I'm still a feminist and feel impatience with the inequities women suffer. I wish I could say I'm less reactive, but my recent response to a male colleague who used the term "schizophrenogenic" gives that the lie. (This outdated term implies that the genesis of schizophrenia lay with mothers giving "double bind" messages to their children, especially sons.) Also, I've concluded men are as befuddled about relationships as women are—*but differently*. And I get a chuckle over cogent observations, such as the bumper sticker I saw recently, which read: "Eve was framed."

Application to My Work with Clients

What meaning does my own journey and these attempts at empathy imaginings lend to work with couples and individual men? Early in my career, my contact with couples was largely around helping them parent more effectively. I was fortunate in having solid instruction in a theoretical understanding of the development of "couplehood" (Solomon, 1973), but had limited opportunity for practice application in strictly marital therapy. One major difference between my understanding then and now is that I recognize I don't know as much and am not as empathic as I used to think I was—simply because I can't be. I'm as limited by my own gender as the men over whom I felt smugly superior to during the third phase above. Earlier, if inklings of these issues ever crept through my conscious awareness, I reacted defensively and felt uncomfortable. After all, I was an experienced therapist and supervisor who talked, thought, and taught about self-awareness—that should handle it, right? Wrong!

Some of the things I have tried to do differently with couples and the men I currently see in treatment are:

1. *Acknowledge my own limitations.* It seems relieving to couples when I speak of the inherent limitation I bring as a female therapist. Sometimes the limitation seems to

favor the man, sometimes the woman, but no matter which way it goes, it seems too important not to acknowledge it. Sometimes I can serve as a sort of translator. For example, I have begun to speak to women about the heartfelt meaning for men in being the provider for the family. Perhaps it is a vestige of the role of the hunter who fed his family by bringing home the prey. But I know that when I was a single working parent, earning and providing did not touch my identity in the powerful way I've heard men describe. I knew I had to carry out the responsibility, and it was sometimes pleasant and energizing, sometimes not. I never thought about it in the way a male client did, who told his wife repeatedly that he shows his love for her every day by going to his work. When I was threatened by a possible layoff, and later when I actually was downsized, I felt mad and scared and unappreciated. I wondered if I was disliked, and thought of mistakes I'd made, but never did it occur to me to question my adequacy *as a female*. Even though I really don't understand this from my own experience, I've heard about it from men and read enough about its importance to be convinced. So I can say, "You know, this is one of those 'guy things' in which your husband expresses something in a way that

makes sense to him."

2. *Educate clients about possible biological bases for gender differences.* In contrast to the earlier views I held during phase three of my development (when I attributed the differences between men and women to socialization or acculturation only), I now have a greater appreciation for the contributions of biology. The advent of new information from neuro-imaging techniques like MRI (magnetic resonance imaging) and PET (positron emission tomography) gets us closer to understanding the apparent differences in the ways men's and women's brains work. Researchers now can look at gender differences using these techniques: see, for example, the work of Rubin and Raquel Gur and their colleagues (Erwin, Gur, Gur, Skolnick, Mawhinney-Hee, & Smailis, 1992; Gur, Skolnick, & Gur, 1994; Shtasel, Gur, Gallacher, Heimberg, & Gur, 1992) and George, Ketter, Parekh, Herscovitch, & Post (1996). It becomes possible to refer to those differences in behavior that are "guy things" and "girl things" in a psychoeducational way. For example, women might be reassured to know there *may* be a demonstrable, physiological, perhaps evolutionary, basis for the way men can compartmentalize their focus in a way that women don't understand, because they don't experience it. Because we women can, and often need to, attend to more than one task simultaneously, we often are both puzzled and infuriated by men's single-mindedness. A common response is to believe the man in her life is ignoring her "on purpose," assuming his behavior is conscious and deliberately hurtful.

Similarly, both men and women may find it helpful to know that the way they respond to children also may have physiological roots; e.g., female brains are thought to be twice as sensitive to sound as those of males. Therefore, a father may not be aware of the noises made by children as quickly or attentively as a woman might; this, in combination, with his single-minded focus on the task at his hand, *may* make it seem that he is uncaring or inattentive. Part

of this type of educational work in therapy helps couples *depathologize* the different behavior they observe in their partners. The final word isn't in on whether these findings show innate differences between genders or whether the differences represent adaptation to socialization factors. Nonetheless, the information about physiological brain differences gives me an alternative way to think about gender-related behaviors. It also helps me understand how it is that sensitive, caring women raised the men who have difficulty with perceiving and responding to feelings in themselves and their partners.

3. *Be aware of gender differences in the recognition and articulation of emotions.* One of the thorniest problems for female therapists and women in relationships is the apparent ability of women to register others' emotions more accurately than do men. According to Hagan (1996), "Brain imaging studies found that women could detect more accurately than men whether faces flashed on a screen were happy or sad. Apparently, women's brains don't have to work as hard to recognize emotions" (p. 2E). Female partners often feel uncared for when men don't acknowledge their feelings. Similarly, Dr. Shapiro (1992) writes that men truly don't comprehend, or even see, women's feelings. This is so partly because of their acculturation as soldiers and also due to their need to be, at all costs, *not female*. Any characteristic or behavior seen as female or feminine is anathema to men. They distance by dissociating themselves from such things.

Recently a thirty-something man working on relationship issues wryly commented that he tries to please his girlfriend: "I even go to chick flicks with her." He meant the kind of movie seen as appealing mostly to women because of themes that explore family, relationships, and love. Because women spend so much time thinking about those themes, they are drawn to such films. Men can see these films without losing face by acting as if they are only doing so *for* their wives or girlfriends, a distinction that apparently avoids any *feminine threats* to masculine identity. And truly, men seem genuinely puzzled about what these film stories are about. Well I remember the lunchtime discussions at work when the movie "The Piano" was in theaters. The men had been good sports and taken their women partners to see the movie. While the women rhapsodized about its romanticism and eroticism, not only didn't the men understand why women liked it so much, they couldn't figure out what it was about. Instead of feeling hurt and assuming men "just don't get it," women may benefit from taking a more neutral, understanding stance, perhaps teaching men how to understand emotions or establishing "prompts" between them that are easy for men to read.

Teaching men about feelings is very

much part of my role as a therapist with couples and men. I do this by interpreting and translating. I might see a man struggling to identify his feelings, especially after his wife has rattled off her well-articulated version. I would say something like, "Let me see if I can reflect what I think may be happening—and then you tell me if I have it right." After I summarize what I think his experience has been, I ask if I have come

close to the mark. Men often say, "That's exactly it." With women I would be more likely to ask brief clarifying questions because most of the time they will tell me a great deal about their feelings. I wonder if this works because men can save face; they are not exposed as being inept at something. This is modeling for both partners—for him to hear something about how to articulate emotions, and for her to see how she might give him prompts. It may seem unfair that women have to do this extra work in their primary relationship, but that seems to be the way things are.

The following case example of men's difficulty understanding women's feelings illustrates this point. Ken (not his actual name), a successful engineer with a Fortune 500 company, was in an accelerated graduate program as well. It was his behavioral response to the combination of full-time work, his studies, and his family that had brought him to seek treatment. In the course of our work together, he related the following incident: his all-male study group planned a camping and fishing trip during the summer break. To finalize the plans, they met at one of the men's homes for a get-together with their wives, who, of course, prepared food for the event. Ken and his colleagues were amazed that the wives thought they were included in the camping trip. However, this had never been the men's intent. The wives were equally amazed. Some were outraged, others hurt, but all felt ill-used by "catering" a get-together where spouses would be planning an event from which they were excluded. When I asked Ken what he thought it would be like to be in his wife's place, he easily saw "what was wrong with this picture." He said he would take his new understanding back to the other men. It had not occurred to a single one of them to anticipate the outcome of their plans. I had to subdue my initial internal response of "How could you not figure this out? After all, your jobs and your studies must constantly require you to anticipate possible outcomes of courses of action." However, the skills men learn in their instrumental or task roles in the world of work apparently don't translate into the world of relationships and the tasks of intimacy. As a woman and as a therapist, I still have times when I just can't believe men don't *know* about feelings, and I have to consciously remember and adjust for the fact that not everyone is like me—especially men.

4. *Address intimacy vs. independence*. Another dilemma occurring between men and women is the "consultation/consideration" versus "permission" matter. Deborah Tannen (1990), in her book *You Just Don't Understand*, sets it out as follows:

> When Josh's old high school chum . . .announced he'd be in town the following month, Josh invited him to stay for the weekend . . . He informed Linda that they were going to have a houseguest, and that he and his chum would go out together the first night to shoot the breeze like old times. Linda was upset. She was going to be away on business the week before, and the Friday night . . .would be her first night home. But what upset her the most was that Josh had made these plans on his own and informed her of them, rather than discussing them with her before extending the invitation. Linda would never make plans, for a weekend or an evening, without first checking with Josh. She can't understand why he doesn't show her the same courtesy and consideration. . . when she protests, Josh says, "I can't say to my friend, 'I have to ask my wife for permission!'" To Josh, checking with his wife . . .implies that he is not independent, not free to act on his own. To Linda, checking with her husband has nothing to do with permission. She assumes that spouses discuss their plans with each other because their lives are intertwined (pp. 26-27).

Dr. Tannen describes this as an issue of intimacy versus independence, noting all of us have longings for both. My own view is that there is a constant tension between autonomy and connection, both within ourselves and between ourself and anyone else with whom we have a relationship. The closer and more important the relationship, the more prominent the tension can become, especially if one partner is in the autonomy mode and the other is wishing for connection. In odd contrast to Josh's independence, it's not unusual to hear from wives, "He said he wasn't going to *let* me drive so far by myself" (italics mine). The activity under discussion varies, and let's be clear that we're not talking about the kind of controllingness that can lead to verbal or physical abuse. These statements come from well-meaning husbands with genuine concern for their wives' well-being. My response as a woman falls on the independent side: "I can drive that far by myself just fine, thank you." Bringing this response to the therapy room would be a disservice to both partners. It seems more helpful to reframe the interaction so that the husband understands how much his wife values her competence, and the wife can view his comment in a more positive light, as protective of her because of his love for her. This seems to be part of what men perceive (although not necessarily consciously) as their duty. Perhaps it belongs under the umbrella of taking care of his family by both providing for and protecting them; it's his job.

5. *Address infantilization.* In my observations, men are more sensitive than women about being treated in a way they perceive as infantilizing, especially by partners. I've come to label this in my head as *mother bristle*, and when I used this term recently with a couple, they nodded and smiled, understanding perfectly what I was conveying.

The discussion was about the wife having asked the husband, "Did you already take the trash out?" The husband's response was: "You sound just like my mother -always on my case about something." In fact, she was asking if she could go ahead and mop the floor if no more mess would get spilled on it. I believe it is this fear of infantilization that makes it so hard for some men to tolerate empathy. I can only conclude that there is something very complicated for a man about being nurtured and disciplined by a woman, acculturated not to identify with the nurturer (remember the *not-female* dictum), and then having to choose someone of the nurturer's gender as the primary partner in adult life. In this context, less experienced female therapists quickly learn that empathic comments to male patients are best delivered with the volume turned down low. To do otherwise is to overwhelm some men and invite their defensiveness.

6. *Understand gender differences and sexuality.* How to understand the different meaning sexual intimacy has for women and men, as well as the different physiologies involved? Most of us have heard the saying, "Men make love to have sex, and women have sex to make love," or one of its several variations. A chance comment by a male colleague in a recent discussion about this paper has given me a startlingly new way to think about this. He spoke of men experiencing emotional connection after physiological release during sex, whereas women talk about needing connection first. Wow! I'm going to have to think about that one, and unlike other gender topics, it will be hard to find a way to talk about it with male friends and colleagues. I doubt if the next staff meeting or case consultation will be a format for inquiry. Perhaps in this, as in so many areas, I will be instructed by clients. This idea as

to when emotional connection occurs seems but one of the strange mismatches that plague men and women in their physical relationship, along with the well-known differing ages at which sexual interest peaks in women versus men. Who designed this cockamamie system anyhow? Women speak of wanting non-sexual touch that helps them be sexual at other times. Trouble is, men sometimes become aroused by this kind of touch—maybe for them that's "the beginning of the beginning" of their emotional connections. Although not a sex therapist, I've had some success in working with couples and individual women by presenting the idea that sexuality is a gift they can offer their partners. Similarly, I have reframed a husband's very frequent expressions of interest in sex as very flattering and validating to them: "You're the one he is attracted to, you're the one he thinks is gorgeous and desirable." This approach can sidestep some of the "if he cared, he would . . ." statements women clients bring to therapy.

Psychologists Dan Kindlon and Michael Thompson, in their 1999 book, *Raising Cain,* present what to me, as a female, is another startling notion about men and sexuality. In their chapter "Romancing the Stone," they remind us that nearly all boys masturbate, starting as early as eleven years of age. Despite braggadocio that would suggest otherwise, boys usually don't have their first experience with intercourse until much later. "A boy's experience with masturbation means that he begins to build up a library of sexual memories in his head long before he has any *partnered* sexual experience in adolescence [italics mine] . . .What people might not realize when they justly criticize men for *objectifying* sex—viewing sex as something you do rather than part of a relationship—is that the first experience of objectification of sexuality in a boy's life comes from this experience of his own body, having this penis that makes its own demands" (pp. 204-205)

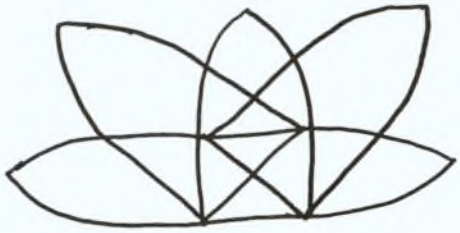
7. *Use metaphors: O. Henry's short story of the "Gift of the Magi."* One day in a therapy session with a couple, I asked them if they recalled the O. Henry story, "Gift of the Magi." Initially they didn't, but as I sketched it briefly in five or six sentences, they began to nod as they recalled it. Nearly everyone recalls it at least vaguely from high school English. The story is of a recently married couple living in turn-of-the-century New York City. They are poor, and Christmas is coming. Each wants to give the other the perfect gift. As they open their gifts, they discover that the wife has cut and sold her hair to buy a fob for the watch he inherited. He has pawned the watch in order to buy tortoise shell combs for her beautiful long hair. I now frequently bring up this story with couples because it is a succinct operational definition of empathy between a couple. Because it's a story, the couple may be able to reflect on it more easily; it isn't about them and the injuries each has suffered from the other. I find metaphors very helpful because they make the complicated relatively more simple. If a metaphor is effective, it will come up again with clients. So it can become a kind of shorthand. If I referred to "the gift" in working with one couple, all three of us knew we were referring to their sexual relationship. Further, if I use a metaphor and check with clients for agreement/understanding, I know we have established some commonality of understanding despite differences in age, culture, experience, and gender.

Conclusion

So I can't really imagine what it would be like to be a man. I doubt I would relish a man's roles and responsibilities. My ongoing internal musings about gender roles continue to be stimulated by chance com-

ments and stories from friends, family members, and colleagues—little bits and pieces from here and there. For example, recently a therapist told of having a "fear-based" response to seeing a young child harshly disciplined. Or the story told about three-and five-year-old boys who were having a discussion about birthday cakes. The younger one said he wanted a Barbie cake on his birthday. When told they were for girls, he persisted until the five-year-old firmly told him he couldn't have a Barbie cake because that would make him become a girl. In addition, there always are further examples of *mother bristle* to observe. Although the bits and pieces haven't settled into a totally clear picture, I continue to collect and reflect upon such incidents.

I like most of the men I meet, and truly treasure a few. Men are generally fascinating, confusing, intelligent, attractive, exas-



perating, creative, and oh so different! I've learned a great deal about the world and about myself from men. And in writing this narrative, I've learned even more about men. One can hope that greater awareness of the nuances of men's experience makes for a more sensitive therapist. As a human, I abhor the things our culture does to and expects from men. When I hear that part of the male experience, I feel sad and want to say, "I'm so sorry. No one should have to endure such things."

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Poems and Reflections

By Tiffany Bucknam

The author is currently a first year MSW student. She has previously worked in schools and early childhood development settings and has provided counseling services in residential treatment centers. She also is a consumer of mental health services.

But Suddenly

But suddenly you find yourself in the middle of a busy street
blaring cars noisily whizzing by you
while you teeter on the white line
as though it could protect you from the encroaching danger.
But the intruders still come, running,
pounding down your door
ringing on the telephone
haranguing your every moment,
haunting your sleep with angry sounds of demand, desire,
and violation.
All the while, responsibility
weighs on your shoulders
as though your jacket weren't leaden enough
and no struggle had already beaten you down.
Inside
the glass cracks
under all the pressure.
You stand, in the black nothingness,
exposed on a cliff of stunted desire
Alone.
Surrounded by the dark, you look down
to see only your naked feet,
watch, impotent, as your hands grope blindly,
madly,
desperately,
for something that isn't there.
So you stand there, on the edge,
abandoned.
Screaming.

Untitled

Suicide
is the complete loss
of the ability
to feel
anything.

Did you know you saved my life last night?

In my needy state,
I closed my tear-blinded eyes
And groped for something tangible to hold on to.

And you were there.

Which is why I'm here.

Robbie

An art therapist once shared a technique with me: the practice of creating art alongside the client during his/her session. I think this is a powerful tool, one that adds depth to my understanding of clients and is, at the same time, cleansing. I wrote the following poems while observing special education students in mainstream classes. This was part of a study on how the classroom system creates child outcasts among some of its members. I am not using the client's real name.

DON'T turn your back on me.
DON'T close your eyes.
I'm lonely, dammit, and I need you.
DON'T turn your nose up at me.
DON'T look away.
You're hiding from me but I can still see you.
DON'T pretend you don't notice.
DON'T move farther away.
You can't hear how my heart cries,
Or see how much it hurts me.

PLEASE turn your back on me.
PLEASE close your eyes.
My loneliness is my shelter from your pressures and my awkwardness.
PLEASE turn your nose up at me.
PLEASE look away.
It lets me hide a little better,
Withdraw into my shell.
PLEASE pretend you don't notice.
PLEASE move farther away.
I'm embarrassed by my pain
And the power you exert over me.
But don't be surprised if you turn around one day
And I'm not here.
Because the tighter you close your eyes, the easier it becomes for me
To disappear.

Fragment

Sweatshirt and jeans all one color:
ashen blue, the color of the steel,
polluted sea on a lifeless, dreary day.
I saw that sea when you looked up
with your pain-angry eyes
unkempt wheat hair, strewn from your ponytail
across your furrowed head, falling into the sea,
the gray sun blurring the boundary between
sky and sea on that same dreary day.
Who put you there, child?
Set adrift on that
which has now consumed you.
The boys near you teaching each other how to be
angry, energetic, and repressed. The subtle
tremble under the surface, brief-shifting—
rattle, tremor—not sure of
sanity, not sure of reality, except that it's buried
and ready to let go. A mirror?
The source of the waves on your sharp seas common?
Except that on your driftwood stronghold,
there is room for only one. Only lost.
And in your pleading eyes,
only scared.

Repetitive: A Reflection

I remember being scared as a small child kneeling in the corner waiting for a blow or a yell or a "you can go to bed." I remember being scared of the boogey man that was under our bed and in the closets and huddling up giggling nervously and waiting for mom to come in or for the boogey man to come get us or for sleep to come, because it was all the same anyway. It was dark—it was always so, so dark no matter how bright the lights were it was dark and I remember being scared of the dark so scared. I grew up at some point, with a little girl who remembers being scared in my heart and she remembers being scared so well that it just never goes away. And that darkness, of which I was so afraid, also never went away and it stayed part of me and I began to wonder maybe it is me and I remember being scared of the dark and if I'm scared of the dark does that mean that I'm scared of myself? And if the darkness which is me makes me scared of myself and what does that mean? Does that mean I might hurt myself? I remember being so scared of the dark and then there were blades and pills and deep, dark pools of blood and water. And I don't even have to remember being scared of sharp objects and pills and depth and dark and blood and water because I'm still afraid of all those things. And I remember being so scared of the dark and of myself long after the pills and the deep dark pool went away, lest they return again—which they did, every night in my dreams. I remember always being scared of sleep because the boogey man and my mom came to get me in the dark depth of my slumber and my dreams aren't dreams anymore but nightmares and I can't even sleep because it hurts then, too. I remember being scared every night before bed because I didn't know who was going to come and get me when but they always did and the fear and the sadness—the horrible, deep, dark, sadness—started to stay with me again and this time I recognized it for what it was and then I remember being scared of myself again and I didn't want to be so I went and told someone and now it only hurts while I'm asleep, even though I'm still afraid of the dark, which is no longer me.

Silken Threads Woven into Cables: Reflections on an Inter-professional Relationship and a School-based Prevention Project

By Gloria E. Miller, Ph.D., Director, School Psychology Program, College of Education, University of Denver and Connie Clifton, MSW, LCSW, school social worker, Denver Public Schools

A school psychologist and social worker brought together while collaborating on a middle school, truancy, and drop-out prevention project called the Alliance Team Program, jointly wrote this article. The program was conducted within a largely Latino, urban middle school where student disengagement and disenfranchisement were identified as top community and school concerns. This article is about the personal discoveries they made over the last three years while collaborating on this project. It is their hope that their professional journey will stimulate discussion on how best to promote inter-professional relationships, because they provide the cornerstone for preventive, school-based, therapeutic efforts.

Introduction

We viewed the invitation to contribute to this special issue as a unique opportunity to share our ideas about an ongoing school-based prevention project, called the Alliance Team Project (ATP), which has played a major role in our professional development during the last four years. This project is designed to build adult-student relationships during the transition from elementary to middle school as a means of preventing truancy, disengagement, academic failure, and dropout. Nationally, these issues affect over one-half million middle and high school students a year. In Colorado schools, non-completion rates have ranged from 20-24% in the last two decades. These figures, however, hide the substantially higher school dropout rates associated with students of color. On a national level, up to 35% of all Hispanic school-aged students will not graduate with a traditional high school diploma (Hispanic Dropout Project, 1998). Unfortunately, these statistics are even higher in the school where the ATP is located.

Our goal in this paper is to focus less on the details of the project and more on the critical, interpersonal relationships that developed from this work. The project began with a simple premise, to strengthen adult-student relationships by inviting teacher-identified students to join an after-school team that would focus on leadership and community service. While the development of an alternative school-based venue to build prosocial adult-student relationships was the original focus, it was not long before we realized the relationships we sought to foster with students had a strong impact on our professional relationship as well. This article is about the personal discoveries we made while collaborating on this prevention project. We have chosen to focus on the relationships that sustained us, broadened our professional knowledge, and, most importantly, transformed our clinical competencies and supervisory skills.

Joining Forces

Our prevention project was propelled somewhat fortuitously by a joint concern for a particular, urban neighborhood. Connie

had recently been assigned as the new school social worker within the ATP community to work specifically on a state-funded truancy, suspension, and expulsion prevention project. Along with her school social work supervisor, Virginia Castro, Connie had instigated a pilot project for transitioning fifth-graders that involved a series of experiential outdoor leadership activities (i.e., rock climbing, a low ropes course). She also had conducted several fifth-grade focus groups where students were asked to express their fears and concerns regarding this transition.

Gloria, a new faculty member in school psychology, was committed to collaborating in local schools. She immediately had joined a university-community partnership based in the same ATP community. This partnership, composed of school administrators and staff, community members, and University students and faculty, had been in existence less than one year and had been an outgrowth of the University's service learning program. Its purpose was to collaborate on solutions to community-identified problems. The transition to middle school and the high levels of student academic disengagement already had been identified as top neighborhood concerns. Gloria volunteered to meet with a subcommittee of professionals, parents, and community members already working on these issues, and it was here that she met Connie's supervisor. A subsequent meeting with Connie and her supervisor, to share ideas and strategies, eventually led to our joint collaboration on an entity called the Alliance Team Project.

We came into this joint project with no false illusions. Each of us had prior responsibilities for developing, implementing and coordinating other projects with multiple stressed families and children in urban settings. Gloria had over twenty years of university and public school teaching, clinical experience, and supervision of practicing psychologists in school settings. Connie had over twenty years of social work experience in a variety of agencies, had successfully weathered the storm of raising two teenagers, and most recently had established an outstanding reputation as a school-based social worker and supervisor of social work interns. While our combined history added confidence to pursue this challenge, it also had seasoned our sensibilities about the fallibility of school-based prevention efforts to address complex phenomena.

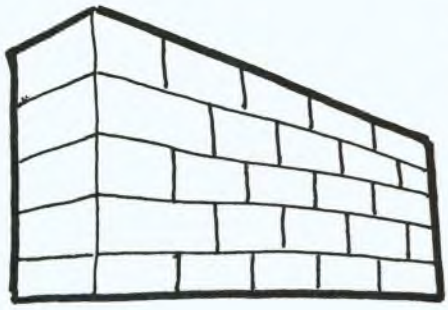
Building A Foundation

As we look back, it is not clear what explicit steps we took, yet somehow our earliest actions affirmed our shared beliefs and values, enabled us to build a strong trustful relationship, and led to a greater appreciation of each other's positive personal qualities. In retrospect, this common ground established the foundation of our relationship and forged a deep mutual respect that has permeated all of our subsequent work.

We immediately discovered our shared views about prevention and about what kids needed to become more successful. We both felt the traditional 50-minute individual therapy session was untenable for meeting the needs of most students within a school-based setting and saw prevention efforts as the most defensible and sustainable therapeutic strategy in schools. We also shared a distain for the label "at risk"—a term frequently attached to students unlikely to complete high school or to acquire skills necessary for higher education or employment. While well aware of the array of documented "risk variables" associated with our target population (e.g.,

poverty, alcohol or drug dependency, mental health concerns, high rates of delinquency, family abuse and violence, and single parent households), we did not feel this term adequately represented the leadership potential within these students. In fact, we informally agreed in an early meeting that we would instead use language that characterized students as having unlimited potential for educational and personal success.

Our trust in each other grew as we observed over and over again behaviors that demonstrated a commitment to the project. We both attended lots of meetings that could easily have been handled by one, and neither of us missed our weekly planning meetings. Even though keeping up with all of our other demands was difficult at times, it was as though we made an unstated pact that our planning time was sacrosanct and that missing a meeting would let the other person down. Our trust also grew as we consistently followed-through on things we volunteered to do. We remember feeling—OK this is a person whom I can really count on. This mutually demonstrated commitment helped bolster our spirits and strengthen our resolve to get the project off the ground.



Our complimentary views of each other's positive personal qualities provided another critical building block. Connie was struck by Gloria's visionary and leadership qualities, seemingly unlimited energy and enthusiasm, and ability "to be real and not stuffy or academic" with 11 year olds, with their parents, and with high level officials in the mayor's office, the school district, or at the University. Gloria was struck by Connie's ability to relate authentically to students, staff, parents, and administrators and was inspired by Connie's strong sense of caring, her ability to stay focused and calm in even the most hectic situations, and her keen awareness of the needs of individual members within a group. Thinking back, we now realize that our qualities and strengths complemented each other and enabled us to forge a relationship outside of the project.

Our meetings at school were somewhat formal in order to achieve our goals and tasks, but at some point we also began meeting outside of school over lunch or dinner. These informal work sessions were productive and yet also allowed us to digress from work and to share with each other on a more personal level. These times became invaluable to us. We both recall a high point when we spent one summer afternoon hiking together in the mountains. It was clear that these out-of-school encounters allowed us to engage in discussions not only about the project and professional lives, but also about our personal and family lives, which further developed the connection between us and, indirectly, further cemented our commitment to the project.

Defining Our Vision

After several initial meetings where we shared prior experiences and accomplishments, we began to make plans for the specific format of our alliance. We now realize that the foundation of our professional and personal relationship also served as a metaphor for what we hoped to create with our ATP students.

We first reviewed what we knew from the literature on successful dropout, violence, and truancy prevention efforts. Two critical protective factors surfaced that seemed to be included on every list published within the last decade—the existence of supportive adult-student relationships and the development of individual social and leadership skills. Our initial thinking

about the project also was strongly impacted by Gloria's familiarity with a theory of social bonding, originally proposed by Catalano and Hawkins (1996). This theory stresses pro-social connection and communication with significant adults as a buffer or deterrent against negative outside influences. We were encouraged by several studies that supported the notion that meaningful participation with significant adults who set high educational expectations, who model and foster effective interpersonal skills, and who recognize individual accomplishments can strongly contribute to students' educational success and social well-being. We decided that the formation of strong adult-student relationships would be the cornerstone of our joint venture.

Next, we struggled with the form our adult-student relationships should take. We did not feel that our normal roles of counselor, therapist, teacher, or supervisor adequately stressed the equal footing envisioned as part of forming a true "alliance." The thesaurus provided us with synonyms for such an alliance: "A grouping, association, union, coalition, league, connection, or partnership." Webster's (1977) Second Edition *Unabridged Dictionary* defined alliance in seven ways, only two of which seemed to capture what we thought of as central features: "(a) a union or connection of interests between persons, families, states or corporations, and (b) a similarity or relationship in character, an affinity." A more acceptable definition was obtained from a student dictionary where alliance was defined as "a union or joining and a close association for a common objective and mutual benefit."

We decided that we would strive to build strong adult-student relationships via meaningful group activities that contributed to the welfare of others. Instinctively, we felt our development had been strongly affected by the times we unselfishly contributed to others. We shared personal stories where this sense of giving without gain had significantly impacted our childhood (e.g., taking baked goods to an old folks home, helping out at a local hospital, giving our hard-earned allowance to a food-drive) and adult lives (e.g., sitting all night with a student whose mother was ill, directing a student written play, volunteering to coach the girl's basketball team, serving at a homeless shelter). As we shared, our vision for this project was further clarified. It revolved around the notion that strong adult-student relationships were essential as students transitioned into middle school and would best be fostered through leadership and team-building experiences where adults and students collaborate on projects designed to address important needs within their school or community. While our "vision" was not entirely new, we felt that this notion of having adults and students work together on school and community-service projects was a unique framework for a dropout prevention program.

Initial challenges, doubts, and triumphs

Our next challenge was how to "sell" this prevention project to others and obtain initial funding. An after-school program format was selected because we were uncertain if the school administration or faculty would support this effort as a core "academic" endeavor. Besides, we felt that an after-school program would enable interested teachers and parents to attend and would create an informal environment where adults and students could work as "equal partners." However, funding from the school district was unlikely for an "after-school" activity that was viewed as outside the central mission of the school. While the middle-school principal was supportive, it was clear that monetary support would be unavailable from his budget, so we wrote a

grant and sent it to several nonprofit organizations.

Our stated goal was to facilitate successful transitions to middle school by increasing students' school attachment and engagement as a means of ultimately increasing high school completion. We said we would form a team of teachers, school staff, parents, sixth-grade students, and university graduate students who would meet weekly after school during the entire school year. All participating adults would be compensated in a small way for their time. We also built into our initial project funds for an activity budget that would be dedicated to team-building activities and to school and community service projects. We planned to recruit up to 20 sixth-graders by asking teachers to nominate students with potential leadership abilities, no matter if these abilities were expressed in a negative or positive fashion. Parents of these students would then be invited to an evening dinner meeting where we would explain our hopes for the project and ask parents for permission for their child to participate. On paper the Alliance Team Project was born.

It was not until midsummer that we were notified we had received grant funding from a city initiative focused on dropout prevention. While we were thrilled and encouraged by this news, we also were stressed by all the practical hurdles and required human subjects' approvals that would be necessary before we could begin the project in September. We remember the long hours that first summer and how we ended up having to divide the responsibility for a seemingly unending number of tasks. We also began to worry about how to find staff willing to work with us on this adventure. A high point was when four University of Denver graduate students signed on, two from social work and two from school psychology, and when two bilingual teachers and one counselor also made the yearlong commitment after Connie introduced the project at the initial faculty meeting.

During the initial meetings with our "new" ATP team members, we struggled with how to translate our seemingly idealistic concepts and theoretical notions into practice. Our project was located within an inner city middle school occupied by sixth through ninth grade students of whom 91% identified themselves as of Latino descent. High levels of poverty, single parent homes, substance abuse, and gang and domestic violence impact the neighborhood associated with the project. One in five families earn less than $15,000 a year, and crime rates in the neighborhood are as high as 123 per 1,000 persons. Approximately 86% of the students receive free or reduced lunches, and standardized achievement scores fall way below local and national averages. These factors often spilled over into school and manifested in high levels of peer conflict and school-related discipline. As we made plans for the project, we worried that an unrelenting force had propelled us into uncharted territory. What could we hope to know about building relationships with seemingly "alien" adolescent beings, differences in cultures notwithstanding? Were we really ready for this adventure?

We remember thinking how great it was to be working with very committed adults who were so knowledgeable about these students and the intricacies of working in this particular school. But we also felt discouraged when our early ATP staff meetings got bogged down with discussions of what we would do "for" and "to" students rather than "who" and "how" we

wanted to be with students. Maybe we all felt overwhelmed and hesitant about volunteering for something that was so undefined. Yet, we could not help but wonder if we missed important opportunities to focus on the relationships we hoped to create. While everyone implicitly agreed on the importance of this issue, practical necessity dictated that a tremendous number of "arrangements" dominated early staff meetings. Locating a meeting place, obtaining transportation, purchasing and collecting materials, following up with permission forms, and contacting all appropriate people (including janitors and bus drivers) were just a few of the many tasks to be completed.

We were elated when over 60 family members and students attended the introduction meeting and when over twenty students signed up to make the yearlong commitment. We scheduled our first meeting with students for mid-October. We found ourselves rejuvenated by setting a date to start. Yet, as we prepared for our first meeting, it was apparent that our staff was divided by "practical" versus "dreamer" concerns. Gloria, the dreamer, was most interested in focusing on how to immediately make this experience one where adults were in a collaborative versus authoritarian partnership with students. Yet most other staff members were convinced that these sixth graders would require substantial adult guidance before they could fully collaborate as equals or be expected to apply leadership skills. Thus, Gloria reluctantly agreed that initially adults would need to play a more directive, instructional role by preparing structured, non-competitive team-building activities to foster group problem solving, conflict resolution and decision making.

Our first meetings with students went well—or as well as can be expected when 24 hormone-injected, mixed-gender, sixth-graders meet after a long school day. Teachers tended to take a back seat and let the graduate students lead the meetings. Activities were conducted that centered on communication, respect, and consideration of others, active listening, and handling disagreements and conflict. Discipline was a concern since kids were tired of sitting all day and wanted to move and socialize. We wanted them to be able to do this but within a structure that also allowed us to accomplish our goals. Staff were often tired at the end of the day and did not seem to have the energy to use all their classroom-management tricks.

Much of our early staff planning time was spent discussing discipline problems and strategies. While discouraging at first, we worked through these issues and ultimately came to a compromise of structure and developed some clear ground rules so the group could move forward. It felt awkward needing to encourage our teachers to take more active group facilitator and enforcement roles so that our graduate students could learn effective group-management skills. By December, however, it seemed that a shift occurred where staff members implicitly increased their trust in each other and in the students. We began to feel that the ATP meetings reflected more of the collaborative spirit that we had envisioned. Students were encouraged to take on more mutual decision-making responsibilities during the meetings.

Valuable Early Lessons

Looking back, we think that an important impetus for this change was when the team began using part of the meeting to discuss how to spend the team's activity budget. It should have come as no surprise when the first unanimous "student-generated" proposal was to use the ATP funds to pay for an evening excursion to an indoor amusement center. Our initial less-than-

enthusiastic reaction centered on how this expenditure could be justified as a service-oriented, community project! A heated discussion of the pros and cons of this activity dominated our next staff meeting and we ended with a split decision on whether to approve this expenditure. We resolved to place the burden of justification on the students. Unknowingly, this initial spending dilemma and our subsequent staff decision to engage the students more strategically in this decision led to several critical and valuable early lessons.

• *The importance of resolving real-life dilemmas.* Never deny the cleverness of adolescents. They argued, quite convincingly (and with unanimity), that this excursion would help all members become more connected and that they would learn valuable leadership and problem-solving skills as they worked together to plan the evening's activities. Was it our imagination or was there a noticeable change in our students' demeanor as they rose to the challenge of convincing the adults that their decision had not been made lightly? In the end we went along with their decision when we realized that the collective and unanimous voice of the students actually represented the self-determination and reflective decision-making we sought to instill. Fortunately, the evening went without a hitch and it also unexpectedly fostered a great deal of family involvement since more than half of our students invited family members to attend.

• *The importance of compromise.* We were humbled! Our students were right to predict that this event would allow us to become more of a team. As a consequence of collaboratively resolving this real life dilemma, we all learned a lot about the tenacity of a group of adolescents coming into their own. It was clear to us that this experience had strengthened and ignited our relationship with the students far beyond that which had been achieved from any artificial team-building activity. We learned a valuable lesson, that our initial collaborative success would be fostered by demonstrating a willingness to meet on turf familiar to students and to work through decisions that result in real-life compromise. Finally, we sensed that our student partners recognized their input was valued and would be weighted equally in all ATP decisions.

• *The importance of staff relationships.* Another outgrowth of this activity was that it forced our adult team members to more clearly define our mission and to more specifically focus on building our own relationships. Until then, it was not clear that all staff members truly believed that Connie and I sincerely wanted to empower the team with all major decisions. We also took some explicit steps to nurture and build our staff relationships and we held a staff retreat where we explored our common mission, values, and beliefs. Most importantly, we began to share some of our personal issues and life outside of school. As we became more attuned to each other, we began to recognize that this advanced our mission in many unexpected ways. We smile thinking of one special instance that helped us recognize the benefits of improved staff relationships: during a staff meeting we listened to one teacher discuss several stressors in her life and, to our surprise, at the next meeting we all, unsolicited, brought in several needed items for her family.

Taking Pride in Our Accomplishments

Looking back over the first and subsequent years of the project, we are astounded by the variety, quality, and quantity of our team accomplishments. Each year, ATP members have planned a family activity night for the entire sixth-grade class; have

participated in outdoor and rope-climbing excursions—some in conjunction with middle school peers with troubling attendance records; and have taken field trips to local colleges and universities where they experience campus life and talk to student leaders and career counselors. During the first year, ATP members, with the help of a media arts graduate student, developed a video about what it was like to be a sixth-grader and wrote an accompanying Student Handbook. This video has been shown and the handbooks have been distributed each year as ATP students give presentations and lead school tours for incoming fifth-grade students.

At the end of our first year, evaluations from students, parents, teachers, and staff overwhelmingly supported the success of the project. ATP students reported higher self-confidence, greater social problem-solving competencies, and more positive attitudes about school and the future on several objective measures. They also improved their grades and attendance and parents reported that students evidenced greater leadership skills at home (Miller, Clifton, Whitehouse, & Reed, 1999). Our project evaluation also pointed to several important suggestions for change. Nonparticipating teachers voiced a desire to find a way to share regular information or concerns about a student with ATP staff, and ATP staff recommended that the team engage in more service activities that went beyond the school walls.

We strongly resonated to these suggestions and, in subsequent years, have taken various measures to address these concerns. Most significantly, we shifted our goals to include team activities that focus on serving one's community without expectation of personal gain. For example, in years two and three, ATP members decided to make regular visits and to bring handmade holiday gifts and cards to the residents of the local nursing home. They also planned an Easter egg hunt for the neighborhood preschool. During these and other activities, our students not only presented their gifts but also seemed to present themselves. Our favorite recollection of the magic of such simple, self-giving experiences was when a macho male student with significant behavioral challenges sang a holiday song to one of the elders at the nursing home and then encouraged the rest of us to join in for a group serenade.

Other fondest accomplishments are our recollection of students' personal stories. One initially shy and withdrawn student amazed us by volunteering at the end of the year to speak to a community grant panel about the team's accomplishments. Another student who had been referred by her elementary teacher for several high-risk behaviors became one of our most outstanding contributors and received a school-wide leadership award. A different female student with a dismaying history of family abuse and truancy has stayed in school, has continually volunteered to be an ATP peer mentor, and, most significantly, this year as an eight grader found the courage to run for the student council (which she subsequently won). Overall, these stories of personal transformation and our continued observation of students' increased poise, confidence, and leadership are the main reasons we have sustained our motivation for the project over the years.

The Challenge of Sustaining A Project

Without a doubt, three prevailing issues—change, staffing, and funding—have posed continuing challenges in sustaining our collaborative efforts. Fortunately, our ability to address these challenges have slowly and subtly been transformed over time. Initially, we were determined to attack these issues head on so that the ATP would not just fizzle and die like other initiatives

that have a great initial spark. With each passing year, however, we have moved from a kind of frenetic obsession to a more reasoned expectation that staff turnover, changing school circumstances, and the lack of continued funding are natural elements of any ongoing, school-based prevention effort. Thus, even though these issues have continued to dominate our future planning, our changing expectations have led to several important revelations.

Even within the same school and with returning personnel, there have been substantial changes in the ATP format each year. Systems and environmental changes in schools are a given. We struggle yearly with reassignments, new staffing, varying school priorities and policies, and shifting community demographics. The survival of a school-based prevention project, like the ATP, is clearly tied to its ability to weather the tumultuous storm of change. One way we have tried to accomplish this is to create flexible formats and parameters that still allow us to sustain the project's core goals and mission. Another strategy has been to encourage school personnel, who have been only peripherally involved, to take a more directive role in determining the form and function of the project.

Over the years, changing staff members have brought personal strengths and talents that add new dimensions and energy to the project. For example, after discussing the year one evaluation and setting our new goals, staff members in the second year developed several team rituals and ideas that helped foster a greater team and community focus. Meetings began with a pledge song authored by the school psychologist who had joined the team, and ended with the passing of a talking stick around a circle where each team member was encouraged to add a personal reaction to the day's activity. Finally, a bead symbolizing the theme of the meeting was added to a personal necklace and the completed bead necklace was ceremoniously given over to each partner at the end of the school year to represent the team's accomplishments.

With each passing year, our funding has come from a variety of new community agencies. While piecing together alternative sources of funding has at times been viewed as a mixed blessing due to the frustration of figuring out the appropriate channels for reimbursement and salaries, in reality we feel that our students have benefited tremendously from these new community partners. The greater involvement of non-school personnel also has helped ease the staffing issues that we face each year. Moreover, these partners bring a wealth of personal resources and provide students with new relationships and community-based opportunities. For example, last year and for the upcoming year, our project received funding from a neighborhood community health clinic. This affiliation has led to an important new aspect—high school team members who regularly attend our ATP meetings and who are responsible for presenting monthly "mini-lessons" on youth health topics (i.e., drugs, dating). Last year we also benefited from funding awarded to a local mental health residential center that enabled its staff to work collaboratively with us on a variety of outdoor, team-building, experiential learning activities during the year. Thus, we now more optimistically anticipate new staff, funding, and community collaboration opportunities since they bring a renewed enthusiasm that has more than compensated for any reduction in our overall funding.

A significant challenge for sustaining the project will be posed during this upcoming fourth year. Changing circumstances will force both of us to play a less central role in the project as Gloria takes over as school psychology program director within the

University and Connie takes on a new supervisory role within the District. Even so, we are confident that key school staff and administrators will continue to support the project and that personnel changes and new community liaisons will create an ATP format that will grow and flourish over time.

Continuing Lessons

The last three years have taught us many lessons about ourselves, students in general, and working collaboratively in schools.

• *What we have learned about ourselves.* We have learned to stretch ourselves: Connie in the area of public speaking, team coordination, and supervision, and Gloria, in the art of compromise and in gaining a fuller appreciation of the time it takes to give all team members a voice in a collaborative partnership. From the adrenaline rush of jumping from the platform of the high ropes course, we both experienced an afterglow of self-confidence and renewed trust in others as we worked together as a team. Our community activities surprisingly brought an enhanced sense of the gift of service as it enriches the giver as much as the receiver. Finally, we agree that somehow this experience has led to renewed motivation for our work, which had begun to waiver and wane from the stress of being pulled in too many directions.

While both of us came into this effort with the prior realization that the world of professional helping goes beyond the 50-minute therapeutic session, this project has, in fact, affirmed our trust in the power of therapeutic prevention activities to affect significant client and system change. As our ability to articulate what we have accomplished through the ATP project has grown, this experience has spilled over and significantly touched other areas of our lives, including our teaching, mentoring, supervision, and parenting. We have come to recognize the importance of promoting leadership more through example than discussion, setting clear goals without imposing one's expectations, and pushing students just beyond but not over their current views of the world and means of solving problems. The fact is we have begun to internalize our role as a gardener who strategically plants seeds (e.g., lessons) and then fertilizes, weeds, and trusts that most, on their own time, will blossom into newfound skills.

• *What we have learned about students.* This project has strengthened our belief in kids and their resilient capabilities. While they continue to struggle against a multitude of external pressures and with the difficulty of successfully working in mixed-gender groups, our ATP students proved over and over that they could make powerful and positive personal choices. Over the year, our students never failed to surprise us with their ability to buckle down, to make responsible decisions, and to work wholeheartedly towards team goals. We saw them learn to attribute personal and team accomplishments to effort rather than chance or outside influences.

Clearly the relationships and skills developed in one year are tenuous at best, but an old Spanish proverb has helped us to view these new associations as silken

threads that, like habits, will strengthen into cables overtime. Our dream is that relationships developed as part of the ATP are stepping-stones for young people on their journey towards creating value and meaning in their lives. An important message conveyed to ATP students is that we all can choose our life story — that people "are not formed by destiny alone but by free will and determination." As adults, we have tried not only to tell but also to model this truth within our team relationships. We also have underscored how joining together with others to work towards a common objective can lead to untold rewards and personal gains.

Yet, we know these students will continue to struggle with tough life choices. Our hope is that the skills and relationships gained here will help pave the way for ATP students to stay committed to school, to take part in pro-social extracurricular activities, and to view themselves as leaders who can make a difference. Our sense is that many students experienced significant and indelible personal change while working and contributing to a team whose goal was to implement solutions to important community issues. Our hope is that these students will have a new means to reflect upon important life decisions because of the alliances experienced here.

• *What we have learned about collaboration.* Our early feelings about what it means to be involved in a collaborative alliance have been both affirmed and clarified through this ongoing effort. We have come to believe what we originally only acknowledged—that successful collaborative school-based prevention will be achieved only through generative, ongoing, and creative liaisons with numerous agencies, across various disciplines, and with the input and involvement of home, school, and community members. Components that seemed critical in the beginning, such as the importance of joint discovery, of feeling connected, and of creating a sense that every member makes significant contributions, are still at the forefront. Yet, we also have developed a deeper appreciation of the importance of building strong professional and personal relationships based on shared values and a clear, jointly developed vision.

We attribute our collaborative success to three other critical lessons. The first is the recognition of our collective and unique strengths that allowed us a wider array of means to achieve our goals. For example, Connie was able to provide ongoing supervision for graduate students in counseling and school psychology that helped to broaden their internship experiences and also helped fulfill our staffing needs. The second is the importance of empowering others to assume co-facilitator roles. Such empowerment was especially critical in year three when Connie's assignment at the school was reduced to two days per week. As a consequence, an additional social work graduate intern, a willing first year teacher, and a newly appointed coordinator at the local health clinic all took on greater ATP coordination responsibility. The third is the absolute necessity of overcoming scheduling issues so meetings can be held with everyone in attendance. Invariably, we learned that if we eased the scheduling burden by conducting meetings without everyone present, we lost the benefit of team cohesion. But alternatively, if staff meetings were shortened so that everyone could attend, we lost the ability to percolate ideas and the opportunity for true group decision-making.

Finally, it is clear to each of us that our interest and energy could not have been sustained without the unswerving dedication of a collaborator whose support consistently boosted spirits and refueled a desire

to face the many challenges confronting us each year. The strength of having a colleague who then becomes a friend provides the inspiration to keep going forward. Our respect for each other's roles has been broadened and we have cherished the experience of sharing work, frustration, and triumphs with a professional in another discipline who lives what she believes.

A Look Towards the Future

Taking the time to reflect upon the project in this fashion after three years has given us the opportunity to assess what worked and what did not and to identify where we may need to go next. It also helped us to more specifically appreciate how this inter-professional relationship has impacted our teaching, supervision, therapy, and personal lives. We hope others can learn from these reflections and may be inspired to create similar structures to foster adult-student relationships in school-based settings. While we have been strongly encouraged by our findings, we recognize that without a true control group, we cannot definitively allude to causation nor are we comfortable suggesting that such outcomes can be easily replicated.

Nevertheless, our lofty dream is that the Alliance Team Project will continue self-sufficiently and indefinitely. We hope that the ATP will become a more integrated and sustainable aspect of the school. The many school and community partnerships forged over the years have strengthened our confidence that there will be individuals who will continue to refuel, regenerate, and sustain its momentum in the future. We fully expect that the ATP will take on new formats reflecting the changing personalities and circumstances of its members. However, we also are certain that the core mission of the ATP will remain focused on developing strong adult-student relationships through a year-long collaborative effort where team members plan meaningful service projects that require the application of critical team-building, problem-solving, and leadership skills.

As professionals interested in students' academic and mental health, this experience has strengthened our conviction that we all must work harder to build unique and sustained adult-student relationships, especially during the critical transitions into middle and high school. Of course continuing questions remain. Could we integrate similar team-building, leadership and service activities more fully within the academic mission of the regular school day? Could we find ways to involve parents and high school students as more active team participants? Significantly, as we came to the end of this article, each of us had a dream about a time in the future when we found ourselves in a life-and-death situation, fully dependent upon our ability to work side by side with a past Alliance Team student. What more evidence is needed that the cost of responding to students by building relationships is minimal, but that the cost not to do so will be much higher.

A Post Script

We must admit that we initially were hesitant to write this article since neither of us was sure of how to construct a narrative or "professional story." More daunting was the question: Did we have a right to share a "subjective" version of our own collaborative project? Thankfully, John Kayser, a colleague in the School of Social Work, shared his enthusiasm and insights on narratives (Kayser, 1995, and personal communication) and encouraged us to read several articles that clarified the important role narratives can play in therapeutic and psychological discovery. Our effort was most strongly influenced by Miller Mair (1988) and George Howard (1991). These authors argue, respectively, that personal

life stories represent our struggle to discover meaning and that narratives can be viewed as an alternative scientific activity that does not only reveal empirical relationships, but helps to build theories through an alternative form of reasoning. Since our training had been similar to that of many scientist-practitioners, we at first found it difficult to abandon a regimented "scientific" packaging with a narrative form. However, one of Dr. Howard's arguments particularly resonated with us: "Just as one would never say that a squirrel is a better animal than a chipmunk, one should not make the bold assertion that scientific insights are superior to the wisdom of the humanities. Instead different types of stories serve different functions" (p. 189).

Our remaining fears about constructing a narrative were abated by a final "consultant" closer to home—the first author's seven-year-old daughter. When asked, "What is a story?" she replied: "A story is lots of ideas combined together. You can write mostly anything and you can write stories about your life" (Erica Czajka, 2000, personal communication). Thinking back to the countless hours we have spent reading narratives to ourselves and with others, we were struck by the "raw" truth to this definition. Wasn't it Jung who said that "we are motivated not by reason or reinforcement but by fantasy?" Shared stories have certainly helped us to experience, explore, and ponder complex issues such as life-death, love-hate, good-evil, and truth-reality.

These readings and personal accounts were instrumental in overcoming our hesitancy to construct a narrative. While the unfamiliarity of this genre should have left us little doubt about the difficulty of the task ahead, we grew excited about the opportunity to write a narrative account of our prevention project. We hope that our shared insights will foster other interprofessional endeavors that will further our understanding of how to develop and sustain effective school-based prevention programs.

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From the Frying Pan into the Fire: Three Advocacy Tales in Child and Adolescent Mental Health Services*

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A persistent criticism of helping professionals in certain disciplines, such as social work and psychology, is that their psychotherapy, counseling, or mental health work with clients occurs at the expense of macro-level efforts to achieve social justice, equality, and changes in the social environment. The authors offer the following narratives as a counterpoint to this view, as they demonstrate integration, rather than polarization, of micro- and macro-level approaches in child and adolescent mental health practice.

Advocacy is an essential skill in contemporary child and adolescent mental health practice which must be developed by a variety of stakeholders—individual clinicians, policy leaders, program administrators, educators—not to mention parents and families. In this narrative, we describe three stories of advocacy interventions undertaken in widely differing practice contexts, identify the strategies and skills we found useful in developing advocacy interventions, and informally assess the effectiveness of these interventions. We hope this article will suggest ways in which readers can help create responsive mental health services for children and youth in their home communities and practice settings.

Conceptual Framework for Advocacy

The two disciplines we represent—social work and psychology—have differing traditions regarding their understanding of advocacy. Psychology—at least as practiced in North America—has traditionally adopted a narrow interpretation of advocacy as actions taken primarily to benefit the well-being and functioning of the individual client system. The major criticism of this approach historically has been that advocacy interventions taken on behalf of the individual often occur at the expense of those directed towards enhancing the welfare of the entire community or society (Prilleltensky, 1991).

Social work, on the other hand, has a greater tradition, at least in certain periods of its history in North America, of emphasizing the role of the social environment as it interacts with the functioning of individuals, families, or groups (Takanishi, 1978). Thus, advocacy in social work has tended to emphasize macro-social interventions—that is, social reform actions leading to structural changes in the social institutions of society to achieve social justice. Historically, the major critique of this approach has been that social workers may get more wrapped up in improving the client's environment and forget to address the individual needs of the client system itself. A secondary criticism has been that the advocate role may foster paternalism—that is, doing *for* clients what ultimately they may be able to do for themselves (Parsons, Jorgensen, & Hernandez, 1994).

Increasingly, however, both of our disciplines are moving toward a conceptualization of advocacy as embracing a continuum of interventions with both

individual persons, on the one hand, and the social environment, on the other. Thus, advocacy can be defined as: "The act of directly representing, defending, intervening, supporting, or recommending a course of action on behalf of one or more individuals, groups, or communities, with the goal of securing or retaining social justice" (Mickelson, 1995, p. 95).

In the stories that follow, we describe advocacy interventions ranging across this continuum. The first story focuses on *individual client advocacy* as an essential part of child psychotherapy and parent counseling done by a clinical psychologist in private practice. The second story focuses on *group advocacy* by a school psychology educator responding to the Columbine High School shootings in Colorado in April 1999. The third story focuses on *advocacy for system change* undertaken by a social work educator in an urban school district. These stories aim to capture the more personal aspects of advocacy work—those times when we as practitioners or educators were faced with doing difficult but essential tasks: going the extra mile to obtain client services, jumping from the frying pan of everyday academic life into the emotional fire and community distress in the aftermath of the worst school shooting in U.S. history, or engaging in an uphill battle against a school district bent on making massive cuts in the school social work staff.

Advocacy Work in Private Practice: Judith's Narrative

I have worked as a clinical psychologist in solo private practice for the past 25 years. Although I see a broad array of clients, my specialty is working with children and families. Like many practitioners, my work with clients also means frequent, often unpleasant, interactions with managed care companies who act as gatekeepers in regulating mental health benefits for employees and their dependents. The aim of these for-profit companies typically is to reduce utilization of the most expensive form of services and to hold down the overall costs of care. My aim as a psychologist is often quite different—to get clients the clinical services and benefits I believe they need. As a result of these opposing aims, I often find myself in an advocate role for and with my clients.

Some time ago, I received an evaluation referral for a five-year-old boy experiencing symptoms suggestive of attention deficit/hyperactivity problems. Needing to "pre-certify" my contacts with the child and family, I called the managed care company to seek approval for my request to do psychological testing in order to sort out the attentional and hyperactivity problems from other possible contributors and conditions. My initial request for testing was denied. When I called the case manager for an explanation, I was shocked to learn that the managed care company's position was that they do not approve *any* psychological testing. The case manager stated that children's attention problems are "learning problems, not psychological problems, which are the school district's responsibility to take care of."

(Memo to the American Psychiatric Association: Please promptly remove the diagnosis of attention deficit/hyperactivity disorder from your *Diagnostic and Statis-*

tical Manual's list of mental disorders. Tell clinicians they can relax. It's a learning problem, ***not*** a mental health problem! Schools around the country will be so pleased!)

Not to be deterred, I pressed the case manager, then the case manager's supervisor, and finally, the CEO of the company to provide a rationale upon which its decision of denial was based. As a result of such persistence, I discovered that the managed care company had no written policy or criteria regarding the psychological evaluation of young children for any presenting problem. Previously, all such requests automatically had been denied.

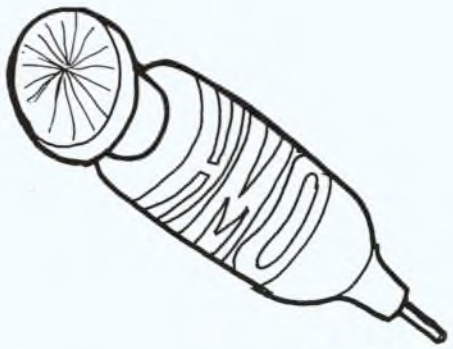
At this point, I developed multiple advocacy strategies. First, I involved the child's mother in appealing the managed care company's decision. I knew that this particular parent was herself a strong and articulate advocate for her child. Together, we worked to make sure her employer (she worked for the state government) knew of this denial. Because managed care contracts are re-bid each year, employee dissatisfaction with the benefits plan or the services provided by a managed care company can be an important factor in determining whether an employer decides to retain the insurance carrier and managed care company. Managed care companies, of course, do not like this type of strategy, and often try to silence providers through intimidation, threats of withdrawal of referrals, or the possibility of being dropped from the panel of approved providers. However, providers hold some power too, since managed care companies cannot drop every professional who complains or raises an issue. They need to have providers available to see clients, particularly in areas such as where I work, where there are few practitioners available to see young children. In this case, however, the more important advocate was the parent who was the consumer paying for services through her monthly health care premiums.

A second strategy was to arrange a meeting with the head of the managed care company and the mother. I took the position that it was important to educate the company about the standards of practice in psychology regarding the assessment of young children. I pointed out the necessity of assessing the level of children's functioning in a variety of areas in order to determine appropriate interventions for their emotional, behavioral, or social difficulties and/or mental health disorders. In effect, I shifted the conflict from being one between me (as an individual mental health provider) and the managed care company's policies to being a conflict between the managed care company and the usual and customary standards of practice in the discipline of psychology regarding appropriate client care. I pointed out that the company's automatic denial of testing, without any written policy or justification, was potentially illegal since it put psychologists in violation of the state's psychology practice act, which requires psychologists to adhere to the standards of practice of their profes-

sion. Those standards clearly pointed to the necessity and appropriateness of systematically assessing children's cognitive abilities when evaluating their emotional and behavioral difficulties. (I pressed the legal angle because of the managed care company's obvious vulnerabilities in this case. In effect, they had been caught with their pants down. Having no policy at all on the assessment of young children could not be defended or justified.)

As a result of this two-pronged advocacy intervention, I worked with the managed care company to draft written guidelines regarding the psychological assessment of young children. The end result was quite favorable. The managed care company not only approved the requested services for this particular child client, but also established a new set of policies and procedures for handling requests for psychological evaluations for both children and adults referred for testing. Thus, what started out as advocacy for one individual child and family turned out to have system-wide implications for many other children whose insurance policy mental health benefits were managed by this particular company.

What I learned from this experience was that taking a pro-active, problem-solving approach, based upon knowledge of the acceptable standards of practice in psychology and the mental health field, can move a managed care system into changing its exclusionary policies. In this case, not only my own client, but also other consumers served by this particular company, had their mental health services enhanced. The ongoing challenge for me as a solo practitioner, whose income depends entirely upon what I earn in my private practice, is to not become worn down by the numerous obstacles and delay tactics that managed care companies continue to cleverly devise. I have to walk the fine line of being able to continue to work with such companies in order to serve my clients, while also not responding to overt or covert pressure they may bring on the individual provider. Often, it seems, I am invited to "give up" on the client, to "give in" to narrow, simplistic treatment protocols, or to "give away" my power and advocate's voice when the company becomes more concerned with profits than patient care. I believe advocacy by mental health providers is essential when clients are not able to effect the desired changes in their environment or themselves because of some *condition*, such as severe and persistent mental illness, *status* such as children or adolescents who lack legal rights, or *power differential* between clients and the various institutional systems of care with which they may be involved.



Group Advocacy in the Aftermath of the Columbine Shootings: Mark's Narrative

The following narrative examines my group advocacy work as a school psychology educator. These events occurred in a school and community experiencing a major emergency mental health crisis resulting from the Columbine High School shootings in April 1999. The details are still shocking. Thirteen students were killed in a calculated assault carried out by two of their teenage classmates, who subsequently committed suicide at the end of the mayhem. The horror of this event sent shock waves

throughout the Colorado suburban school district where it occurred—and indeed to every other school district in the state (and probably the nation). The shootings occurred on a Tuesday, and as a result, the school district canceled classes for the remainder of the week. When students returned to school the following Monday, an atmosphere of shock and crisis continued to permeate many schools, affecting students, parents, and families, as well as teaching and support staff throughout the entire district.

As a school psychology educator, I spend considerable time out in the community, working with individual school psychology interns, their supervisors, and entire schools. In the immediate aftermath of Columbine, I was asked to work with a junior high school (7th and 8th grades) serving 800 students. This specific junior high school was particularly traumatized because it served as a "feeder school" for Columbine. Many of the students were well acquainted with both the two perpetrators of the shootings as well as their victims. In addition, a number of returning students at the junior high school were siblings of those who had been injured, some of whom were still in the hospital in serious condition.

Existing mental health staff in the district (i.e., school psychologists, school social workers, and school counselors) faced an overwhelming volume of requests for mental health services. A team of outside mental health specialists was assembled to assist with the transition back to school in these difficult circumstances. I worked to place as many mental health resources at the school district's disposal as I could. Initially, I arranged with my university administrators to suspend most of my usual duties, except for teaching and advising students, for a period of several weeks in order to participate as a member of the mental health team at the junior high school, aiding the students and teaching staff with transition back to school. I also recruited and coordinated the schedules of other faculty members who had mental health expertise in order to assist the school's effort in coping with the aftermath of Columbine.

My advocacy work directed at the group level was to help establish and participate in a systematic process to facilitate classroom debriefing meetings and consultations during the students' first day back, followed by group and individual counseling sessions for students in need during subsequent days. Working with others in the school and community, I participated in a systematic screening of the student body for acute and long-term mental health concerns. I also disseminated a number of educational handouts for students, parents, and staff on likely reactions to disaster and warning signs of subsequent problems developed by the National Association of School Psychologists and other agencies. Additionally, I participated in debriefing sessions with staff and administrators on a regular basis. As familiarity and trust increased among school administrators, they also asked me to consult on a number of sensitive issues that arose during that first week. At the university, I was able to infuse content on crisis intervention work, advocacy, and school violence into my course lectures and presentations to school psychology students, interns, and other students in the College of Education. In fact, a special meeting of students was convened to address these issues, with a number of students volunteering to provide continuing assistance to the schools in whatever capacity might be appropriate.

Along with the staff and administrators of the junior high, the mental health team helped foster a relatively smooth return to regular school routines. The vast majority of students appeared to regain a sense of

control of their immediate environment during that first week back at school. Students identified with acute reactions to the tragedy were referred to appropriate sources for treatment, both inside and outside of school. Additionally, a number of youth with more chronic or serious mental health problems were identified and also referred for appropriate treatment. The administrators and staff at the school developed a sense of trust and collaboration with several members of the mental health team and their agencies, which was invaluable for further collaborative efforts. (For example, the following academic year, the district began a volunteer clinical consultation program, linking the district's mental health staff with outside mental health practitioners and educators to provide ongoing resources for case consultation and staff development.) Efforts of the mental health team, and those of personnel in other district schools, also were incorporated into a more comprehensive plan for response to future disasters.

My advocacy work in this particular school was but one of many efforts by mental health professionals both in Colorado and throughout the United States in responding to youth violence. Advocating for families, groups, and communities is essential when they are experiencing difficulty accessing services or are in crisis or conflict about the adequacy of services being provided. As a result of this collective response, there has been much greater sustained public attention given to topics of youth mental health needs, school violence, violence prevention programs, gun control, and the management of large public high schools. My hope is that such attention will lead to political action, policy changes, and, perhaps, fundamental societal reforms.

What I learned most from this experience was the vital importance of mental health professionals to be responsive to the needs of their communities and to continue to advocate for needed services in an era of intense competition for resources. Working with so many dedicated professionals from other mental health and community agencies also strengthened my commitment to the notion of interprofessional collaboration and service provision. While our efforts were by no means "perfect" in attempting to respond to the needs of students, parents, administrators, and staff, as well as the community, in this tragic situation, the combined efforts of many professionals and agencies created a synergy that was highly productive. I witnessed many instances of direct benefit to students, staff, administrators, and parents, alike, from the individual and collective efforts of the mental health team. The ongoing challenge, however, is how to sustain such efforts over the long haul, especially in times when crisis conditions do not galvanize the community to the pressing mental health needs of many school-aged children and youth.

I also learned much about the deeply personal nature of helping in the aftermath of tragedy. My contacts with individual students, groups of students, teachers, paraprofessional staff, administrators, and parents affected me in ways I could not have predicted. The mixture of grief and shock, anger and confusion, pain and reconciliation that permeated the school in those first days after the tragedy was palpable. Many of the students who were friends, or at least acquaintances, of the two perpetrators as well as the victims, were agonizingly confused about how they were supposed to feel. On the one hand, they hated what had occurred, but on the other, wanted to confess that they had actually liked the two perpetrators. Understandably, many were fearful and guilty about expressing this view at first, but as the days passed more and more students voiced such feelings. Many were also frightened by what

they perceived to be similarities in their own behaviors with those of the perpetrators. In a group session near the end of the first week back at school, one young man said, "I like a lot of those same video games that Harris and Klebold were always playing. Now everyone says they're bad. Am I going to end up like them?"

My conversations with students consistently led me to appreciate the insight that many had into the conditions surrounding the tragedy. While many media reports seemed to alternate between portrayals of Harris and Klebold as "diabolical killers" and the school as too lax in controlling the influence of negative peer pressure, most of the students I talked with seemed to understand that the truth lay somewhere in between. While acknowledging that Harris and Klebold had committed a heinous act for which they ultimately must be held accountable, most also acknowledged that school was a harsh place for some students. We talked at length about the conditions that seem to create and sustain such an atmosphere, with many students expressing both a desire and a commitment to try to help change the peer climate. It was one of those rare "teachable moments," where a terribly tragic event enabled students to speak candidly about issues and concerns they normally would not share with adults.

Many of the staff were similarly affected. Most had been teachers in the district for a number of years and had had Harris and Klebold, as well as the students killed or injured, in their classes. To help reestablish familiarity and routine for their students, most attempted to get "back to business" in their classrooms, following the initial de-briefing sessions held on the first day. Still, a profound sorrow was evident in their interactions with other staff and with me. It was humbling to see the way this sorrow played itself out in the lives of both students and staff and painful to watch how the effects of the tragedy rippled into other areas of vulnerability. One teacher, for example, who initially declined my offer of assistance in her classroom and wanted nothing but to get back to the business of educating her students, eventually confided in me that she had recently been diagnosed with a heart condition. She needed to maintain a very regular schedule of sleeping and rest, but under the circumstances was finding it difficult to do so. Additionally, she told me she had the primary responsibility of caring for an elderly parent who was in failing health. I found it inspiring to watch her determination in fulfilling what she believed were her responsibilities to her students, and heartbreaking when trying to provide her with some assistance in balancing this with the need to protect her own health.

Finally, I feel I should say a few words about my experience (or rather, lack thereof) with the media during the weeks I volunteered at the junior high. I'm not sure I can communicate this clearly, but I feel that I should try. I had several opportunities to speak with both local and regional media about my experience in responding to school violence and received strong encouragement to do so. I'm sure you are aware of all the arguments for complying with such requests: it will be good for the profession, it will help create needed visibility for mental health in the schools, you should let people know what our profession has to offer, and so on. Valid arguments, all; but I never did.

I'm not a media basher, and I have no animosity toward the press. Certainly, one of the greatest assurances of a free society is a free press; and people have a need to know about events such as Columbine. But under the circumstances, it seemed somehow disrespectful to me to talk about my experience with responding to crisis, even in a general way. Perhaps the issue is timing—

in the midst of such turmoil and shock and grieving, much of which was intensely personal, it seemed somehow inappropriate to talk with others about the tragedy in a detached, impersonal way. Most of the students I was talking with were making it clear that they were unable to cope with the volume and relentless pace of media coverage about the incident. Some staff and parents were as well. So I chose to ignore the urgings of several colleagues, declined the offers I received to speak with the media, and followed my own inclinations. I'm still not entirely certain I did the "right thing" here, but that's the thing I did.

Advocacy at the Institutional/Policy Level: John's Narrative

The following narrative concerns events that took place in a large urban, racially diverse public school district in Colorado, in which more than 25% of students are classified as living in poverty. The poverty rate in some individual schools is over 80%. Because of chronic underfunding of elementary and secondary public education by the state government, this local school district had been forced over several years to cut numerous non-teaching positions. As a result, the school social work department had seen its staff positions gradually erode from a high of 55 down to a low of 38. Now, the district was proposing to cut an additional one-third of the remaining school social work staff because of a projected multi-million-dollar budget shortfall. These cuts threatened vital social work services, including special education services, individual counseling, parent outreach and education, suspension and intervention services, and truancy prevention programs. Also problematic was the demoralization of the social work staff who had seen their numbers dwindle along with (not surprisingly) a corresponding increase in the demand for their services.

My role in this advocacy effort began when I was assigned as the social work faculty/field liaison to organize and lead the field seminar training that students placed in this district took over the course of their practicum year. I should add at this point that, by temperament, I am an introvert, and that my practice background comes from clinical social work—not always the best combination for advocacy or activism. Although I have tried to consistently affirm and integrate direct and indirect practice as a unified whole into my thinking, it has been far easier to talk about these ideas, rather than to take action—especially in such a public arena as school district politics. This particular advocacy effort afforded me unusual opportunities and challenges to "put my money where my mouth is." As the story reveals, I had to combine the roles of educator, researcher, activist, and advocate.

My initial advocacy intervention was largely a solo effort and actually was an intuitive "lucky shot" rather than a carefully pre-planned strategy. As field liaison, I had agreed to offer testimony at one of the public hearings the school board was holding in late April and early May on the proposed staff and program cuts in the following year's budget. On this particular rainy night, a very large number of people were in attendance—parents, school personnel, and community members—seated in the auditorium of one of the district's middle schools. Not everyone was there for social work, of course, since a number of other programs were also being threatened by proposed budget cuts. From the outset, I was concerned that there would be too many voices about too many different concerns. It would be all too easy for social work to get lost or overlooked in my being able to make an effective presentation.

The meeting began with the superintendent's opening remarks. His

handout of budget figures clearly showed the budget shortfalls and what the various proposed staff cuts would do to address the problem. Somewhat condescendingly, I thought, he expressed his "regret" about the proposed school social work staff reductions, somewhat in the manner of the country squire fallen on hard times who has decided to let the hired help, long a part of the family, go. So sorry, but what could he do!

A large number of people, about 50 or so, came forward when public testimony was invited, lining up behind two microphones to address the school board, who sat above on the stage. The school board president solemnly advised that each person would have only three minutes to make his or her point. I deliberately chose to be about tenth in line to speak. I wanted enough time to see what points other speakers would make as well as to gauge the school board's receptiveness. I was not very encouraged by what I saw. When a well-respected African-American woman social worker from one of the district's high schools gave a fiery presentation about the devastating effects social work cuts would have on the largely minority community her school serves, the predominately white board sat impassively. When a white social worker spoke of social work as being "the only discipline in the district concerned about 'persons-in-environments,'" their eyes glazed over. What, I wondered, could shake these people? I looked over at the superintendent, sitting on the side with his self-satisfied smile, and got angry. I decided to gamble on a risky strategy, namely, when you don't know anyone powerful, act as if you do.

In my testimony, I chose a deliberately provocative strategy to try to get the school board's attention. I reminded the school board of my university's *investment* in the district. Shamelessly name-dropping, I pointed to the Chancellor's very strong interest in public education and reminded the board that the university and the district already had developed a joint venture elementary charter school serving low-income students. "Another part of the University's investment," I said, "is the 40 or so social work students the School of Social Work places each year throughout the district's schools." I told the board that our student interns provided an important extension of the regular school social work services to pupils and families. "If there are massive cuts to the regular school social work staff, so also would the student intern training program and placements have to be curtailed, since they would have no one to supervise them." This statement indeed got their attention, particularly when I pointed out that in some schools, there were certain days in which the only social worker in the building was one of our students.

In the following week, I heard from the head of the district's school social work department that my testimony was the one thing that had made an impact on the board. In fact, she had been ordered by the superintendent to write a letter to the Dean of the School of Social Work at the University stating that any budget cuts in the

school social work staff would not affect the district's ability to support social work student training. Apparently, the district administration had no qualms about letting go the paid staff, but began to panic when the "free volunteer labor" by students in field placements was threatened. Perhaps the cynics-at-heart would not be surprised to learn that the school district eventually decided against making further cuts in the social work staff (at least for that budget year) because the city agreed to fund some school social work positions, thereby restoring some earlier staff position cuts. My lucky shot apparently had hit at least part of the target, although privately, I also heard that some school board members vowed never again to hold those types of public hearings on staff cuts.

The following September, at the start of the new school year, the head of the school social work department called to ask for further assistance. The district now had decided to appoint "review committees" of experts from the district and community to examine each of the "related services disciplines" (i.e., social work, school psychology, and nursing) regarding their functions and appropriate staffing levels. It seemed to her that these review committees were just another district ploy to cut staff, this time getting committee members to do the dirty work in a far less public fashion.

I had no illusions that another solo "lucky shot" would be successful. What was needed at this point was a much more coordinated and collaborative effort involving people in greater positions of power and authority than I. Fortunately, as the saying goes, timing is everything. At around this time, the Dean of the College of Education (who was favorably disposed to social work because her daughter was an MSW graduate from our program) and the Dean of the Graduate School of Social Work convened an interprofessional task force of University and community leaders to address the problem of social work cuts in the district. This interdisciplinary collaboration was crucial, as it now could not be argued that protests against the budget cuts were merely social workers seeking to protect their own turf or staff positions.

I took the lead in this committee in drafting a report regarding the populations and services currently being provided by the district's school social workers. The interprofessional task force, in turn, drafted a "position paper" based on my original report, which emphasized, among other points, the money currently being generated by the school social work staff as well as the "dollars saved" by the district because of the presence of student social workers. (We chose to emphasize budgetary matters in order to speak to the areas about which the school board was most concerned.) This report, in turn, was circulated to a variety of stakeholders, including the school social work staff, the school board and superintendent, and the media. In addition, the position paper was used by the two Deans in their subsequent meetings with the Chancellor as a way of keeping him abreast of events and as a means of soliciting his support and involvement. Eventually, both Deans were asked to serve on the district review committee for school social work services. Each of them was able to play an influential role on this committee because of their early involvement in establishing the interprofessional task force, and because the position paper had provided them key facts and figures about the services school social work provided. Further cuts in the school social work staff were forestalled once again.

At the end of the academic year, exactly 12 months from my first testimony before the board on the budget cuts, another group of us—three school social work staff who served as field instructors,

two students placed in the district, and I—testified again. Since the board likely was expecting another broadside from the social work community, I advocated for confounding them by "playing nice." We began our testimony by thanking the board for its ongoing support of the school social work student training program. We distributed a detailed report regarding the services performed by students as well as a list of the individual research projects the students had undertaken in the schools.

The board appeared to listen a bit more attentively this time, although their questions after our presentation revealed how little they understood what school social workers actually do. Mainly, they wanted to be reassured that children were not being taken out of their regular academic instruction periods for (much less important) individual or group social work counseling or special education activities. Their sole concern was about advancing student cognitive performance and academic achievement—not addressing students' emotional, social, or family issues. (No doubt this concern was shaped by pressure from the state's "educational accountability mandates" to measure student performance annually through standardized achievement testing.) Fortunately, the school social work staff had a ready answer to this, stating that there already were "life enrichment" periods built into the regular curriculum that they used to conduct their activities. I left the meeting thinking how necessary it would be to repeat such a presentation to the school board on at least an annual basis, since it was clear that their only knowledge of school social work came secondhand from the superintendent and district administration officials.

On another front, a doctoral student and I also undertook a research study on the effectiveness of the school social work student training in the district, and reported results to the school board and administration (Frey & Kayser, in press). In addition, we used the emerging situation to educate the student social workers in their field seminar class about the need to develop advocacy skills. Many of them initially were uncomfortable with advocacy and the possibility of becoming politically active but over the course of the year began to see the larger picture.

The outcome of these individual and collective advocacy interventions was positive. As a result, the district's efforts to cut school social work staff seems to be on hiatus, although for how long is anyone's guess. Remarkably, some grant-supported social work programs, such as the suspension/intervention services and truancy prevention programs, actually have been expanded from selective "at-risk" schools to become a district-wide program.

What I learned most about this experience was that advocacy efforts need many helping hands, and name-dropping about having powerful friends doesn't hurt, either. In fact, there *were* powerful friends involved—the Deans from two academic colleges (and through them, the indirect influence of the Chancellor)—which helped bring the weight, prestige, and self-interest of the university into the school district's consciousness and budgetary decision-making process. Without the involvement of these stakeholders, it is very likely that the outcome would have been less favorable. In effect, the school board was forced to shift its thinking from seeing social work only as an expendable "cost center" to viewing it (even if only temporarily) as an *asset* with a strategic partner.

On a personal level, I also learned that, when necessary, it is possible for me to overcome my own temperamental introversion and undertake advocacy work in a public, political arena. I believe that advocacy at the institutional level is needed to

enable social institutions to become more responsive in providing the required resources to individuals, families, groups, and communities. With some existing organizations, advocacy might result in the creation of innovations - such as prevention and resilience projects in schools, neighborhoods, and community centers, or through collaborative initiatives among helping professionals, parents, government, and community leaders - to remove barriers to existing services. It also might mean advocating for the creation of new services, programs, or organizations. These outcomes occur through political or legal action to strengthen the position of deprived individuals or groups and/or to seek a more equitable redistribution of resources among competing parties in a dispute.

Conclusion

Advocacy means striving for social justice, social responsibility, and social ethics in order to achieve a fundamental shift or radical re-altering in society regarding the distribution of rights, opportunities, and protections available to people within society. In the professional helping literature, advocacy interventions are classified as either *case* or *cause advocacy* (Mickelson, 1995; Parsons, Jorgensen, & Hernandez, 1994). As the above narratives indicate, advocacy at the individual or group level of social interventions can be termed case advocacy because mental health professionals are advocating on behalf of a single entity, a "case" or client system (i.e., individual, family, group, or an entire community). Case advocacy typically focuses on achieving some type of change in the client's immediate situation or circumstance. Advocacy at the institutional or sociopolitical levels, on the other hand, can be termed cause advocacy (also called "class advocacy" or "issue advocacy") because the effort is intended to promote an issue or act on behalf of a population, or class, of individuals. Cause advocacy typically is aimed at achieving social reform or structural change within social institutions.

Both types of advocacy are important and interrelated. As demonstrated in the stories above, advocacy that originally starts at the individual and/or intermediate levels of social interventions often has important ramifications at the social systems/institutional/policy level, and vice versa. We believe that mental health professionals are *ideal conduits* between individuals and groups in need and those in positions of power in determining who gains access to services. Advocacy interventions are an important aspect of mental health practice at whatever level they occur—from lobbying and political organizing of groups, to seeking policy change at the macro-social level, to case management, counseling, and psychotherapy with individual clients. They appear to be particularly important when working with child and family clients and/or the professional groups and institutions serving children and families.

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Clinical Supervision—Then and Now: The Professional Development of Social Workers

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This narrative is a reflection about the process of clinical supervision in the practice of psychotherapy. It traces the author's own experience in supervision over the course of his career, from the days as an MSW-student supervisee to post-master's entry-level practitioner to social work educator and trainer of other professionals about the process of clinical supervision.

This narrative grows out of my present work in teaching clinical supervisors how to supervise. Throughout my career, I have sought out supervision from more senior members of my profession to help me clarify my thinking about cases and to strengthen my professional use-of-self. Clinical supervision has been an important part of my life since my internship years, and the patience and skill of my supervisors has enabled me to become a much more confident and skillful social worker.

The current crop of students and new graduates (and even some professionals with considerable post-MSW experience), however, appear not to have had the same type of professional growth experience in supervision. Often, they appear to lack confidence in their knowledge and skill development and, perhaps, are less observant or reflective about themselves. In addition, many of these practitioners struggle to formulate ideas about clients' present and past development as well as about the change process—how their therapeutic interactions will help clients move from point A (the reason help was initially sought) to point B (the goal sought or change desired).

I am both saddened and angered about the present state of affairs and believe part of the problem lies in the poor quality of clinical supervision presently available. I realize that what I received in terms of preparation for this profession is not being offered today, and probably has not been offered for the past decade or more. The present narrative traces my own experience of supervision, from student days to my current work in teaching supervisors how to supervise. The unifying theme of these diverse experiences is the critical role supervision plays in the professional development of the worker.

My Experience of Supervision as a Student

Twenty-two years ago, I graduated with an MSW and was voted by my fellow students as "most likely not to stay in social work." This dubious designation was due not only to my age (at 23, I was the youngest in my class) but also to my ambivalence about social work. I was unsure if it was the correct pathway to the counseling work that I hoped to do.

Like many folks, I entered the profession knowing that I wanted to help others. While I was willing to learn, I had little idea about what learning in social work actually meant. My professors and field instructors, however, challenged me continually to think about *what* I was doing, *why* I was doing it, and *how* I could help my clients move from point A in their process to some undetermined point B. Looking back, I can smile (now) about my own struggle as a student—wanting to be good at something, yet at the same time feeling that I did not know anything.

I had two block field settings during my MSW training. The first was in a general hospital in a metropolitan area where I was assigned to the Family Practice Unit, working with clients usually over the age of 55 or under the age of 25—generally those people who did not have their own family physician. The department of social work had a strong and wonderful reputation. Over twenty social workers as well as interns from three different universities staffed it. My second internship was at a University Counseling Center in a small agricultural community 50 miles from a major metropolitan area. Ten professionals including three social workers, three psychologists, a psychiatrist, and two vocational counselors staffed the Counseling Center. The University was home to six thousand undergraduate and graduate students, mostly focused on liberal arts, agriculture, veterinary science, and home economics.

I remember preparing myself for supervision, one and one-half hours per week in those days. I had no idea that the major focus of supervision would be spent on looking at myself as a ***facilitator of change***. I was challenged to look at what I brought to the relationship with clients, how I felt about them and the presenting problems, and how I understood my role in facilitating change. In addition, I was expected to articulate options regarding how to work with clients to alleviate the presenting problems.

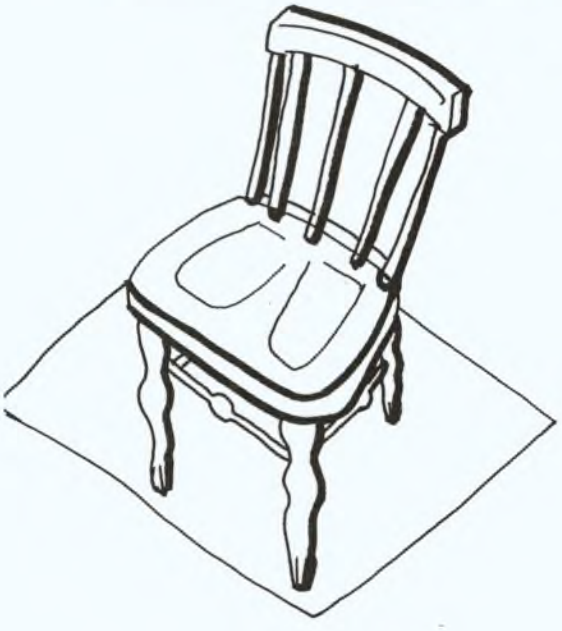
Two memorable cases from my student days come to mind. During my first placement, I worked with a 55-year-old immigrant widow who was on disability leave because of a severe back problem. Her medical course of treatment involved lots of bed rest, medication, and home-based physiotherapy. The client was referred to the Family Practice Unit for help because of symptoms of depression. Her back problem resulted in her first extended absence from work, and she began to experience a profound sense of aloneness and significant dependency needs. She appeared depressed and isolated, having no family or friends except for those from work whom she would not be able to see until she recovered.

My inner gut reaction in this case was fear. I dreaded being exposed as an imposter—someone who had nothing to offer to clients in distress. I remember coming face to face with my own anxiety and how uncomfortable I felt with "not knowing" what I was talking about. I recognized that I had been masking the fear with humor, mostly of the self-deprecating type, in order to hide the discomfort at being asked a question that I did not have an answer to, nor could even imagine where to begin to come up with an answer.

As I presented my work with this client in supervision, my supervisor questioned me about my understanding of depression. What was its etiology? What did I know about the course of depression in people's lives? What were my own experiences and exposures to depression and loss issues? Did I think depression was different in female clients or with clients from differing age groups? In struggling to answer these questions I often felt inept. (My supervisors

in both first and second year placements were seasoned professional women, fifteen years my senior, who made it look *so easy*!) Yet, slowly and surely, a process was occurring in which I began to trust my supervisor to help me find my own way into becoming the professional I would grow to be. I was forced to look at the concept of aloneness and fears of being alone. My supervisor focused in on *my empathy* and its place in relation to this client. She carefully balanced an inquiry into my own personal issues (i.e., times in my life when I had felt alone and past experiences I'd had helping others deal with their aloneness) with explorations of my own current beliefs and theoretical conceptualizations about how therapists help clients deal with the issue of aloneness. She encouraged me to read, to ask questions of others, and to remember back to moments in time where others I had known or worked with had dealt with their own sense of aloneness. She helped me to examine the process of aloneness and loss as a developmental issue that occurs throughout the life cycle.

In my second year placement, a 19-year-old male client came into the University Counseling Center seeking help in his struggle to develop and maintain relationships. I noticed that the client was wearing an obvious full toupee, which is unusual in one so young. While I was understandably curious about it, sensing that it was a significant issue in the client's life, I found I could not ask the client directly about it. My supervisor, being bright and sensitive, helped me explore my hunches about the reasons for the toupee and encouraged me to reflect on the reasons I was having difficulty asking the obvious question: "Why the toupee?" Her prompting helped me get in touch with strong internalized values from my family of origin that kept popping into the back of my mind: "Don't ask something to someone if you have nothing nice to say," and "Don't stare at things that are different."



Session after session, I knew I had to ask about it, but session after session, my family's words kept popping in my head, handcuffing me. Finally after many weeks, with the encouragement of my supervisor and her ability and patience to explore my family's values, I awkwardly and in a roundabout way asked the client about his toupee. To my relief, he did not have cancer (which was one of the hunches I had to rule out) but, in fact, had a benign explanation to what I thought was an embarrassing topic. Once I was finally able to ask the question (the theme music from the movie *Rocky* playing in my head), I was relieved and jubilant. I spent several more supervisory hours processing with my supervisor this struggle, coming to understand the dilemma I experienced more fully and developing a greater ability to confront uncomfortable things that popped up during the course of clinical work with clients. Although that process was not necessarily a smooth one, I was surprised at my own willingness to take risks about my learning. I began to ask questions and owned up to what I didn't know.

As the above examples illustrate, the infrastructure of the profession was set up to accommodate and help new workers learn. I received support and further challenges from both of my field placement supervisors. They believed that I did know, or if nothing else, at least could offer an opinion. In those days, MSW students were prepared to do an assessment, formulate a diagnosis, and create a treatment plan. The actual learning of treatment would take place in internships and, more often than not, in the worker's first job.

Post-MSW Supervision

In each of my first three post-MSW jobs (each lasting three years), I had individual supervision for one hour a week and weekly group supervision (six to eight workers with a supervisor) for one and one-half hours per week. My first job was in a regional Children's Hospital, organized around a multi-disciplinary team approach focusing on specific diseases or illnesses. I was the social worker to three teams working with children having juvenile

arthritis, asthma, and developmental delays. My second job was in a community mental health center in a small community. I worked on the day treatment team where clients were seen in a group therapy format from 9:00 AM-3:00 PM daily over the course of four months. The work was done in front of a one-way mirror and videotaped. The team was also responsible for the community-based aftercare program involving over one hundred clients suffering from severe and persistent mental illness. The multi-disciplinary team consisted of the social worker (me), a psychologist, two psychiatric nurses, a psychiatrist, and a support staff member. The third post-master's position was at the same hospital setting as my first field practicum, this time working in the outpatient psychiatry department.

Throughout these three jobs, the focus of supervision continued to be on my professional use-of-self and on my development as a clinical social worker. The discussion in supervision focused less on the management or disposition of the case and more on conceptualizations of how I would approach this client. In both individual and group supervision, I had the opportunity to explore in depth how I understood clients' presenting problems, their strengths and supports, and their relationships to the environment (both micro and macro). Furthermore, I explored what I could do to facilitate change, alleviate symptoms, achieve growth, and build on the supports and networks the clients already had established. The entire focus was on my professional development in terms of understanding what I brought to the situation that could help or hinder the therapeutic process and what theories were informing my clinical thinking and judgment.

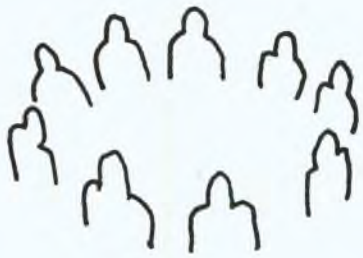
My Current Work in Training Clinical Supervisors

Currently in my private practice, I function as a consultant and clinical supervisor to several agencies and teams at mental health centers, social service agencies, gerontology centers, and an outdoor wilderness training school for difficult adolescents. In contrast to my own rich experience of professional growth through supervision with an experienced senior clinician, many professionals in today's

rapid paced practice settings tell me that, more often than not, they are being supervised by someone with little more experience than they have—at best, just two to five years more. Often, the supervisors are people whose job description and demanding administrative duties have not allowed time for them to develop good clinical supervision skills. As a result, the supervisor's primary interest centers on the movement of the worker's cases from intake to discharge in as short as possible a time frame, rather than focusing on the professional development of the worker. Little, if any, focus is on teaching the skills of treatment. Workers' abilities to articulate what they are observing in their interaction with clients are never addressed nor even asked about directly. Many workers (and supervisors) appear to have never moved from their graduation status in terms of the development of their understanding of the process of psychotherapy. While the supervisors may have multiple years of post-MSW experience, in actuality, they appear to be simply repeating their first year experience over and over again.

The workers' frustrations are evident. They acknowledge openly that they don't know what they *don't* know, and (sometimes, it seems) have difficulty articulating what they *do* know. For example, when I asked a team of social workers in a social service agency to discuss what I thought was a reasonable, straightforward question—what were their standards for returning a child who has been in placement back into a family of origin—"deer-in-the-headlight" looks were everywhere.

Today, it seems, there is little individual time and resources available for "growing" new workers into seasoned professionals. Unfortunately, many senior clinicians and experienced supervisors have left the profession, some out of attrition, some due to managed care constraints, others because of retirement, lack of fulfillment, or struggles with organizations that have become more bureaucratic and impersonal. I leave to future historians the task of tracing what happened to the practice of psychotherapy over the past 15-20 years. I am aware daily of how lucky I was to have received the clinical education and training that I did, yet how "old" I feel in comparison to the many workers that I meet. In contrast to my own experience, in the current age, little or no feedback is given to young therapists about their work nor typically are they exposed to more senior clinicians' work.



In the past two years, I have shared my own experiences in seminars and presentations throughout my state, and pushed heavily to go back to a day when one of the major focuses of agencies was the development of their staff to become seasoned professionals. In that process, I have worked with several agencies on an ongoing basis in the development of ***supervision groups for clinical supervisors***. Meeting weekly with up to eight participants, the focus of this work has been helping them to become better clinical supervisors. The task is challenging since many of the supervisors have not had great experiences themselves when they were being supervised. Typically, these groups meet weekly for six months, focusing on the supervisors' work, their own past experiences with supervision, developing ways in which they imagine supervision to be, and helping them define the roles, boundaries, and teaching styles

involved in clinical supervision. We set a firm boundary around our time in order to focus exclusively on clinical supervision issues, leaving administrative and management concerns for other forums of discussion. Each supervisor is in charge of bringing in topics for discussion on a rotating basis, and half the session's time is devoted to current issues he or she is dealing with.

In one mental health center agency, a second phase of this group supervision—a train-the-trainer model—is now in place. The original eight supervisors now work with their own group of eight other clinical supervisors in their development (64 people in total, working in groups of eight). I continue to meet with the original eight on an ongoing basis to continue helping them to become better clinical supervisors and teachers.

In these groups, I spend a lot of time going back to what I learned clinical supervision to be and how they can translate that into their current systems. With support from their administrations and commitment of time, we are making headway, one small step at a time. The supervision groups focus on teaching the knowledge, skills, and attitudes necessary for the performance of the clinical tasks. This is done through a ***detailed analysis*** of the worker-client interactions. Supervision is directed to the needs of a particular worker, carrying a particular caseload, encountering particular client problems, and needing some individualized support in his or her professional growth and development. Supervisors, in turn, learn to help their workers make transitions from *knowing* to *doing*.

In the narrative vignettes below, I have tried to share the experiences, learning, and teaching moments in these supervision groups. (To preserve confidentiality, the names of the supervisors and workers have been changed.)

Working with "passive" practitioners.

Ellen supervises a number of practitioners working with adults in residential treatment. In the supervisors' meeting, she shared her ongoing struggles with one particular practitioner, Mary, who was reluctant to set goals for supervision and acted in what seemed to be a relatively passive manner—at least in relationship to the process of supervision. Other members of the group immediately responded to this topic, and it became clear that many supervisors had encountered similar difficulties.

Ellen brought up the issue following a particularly frustrating supervision session with Mary. After she vented her frustration, I asked the group to share with each other their own experiences with passivity and whatever meanings they might attach to it. The supervisors were challenged to think about reasons for a worker's reluctance to engage, to set goals, and to be part of the learning process. Collectively, we looked back at times in our own lives in which we encountered passive behaviors, trying to understand the meanings it had and the frustrations which we may have felt. We then focused on the ways a supervisor could intercede, focus, support, confront, and deal with the current issue in Mary's work performance and use of supervision. It was particularly helpful to have the group talk about their experiences of being in Mary's situation as "the supervisee."

I then posed the question as to what supervisors should do to help workers like Mary become unstuck, emphasizing that the process of supervision is one in which the supervisee's experiences of self and other is examined in the presence of a teacher. The experience of focusing and recalling aspects of the client-worker relationship, the manner in which it is remembered, the meaning given to those recollections, and how those meanings are arrived at are the

core of clinical supervision. Going through the exercise, although difficult, proved helpful, as it generated different scenarios, ideas, and suggestions not only for Ellen, but also for all members of the group.

At the next meeting, Ellen brought back to the group her follow-up supervision session with Mary. She had first focused on Mary's strengths and then posed the question to her as to why, in the area of setting supervision goals, she appeared reluctant and passive. Mary was able to respond positively to Ellen's empathy and support and opened up to a direct discussion about the struggle she had with setting goals. Mary began to recognize how she was repeating a non-adaptive pattern from her past with the supervisor and subsequently felt good that the issue had come out.

Enlarging workers' capacity for observation.

Lucia is a clinical supervisor in a specialty mental health unit focusing on Latino issues. She brought to the supervisors group her concerns about the apparent reluctance of workers to describe their clinical observations about clients. Other group members shared her concerns, stating that the issue is not only the workers' ability to describe clients, but also their ability to observe themselves. The group brainstormed as to how supervisors could help workers better understand the clients' concerns, conflicts, and responses to the helping process. The focus of the discussion centered on the role of clinical supervisors in enlarging workers' ability to observe others as well as themselves, and on how supervisors can encourage workers to examine and reflect on the meaning and value they give to those observations. The group discussion focused on not only how to get supervision to focus in this direction, but also validated the supervisors' belief in its importance.

I asked the group to focus on their own first experiences of perceiving a "threat" or "risk" when asked to share client observations. I raised the question of whether anyone else ever had experienced difficulty in not only trusting their own observations but also trusting whether colleagues or supervisors would listen in a supportive, helpful manner. Out of this discussion ideas and suggestions flowed, as the group spent considerable time identifying other potential barriers or restrictions in their workers' capacities to think or feel about clinical material. For example, supervisors were able to acknowledge that workers might struggle with "how to proceed" with particular clients and that this sometimes can be an impediment because workers might feel ashamed or embarrassed at "not knowing." In addition, the group recognized that workers might have certain issues they did not want to discuss.

Dealing with power, authority, and shame.

Jeannie supervises workers whose practice primarily is with child clients. In group, she brought up several workers in whom issues of shame, especially those related to power issues between themselves and parents, kept coming up. Jeannie described her workers' difficulties in confronting issues head on and their reluctance to take an authoritative role or stance with parents. Many appeared to feel ashamed when having to make clinical judgments about parents' harmful child-rearing practices in a crucial and timely manner.

I asked the supervisors group to share their ideas about Jeannie's perceptions of the relationship between power and shame in workers. The group supported Jeannie in reflecting upon her own experiences, particularly the emergence of her own sense

of power and how she learned to become comfortable in exercising it. Other group members shared their own struggles with these issues, bringing out a full range of emotions about power. Gender, cultural, and socialization issues were highlighted and

we began to see power, like most other issues, as ***developmental in nature***. We spent time talking philosophically and then moving to our actual experiences with power, both on the side of having power and also on the experiences of not having power. The stories which most helped supervisors gain perspective and empathy with their workers' difficulties concerned recalling their own struggles to avoid being like someone negative in their past. For example, this might have been a hostile parent or adult authority figure who had confronted them in harsh or unhelpful ways and whom they had taken great pains to avoid becoming similar to. Drawing on these recollections, supervisors were able to help their workers learn ways in which they could be direct or even confrontational, when necessary, while still maintaining a caring and empathic helping relationship.

Creating a safe environment in supervision.

Thea supervises clinicians working with clients suffering from severe and persistent mental illness. In one session, she encouraged the group to look at issues of safety in the relationship between the practitioner and the supervisor. She stated her belief that whether in individual or group settings, clinical supervision, at its best, creates an environment that allows for great learning. Yet often this leads to disturbances in the workers' sense of self. As Thea went on to describe her efforts to create a safe environment in supervision, she identified her own dilemma of creating safety vs. allowing the workers to struggle alone.

The subsequent group discussion highlighted the fact that clinical supervision is clearly a multi-level process. Both the practitioner and the supervisor are ***learning together*** about the client, about one another, and about themselves. The group brainstormed about how supervisors could create conditions allowing workers to learn safely—an atmosphere in which meaningful dialogue can take place. All the supervisors felt strongly that having tact, sensibility, sensitivity, and, most importantly, knowledge of the boundaries of supervision were the real challenges for supervisors to develop and display.

I asked the group to discuss ways in which they could help supervisees learn to tolerate the disruption in their own sense of self, which learning requires, while still living with feelings of ambiguity and vulnerability that often accompany new knowledge. In response, supervisors began to recall their own experiences with learning something that was a difficult hurdle for them, how they came out the other side of the learning experience and were then able to "look back," and what it took for them to have gone through those experiences. The group discussed how supervisees learn to marshal their own capacity for confronting new information about both the client and themselves, and how the supervisors learn to respect the difference between supervision and therapy. Group members shared their own experiences of being in "the supervisory moment"—those times when issues arose that forced them to look at something from their past that was interfer-

ing with their work in the present. Most often, the experience involved dealing with client issues similar to ones that they have yet to sort out in their own lives. This realization helped supervisors appreciate that for most workers, the risk of exposing this type of information to supervisors is a challenge. Sorting out the professional from the personal is a difficult but essential moment in the development of the clinician.

Developing person-centered language.

Stacie supervises clinicians working with clients who have been dual diagnosed with a mental health disorder and with substance abuse, and who often are experiencing other problems as well, such as homelessness. She brought to the group her struggle to develop a language for both supervisor and supervisee that fits both of them. This is an issue close to my own heart. One of Stacie's workers tended to talk about her clients by their diagnostic labels (e.g., "the borderline" or "my bipolar client"). For Stacie, an important facet of her teaching, therefore, was using clinical language which respects clients as human beings and not as disorders.

I asked the group to consider the possibility that workers who persist in describing clients by their diagnostic labels may be doing so to create ***an illusion of professionalism*** so as to obscure their lack of knowledge or deficiency in ethics and values. The group responded by discussing their own experiences at learning diagnostic nomenclature, putting jargon to work, and how understanding the language made them initially feel "professional"—that is, like they belonged. Issues of the degree of empathy and respect for the clients and their conditions then entered the discussion. Finally, the group focused its attention on the supervisors' efforts to facilitate workers' understanding of their own issues of authority and to develop their own theories of how clinical language is used. This discussion led to clearer ideas about how clinical supervision can provide workers the opportunity to discuss the "how-tos" and "shoulds" of diagnostic nomenclature.

Identifying the worker's style of learning and dealing with defensiveness.

Wendy supervises student interns in their clinical placements. She brought to the group the issue of how to identify her interns' learning style. While aware that clinical supervision involves many skills, processes, empathy, and teaching abilities, focusing on the inner thinking of the supervisor—particularly identifying how their workers learn—was a challenging discussion for the group. For many, this was a new, perhaps even foreign, concept. It was helpful to recognize, for example, that many supervisees are visual learners—they need to see something in action first before they can practice it and organize it into their own style. Whatever the supervisee's learning style, however, supervisors must learn how to adjust their role to fit the needs of the individual worker in terms of what the worker wants or doesn't want and what pushes his or her buttons.

I encouraged group members to ask the practitioners they supervise what kind of social worker they want to become, to gauge their openness to differing ideas, and to assess the present stage of their professional identity. This led to an extended and difficult discussion about how to deliver criticism, especially when workers have a history of reacting defensively. I asked the group to consider the question of how *they* preferred to hear criticism in their own professional life. Surprisingly, many of the group members had never been asked how they wanted to hear criticism. As the discussion unfolded, some members shared that they would want to hear feedback as soon as an issue arises, preferably in

private, so that they would have a chance to think about what had been brought up. After this, they felt they would be able to come back to a supervisor and talk about it directly. Half jokingly, others said did not want to hear any criticism at all, and appeared wounded at the thought that something they did might not sit well with a supervisor. The discussion ensued about how supervisors learned to assess and judge their workers' receptivity to constructive criticism. The concept appeared both new and worthwhile.

Subsequently, assessments of workers' capacities in others areas—intuition, empathy, associations, leaps of imagination, and reasoning processes—came up in the discussion. To the group's surprise, they were all struck by the number of supervisees with whom they had worked who were, for the most part, generally caring and empathic clinicians, yet, in specific situations (e.g., when their buttons have been pushed), they responded in defensive, cold, and non-empathic ways. Assessing workers' empathy and ability to care seemed obvious to everyone, yet in discussion the group members were aware of how often empathy and caring were the first things to go in their workers' discussion involving a case. I asked the group to consider that when caring, empathic workers lose their empathy and begin sounding like they don't care, then supervision has arrived at the "teachable moment." Loss of empathy should be a first clue to the supervisors that something has occurred in the clinical process that needs both the supervisor's and therapist's attention.

Working with metaphors and symbols.

Corey, a supervisor on an adolescent team, brought to the group her workers' struggles in deciphering and appropriately responding to clients' symbolic communications. As the discussion unfolded, several supervisors commented that many clinicians, although bright and knowledgeable, nonetheless struggle with client analogies, metaphors, and unconscious communications. She brought up her experience with Anne, a clinician who had difficulty recognizing and conceptualizing a countertransference response to a client—a reaction not usually characteristic of her. Anne had difficulty seeing that the client, with whom she obviously enjoyed working, was communicating indirectly his attraction to her through seductive analogies, symbols, posture, etc. Eventually, this indirect communication needed to be pointed out to Anne in supervision.

The group discussed way in which they learned these concepts—in school, in supervision, through seminars and case conferences, etc. This discussion brought back visual images for many of their own struggle to figure out countertransference issues and to translate theoretical abstractions into the real world of client-therapist interactions occurring in psychotherapy practice. Going back and remembering, then figuring out ways in which one can help a worker deal with these issues and learn about them, proved helpful to the group. I asked group members to talk about their role in helping workers articulate what they know. We then discussed how to match the practice or intuitive wisdom of workers to human behavior theories and diagnostic categories and how to help them formulate clinical hypotheses and inferences.

Understanding emotional reactions to clients.

Georgia supervises mental health workers who liaison with the local county department of social services. She brought to the group's attention her difficulty in getting workers to reflect upon their own emotional reactions to clients, and the related difficulty of controlling their affect.

Many workers struggle with their own feelings about their clients, ranging from looking forward to seeing them to, at the other end of the continuum, feelings of never wanting to see them again. In both instances, supervisors shared their efforts to help workers identify their own affective response to their clients and to examine what things get in the way of their work.

I shared with the group my own observations that it is not uncommon for many new professionals who work with children and families initially to have strong feelings of wanting to rescue a child from "bad," uncaring parents. Good supervision—and ongoing practice—can help workers begin to see parents as individuals in their own right, with strengths and capacities, not just problems or deficits. By facilitating workers' self-reflection, supervisors can help practitioners get in touch with the positive and negative feeling about parents and to sort out which feelings are reality based from those stemming from countertransference. This discussion helped group members figure out additional ways to aid their workers.

Conclusion

Hardest among the many things in supervision is helping workers to develop an ability to look at the supervisor's questions as a ***method of inquiry*** rather than an attack. It was important to help the supervisors understand the threats to workers' own self-esteem and to assess their ability to tolerate shame and exposure. Our discussion focused on our own difficulties in hearing criticism and times in our life in which we felt left hung out to dry. We talked about helping the supervisee develop and articulate his or her channel of thought: "Why am I going in a certain direction?" The supervisor needs to know what their supervisees understand about the individuals with whom they are working. Often, new workers may focus exclusively on the diagnostic component of the client, rather than seeing the totality of the person. We agreed that the supervisor's job was to help the worker talk about the personhood of the client rather than the diagnostic label. The most important aspect from this discussion was supervisors learning ways to help workers understand that diagnostic labels have limited value in and of themselves. It is only as the diagnosis is connected with specific intervention and change plans that it becomes clinically relevant.

Now six months later, the group of clinical supervisors program is progressing well. Supervisors are more confident in their work, are consulting each other about their workers, and feel strongly in their commitment to developing worker skills and knowledge. The process has allowed a renewed investment in supervision that, in turn, will have an impact on workers' growth and development. It is hoped that this process will encourage workers to stay in agencies rather than leave in frustration. Clinicians being supervised, in turn, report perceiving a positive change in commitment from the agency, corresponding to their own commitment to the development of their professional identity.

Maybe there is hope that we can reverse the dearth of quality clinical supervision. In the present era, "supervision" too often has been reduced solely to attention to administrative tasks. In contrast, the effort of this clinical supervision group has been to restore an understanding of supervision as a mutual process whereby strong clinical supervisors teach clinical knowledge and skills to their workers and foster their professional development.

Call for Narratives

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This special issue will focus on the healing powers of humor and how humor can be used in professional practice, as well as how it is used by helping professionals to renew themselves as they engage in emotionally strenuous work.

NARRATIVES:

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Manuscripts are due by July 30, 2001

On My Own: My Experiences Finding Supervision

By Colleen Attoma-Mathews M.S.W., L.C.S.W., in private practice

This narrative describes the author's early experiences in clinical supervision after she received her M.S.W. She reflects on the role supervision played in the development of her professional use of self.

A funny thing happened to me on the way to becoming a professional social worker. Now two years into my post-master's career, I can look back on my entry into the field to share my experiences into the supervisory vehicle that helped me develop my professional sense of self.

My master's program had an advanced generalist social work practice approach in its second year, offering only electives in clinical social work. In order to focus my education toward clinical social work, I knew I had to enhance my own learning experience. The field placements I chose were both direct clinical practice with knowledgeable clinical supervisors having strong psychodynamic orientations. I filled my elective slots with clinical direct practice classes. Additionally, I enrolled in a post-graduate family therapy training program that would give me a theoretical foundation for my clinical practice in family therapy. This training offered me two years of class work in family therapy theory along with individual and group supervision of my direct work with family clients at the program's outpatient clinic. The supervisors in the training program were approved by the American Association of Marriage and Family Therapy. As a result of this education and training, I received a post-master's certificate in family therapy, plus, if I chose, the ability to take the state exam for a license in marriage and family therapy. More than anything, I hoped this additional training would lead to a job working with adolescents and their families, doing therapy, and receiving the supervision I needed to obtain my license and to grow into a strong and seasoned professional.

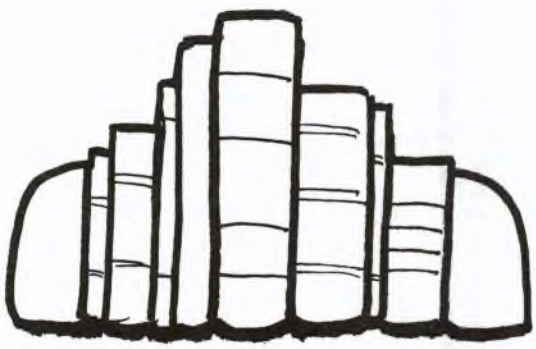
The importance of post-graduate supervision was a concept I learned from "Professor Brown" during the second year of my master's degree studies. (In order to speak candidly, I have changed the names of various educators and supervisors in this narrative.) Professor Brown stressed the significance of quality supervision beginning with my first job. His feeling was that in order to become a consummate professional, one needed to engage in a life long learning process. Along with that he emphasized the importance of finding out what kind of supervision and training agencies had to offer prospective employees. He suggested several points that should be explored with potential employers:

- What is the theoretical foundation of the agency and its clinical supervisors?
- What levels of supervision are available?
- Who would provide direct supervision?
- Was continued education offered with the agency?
- Was the agency's theoretical foundation compatible with my beliefs, values and theoretical interests?

Getting answers to these questions would be important not only for meeting the

state requirements about the extent of supervision needs for licensure, but also for meeting my personal learning goals. Additionally, opportunities for training would give me the opportunity to explore new avenues of clinical social work.

Prior to my entry into the master's of social work program, I had twelve years of business experience in the private sector. My experience in the business world was that of continuous education and training which benefited both myself as an employee and the companies for which I worked. The private business sector spends a large amount of time on training and development as an investment in their human resource stock which in turn contributes to capital growth. I had expected an experience similar to this in human services because the product was much more precious than capital; it is the well-being of people. I was surprised to find that all were not as dedicated to this end as I was idealistically.



My First Supervisor

My career goal, post graduate, was to be able to work with adolescents and their families in a residential or hospital setting where I would be able to practice psychiatric social work. I had experiences with clinical day treatment and inpatient psychiatric settings for field placements. I enjoyed the challenge of working with adolescents experiencing the first signs and symptoms of mental illness, helping them to establish an understanding of their difficulties and to develop coping skills. For my first post-graduate clinical social work job I had hoped I would have multiple levels of individual and group supervision and ongoing training with the latest therapy styles. But, as I learned during my field placement in my last year of graduate school, budget cuts had caused the mandatory continuing education to shrink to individual supervision once a week (not necessarily with a social worker) and multidisciplinary meetings bi-weekly, with very little emphasis on theoretical technique or professionalism. I was disappointed with the lack of investment in employees in human service agencies. I had assumed that innovative training and mentoring programs, as I had found in the corporate world, would be the norm, particularly given the emphasis in the profession of finding a balance and controlling burnout.

As I started searching for my first job, I felt I would be lucky if someone would be willing to take a risk on an inexperienced recent graduate with "no experience." I doubted whether I would be worthy of an agency to take the time and effort to train me. But I knew that my former professor was right, that a job that included substantial supervision and training was important for my continued growth as a clinical social worker. Furthermore, I had begun considering adding post-graduate education in family therapy to my academic experience.

I pictured a supervisor who would take me under her wing, someone well experienced in the field of adolescent and family therapy. A mentor! Someone who would structure our weekly one-hour meeting to review my case load and devote time to the difficult clients for dissection and planning. Someone able to spot my shortcomings and address my countertransference issues in a graceful and nurturing fashion, working together from a strength-based perspective,

establishing trust and mutual caring. I wanted a mentor who believed in me; someone who would help me believe in myself.

My first job out of school was a temporary position as a therapist on an adolescent inpatient psychiatric unit at the state mental health facility. I accepted this position with great enthusiasm, knowing that it could possibly become permanent. But, my enthusiasm clouded my judgment and I ignored Professor Brown's advice. I didn't ask what opportunities I would have for continued learning and supervision. I felt that if I was lucky enough to be a contender for the position, I should take it and hope for the best. I threw out the ideas fostered by Professor Brown only months prior. My decision would soon come back to haunt me.

The social work department at the hospital had a reputation for having a strong psychodynamic orientation. However, the recent change toward managed care, along with the institution of shorter hospital stays for patients, led to a brief intervention model (still sprinkled with psychodynamic theory and jargon), in which the focus of our work was to reduce patient lethality and raise the ability of patients to cope in a community setting with outpatient or residential support. Therapy was brief in most cases. But occasionally, I had the opportunity to work with clients suffering from their first psychotic episode or a patient suffering from severe and persistent mental illness. I could then work with clients to help them cope with significant personality disturbances over a longer course of time.

Group supervision consisted of bi-monthly, multidisciplinary clinical meetings. Led by our team leader, a clinical nurse specialist, we reviewed cases and discussed and brainstormed difficult cases. Mandatory social work meetings were held on off weeks. This meeting was just like the multidisciplinary meetings minus the team psychologist. For one hour a week I met individually with my supervisor, a licensed clinical social worker with twelve years' experience postmasters.

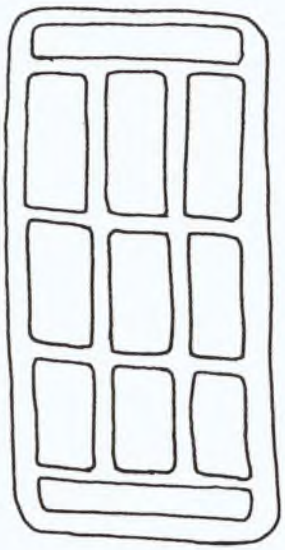
My supervisor, "Mr. Edwards," was erudite in object relations and psychoanalytic and psychodynamic theories. He was known as someone who made a career out of dissecting and knowing these particular theories inside and out. However, we were unable to build an environment of supervision in which I was able to learn from him. Our meetings lacked the structure of the kind of learning environment that I craved, especially being just out of school. He was not interested in setting agendas for our meetings. Instead he wanted a quick run down of my current cases and when I felt that I could have them discharged. His focus was on case management, not the development of my skills as a therapist in the individual, family, or group setting. Mr. Edwards seemed to be a victim of the "golden handcuffs" of state employment, meaning that longevity in a position insured increased compensation and benefits not based on job performance and/or satisfaction. Therefore, he always did just enough work to get by. If I did not remind him of our weekly scheduled meetings, he would let them pass. When we did meet, he kept our meetings short because he had "other

things to get back to." He appeared to have lost interest in providing a stimulating learning environment for his supervisees. I was understimulated by what he did offer me.

Our hourly meetings usually lasted thirty minutes and included superficial chat about the weather. I got the feeling that I was not worth his time. I did not feel cared for and, as a result, I could not trust him to be there for me when I needed him. If I was having difficulty with a child, parent, or case worker he would say something like, "Oh yeah, so and so is really hard to work with, good luck," and move on, instead of helping me think through a difficult situation. Supervision was a part of his job description that he seemed to take part in unwillingly. When I approached him about the situation he begrudgingly agreed that he was not a willing supervisor. I felt dismissed; our meetings became rare. It was a relief not to meet with him but I was disappointed because I had let him off the hook to provide me the supervision that I wanted and felt I deserved. My choice, therefore, offered very few opportunities for me to explore and make use of the theories I had learned in graduate school.

Working in a locked psychiatric facility, with potentially lethal and violent adolescents, was both exhilarating and overwhelming. The exhilaration came from the success I felt when I was able to forge a therapeutic relationship with patients. I felt overwhelmed without a supervisor. I was proud that no one got hurt on my watch and I kept getting kudos for the type of therapy I was practicing, which was a combination of gut-level intuition and nurturing.

But, without strong supervision, I remained unsatisfied with my situation. I ran my cases and sessions by "anybody" on the team who had experience and who would listen. The beauty of my multidisciplinary team was the multitude of subjective and



objective perspectives they shared. The downside was that these people, although somewhat helpful, were not directly responsible for my performance and had nothing to gain or lose by sharing their perspective with me or contributing to my development. However, I remained concerned that I was not meeting my clients' needs due to my lack of experience and knowledge. I was uncertain if my practice was reflective of my formal education or if I was moving on "gut instinct." Approximately five months into being hired temporarily, my position was made permanent.

My Second Supervisor

I found a haven from the mandatory weekly supervision meetings with Mr. Edwards by meeting with the team's attending psychiatrist, "Dr. Jones," whose professional training was in psychoanalysis and psychodynamic theories. In our meetings she and I set the agendas weekly and kept the focus on my use of self and continuing my education. Above all I was challenged by her inquires into my professional self and by her constructive criticism. Dr. Jones was kind, intelligent, and instructive. She helped me make use of and trust my "gut-level intuition" in sessions and in group work with my patients. A break-

through happened in our trust when I brought to supervision an issue I was truly concerned about. I had felt fearful of one of my patients who was experiencing his first reported psychotic episode. I felt as though he was directing his anger toward me for "keeping him in the hospital against his will." I felt ashamed and, well, stupid for being afraid of a patient. She suggested that I pay attention to what I was feeling and label it as intuition. In our attempt to reframe the emotion the patient was exhibiting, I began to see that perhaps this patient was angry but not necessarily at me, that a team needed to address his emotions in order to keep him and the community safe. As a result, Dr. Jones coached me in addressing the nursing staff about the issue to devise a plan to meet and circumvent his anger without incident to anyone. Through this supervision experience, I began to listen, trust, and make use of my intuition in regard to patients, their families, and other integrated systems.

I began to understand the concept of use of self. I was fortunate to have her, but I yearned for a supervisor or mentor from my own profession, to help me develop and define my role as a professional. I began to look for outside supervision from a licensed clinical social worker.

My Third Supervisor

The idea of shopping for my own supervisor appealed to my sense of continuing to direct my own educational experience and follow the guidelines Professor Brown had lain out. I first began my search from within the hospital. The social work director of the hospital persuaded me to try to work things out with Mr. Edwards and offered to discuss the issue with him. He stated that there was not any available skilled child and adolescent supervisor within the hospital to work with me due to demanding work loads. So I discussed my dilemma with several clinical social workers I respected in the community and decided to interview several licensed professionals in the local area. During these interviews, I discussed what I saw as my strengths and weaknesses as a clinician and what I hoped to glean from the supervisory relationship. I told them I was anxious to apply theories that I had studied during graduate and post-graduate work. I was concerned that my clients would suffer from the lack of connection between my education and my practice.

I interviewed a former professor from my graduate program, "Mr. Stein," who was now in private practice, providing therapy and conducting supervision groups and business consulting. Although I had not taken a course from Mr. Stein during my graduate education, I knew he had a reputation for being difficult and demanding. At this time in my career, I felt that taking a good look at my practice with someone who would push me to think was just what I needed. I found that I had a tendency to be critical of my work and was consistently striving to be the best practitioner possible.

I was willing to put in the additional expense of external supervision for more of what I called "scrutinization" of my abilities as a therapist. I told Mr. Stein how critical and demanding I am of myself and that I was looking for someone to push me. Equally as important was my need to connect theory and practice. I found myself asking the questions of him that I should have asked Mr. Edwards at the hospital when I interviewed there. During the first interview with Mr. Stein, I learned that he was educated in family therapy and had a strong background in psychodynamic work, two areas of theory that I was studying and interested in applying to my practice.

Following my decision to hire him, we laid out a plan to work on my professionalism and incorporate theory with practice.

Each time we met we looked at the difficulties I was having with specific clients as well as how I was feeling in my stage of development as a clinical social worker. On several occasions he stated that my approach to supervision was to have him perform "autopsies" on my work, locating the problems and potential mistakes I presumed I had made. His objective was to have me begin to look at the positive aspects of my work and to build on my innate strengths and abilities as a clinician. During this work I began to build a foundation of my own sense of self as a professional. In addition, I began to express my needs and set better boundaries and limits in the workplace. I started to ask for supervision from Mr. Edwards and probe him for information to help me with my clients. I also ceased to take on a heavier work load than my colleagues, even if I was under the impression that they were not "doing their job." When I doubted my ability, Mr. Stein reminded me that he was not shy about telling people when they were in the wrong field, and that he did not believe I was. Although his reassurances embarrassed me, I left feeling stronger and more confident in my abilities and on the right track.

My Fourth Supervisor

While searching for and engaging in supervision with Mr. Stein, my post-graduate course work in family therapy had reached a point where I was comfortable seeing clients at the center. I was able to contract with a client population that I had not worked with in the past to expand my scope of knowledge. This enabled me to round out my skills working with different populations (i.e., women returning to school at a community college). Through my studies I discovered a kinship to feminist family therapy and Murray Bowen's theories.

Prior to being assigned clients, I was paired with other students with different individual and group supervisors. Normally students were assigned these supervisors without direct input as to who they may be. However, through my experiences with supervision I came to see myself as a consumer of an educational service. Therefore, after a careful look at my options and some trepidation, I approached the program director and told him who I believed would be a good match for me according to my interests. My first choice was a therapist who practices feminist family therapy, "Dr. Logan," who is also involved in research and publications of her work. My next two choices were two men who had many years of experience working with adolescents and families in hospitals and outpatient settings. To my surprise the director placed me with two of my three choices.

My group supervision experience with Dr. Logan has been one of the most challenging and progressive learning experiences I have encountered. There were four students in each small group working on a rotating basis conducting therapy with "live" supervision incorporating the use of a two-way mirror.

We met bi-weekly for two hours. The first half hour a client(s) was staffed by the presenting student therapist. During the staffing a genogram and/or a Minuchin Map was presented along with the presenting problems and what the student would like to work on with the client in therapy in the next hour. In addition we discussed how to make use of the group behind the mirror (i.e., as a reflecting team or to present a message to the client(s) at the end of the session). The client(s) were seen in the following hour and were amenable to having the group as an

audience and to be part of this learning environment. Following the session the group would discuss strengths, critiques, and weaknesses of the interaction and help the student therapist devise a plan for the future. This group developed a strong trusting relationship with one another which fostered growth and skill building for all involved. We came to a place of comfortably challenging one another to push for full potential as family therapists.

For me the live assistance and critique of a supervisor and my colleagues helped me to see the strengths and weaknesses of my work in a safe environment. From this direct feedback and encouragement, it has been confirming to realize that I am developing useful and solid skills as a therapist. I am beginning to believe in myself.

Conclusion

My journey, thus far, has taught me to take opportunities for growth and where they do not exist, to create them. I continue to take my learning experiences seriously. I now realize there have been times when I have had up to four supervisors, each one of them contributing to my learning experience in different ways. I understand that it is important for me to continue learning and engaging in environments that foster my growth as a therapist. I also see that accepting supervision at face value may not be in my best interest. It is imperative to research a supervisory relationship before accepting it and to take part in agencies where the skill development of employees takes precedence in order to best serve their population. I am now happy to have become a disciple of Professor Brown's wisdom and evangelical pursuit of higher knowledge for myself.

Reflections readers are invited to attend a conference on "The Power of Narratives"

Reflections is sponsoring a conference on narratives, with discussion of the multidisciplinary applications of narratives in religion, women's studies, anthropology, art and the uses of narratives in therapy and in the presentation of self. The keynote speaker will be Maulana Karenga, Chair of Black Studies Department at CSULB, who will discuss Kwanzaa and its power as a narrative in resisting oppression.

Date: April 20, 2001
Time: 12 noon to 5:00pm
Place: CSULB campus
Reception immediately following

For more information contact:
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You Can Get There from Here, but Not in a Straight Line: A Resilience Tale in Two Voices, One Spirit

By Mark A. Lyon, Ph.D., School Psychology Program, College of Education, University of Denver
Catherine J. Cohn, MSW, Boulder Public Schools, and Doctoral Student in Child and Family Studies, University of Denver

This narrative tells the intersecting stories of a professor of school psychology teaching a class on resilience and capacity building in children, a student-colleague in the class who is a practicing school social worker, and the social worker's clients—a fifth-grade boy facing a set of difficult problems and his concerned and frustrated parents. The story is one of shared learning, a commitment to collaboration, and the application of research and theory learned in class to a school-based intervention.

Resilience in Theory: Mark's Tale

I was just coming off of back surgery and settling into the routines of university life again. Some good days, some bad; but even the bad ones didn't seem so intolerable in light of my recent experience. Due to the extended recovery period from the surgery, I was still scrambling to prepare for my Winter quarter course, "Developmental Psychopathology," my personal favorite. Because I have a long-standing interest in and commitment to prevention of mental health problems, and specifically to the notions of resilience and capacity building, I use a substantial portion of the course to discuss and explore these concepts as they relate to children's and adolescent's development. We talk a lot about what Robins and Rutter (1990) have called "the straight and devious pathways from childhood to adulthood"; the central point being that pathways to healthy or dysfunctional patterns of behavior are seldom simple or isolated from the contexts in which they occur. Instead, they develop in the oftentimes tangled, always changing, context of adult-child and peer relationships. They also occur within a variety of important social systems including families, schools, and communities. The transactions between the developing child and important others in his or her environment help bend the pathways of development in predictable directions, either fostering positive growth or tending toward dysfunction. Where the mechanisms underlying these transactions can be identified, prevention (and intervention) efforts are greatly enabled.

For example, one of the most enduring findings in the resilience literature, which has accumulated over the past 25 years, is that a warm, consistent relationship with at least one adult caregiver affords immense protection to children's development, even in the most adverse of circumstances (see Doll & Lyon, 1998; Garmezy, 1991; Masten, 1994; Masten & Coatsworth, 1998; Pianta & Walsh, 1998; Rutter, 1985, 1990; Werner & Smith, 1982). Most researchers access the "attachment system"

as a plausible causal mechanism for this outcome, as children with secure attachments generally have a positive developmental trajectory, while children with insecure attachments are at risk for a variety of later educational, mental health, and interpersonal problems (Masten & Coatsworth, 1998). A popular example of this notion may be recognized in Frank McCourt's autobiography, *Angela's Ashes*, in which he recounts the story of his life from birth to early adulthood. In spite of growing up in conditions of abject poverty, and with an alcoholic, often absent father, his story is clearly one of overcoming adversity, or resilience. The positive outcomes he describes emerge not only from his own resourcefulness, but also from the relationships he develops with his mother and other key adults and peers in his life, which act as protective mechanisms against the harshness of his circumstances. (See Doll & Lyon [1998] for a review of the major findings regarding both individual and contextual factors related to the development of resilience in children and adolescents.)

Somewhere about the third or fourth week of the course, Cathy, a student in my class at the time, came to me and said, "This stuff is really interesting. It resonates with a lot of the things I've thought about trying to incorporate into my practice. In fact, I have a case right now where I'd like to try some of the principles we've discussed in class. Do you have time for me to tell you about my case?"

"Sounds intriguing," I replied. "Tell me what you've got and what you're thinking about doing."

Here's what Cathy described:

James' Story

James was referred for intervention due to difficulty in his home, the community, and the school settings. He had been previously diagnosed with Attention Deficit/Hyperactivity Disorder (AD/HD) in 1997. As a result of his diagnosis and subsequent staffing as a student in need of special services, he was referred to Cathy as school social worker for counseling.

James is an only child living with his mother, Michelle, and her partner, Dan, both of whom are health care professionals. Michelle and Dan have been living together for eight years. Both are quite involved in James' education and they share the responsibilities of parenting. James' biological father resides in another state and he sees him each year during summer vacation.

Michelle and Dan are extremely concerned about James. Despite trying many strategies to set limits for him, he often does not complete homework assignments or follow rules at home. He leaves home for many hours, wanders around the community, and often returns long after dark. When questioned about this behavior James says, "Well, I know I'm already in trouble anyway, so why not stay out as long as I want?" At times, James sneaks out of his bedroom window to play and does not return until 10:00 or 11:00pm. Some of this might be accounted for by problems with "time sense," as many AD/HD children are reported to have, yet a larger portion of the problem is behavioral. James' parents see him as difficult and oppositional; however, they report things are actually better this year than last. Still, when they try to set limits and withdraw privileges when he

doesn't comply, James seems not to care. On one occasion, they went skiing and left him in the car to work on his schoolwork. They considered this to be an appropriate punishment for his not completing class assignments, and were nonplussed when James did not comply, stating he didn't really know what the punishment was for.

Personally, James seems to lack the capacity to regulate and soothe himself. He is often overwhelmed by his own feelings and his inability to exert control over himself and his environment. He is easily frustrated and when he gets out of control, he is often inconsolable. His running away and occasional truancy seem not motivated by unhappiness so much as by an inability to control his impulses and wanting to do whatever he wants, whenever he wants. He seems to have the same problem in his relationships with peers. Even though he's only in fifth grade, he is already getting into some problematic situations with girls. His attempts at relationships with several girls have caused him problems because he has a very poor sense of boundaries and doesn't seem to understand that he can't just do whatever he wants.

James' home situation is characterized by a lot of conflict. His parents frequently fight, argue, threaten each other with separation, yell, berate each other and James, and don't seem to be able to follow through with him. They have good intentions about setting limits and helping him control himself, but lack the skills to be able to follow through. In short, although they're concerned about James, their relationship would hardly be characterized as very positive or warm. His relationships with peers are also problematic, and his classroom performance is poor as well.

A Collaborative Dialogue Begins

"An interesting case," I said. "Like a lot of things you see in schools. Problems that run across several systems, not easily solved with any one approach. Also like what we just read by Pianta and Walsh (1998) for class today, not helpful to locate the problem exclusively at the individual levels of the child, the family, or the school—the invidious triangle. So what are you thinking about doing?"

"Well," Cathy replied, "I'm definitely going to see him for individual counseling as planned. I want to work on some self-monitoring and self-regulation strategies with him. I've done a lot of that in the past and I think it will be helpful for him, especially with his AD/HD. I'll also see him in a group I run for social skills, friendship problems, and improvement of peer relationships. He's starting to get into a lot of trouble with peers and I want to see if I can help him avoid some of that. I'm afraid he's eventually going to drift into a negative peer subculture. But what I'm really interested in is working with his parents. I'm thinking that if I can somehow help restore their relationship with him, other things might be easier to accomplish. I think I can also get a few other key adults in his life to establish a more positive relationship with him. And I

want to get him engaged in more pro-social activities at school and in the community. He's got several strengths I can build on, too, like good potential in drama and music. So, what do you think?"

"I think those all sound like potentially good strategies to try," I said. "But it's

pretty ambitious. Can you actually do all those things in your position as school social worker?"

Cathy replied, "I think I can. Besides, what's the alternative? I know I'll be attempting to effect change in a couple of systems that likely will be resistant, but it still seems like it's worth a try. In fact, I can't see what good I can do working with him completely on an individual basis. He needs lots of support, and some of those supports need to come from his family and the school. I'm just wanting to see if I'll get more positive and maybe lasting effects if I work this way, rather than the usual see 'em in your office routine."

"I definitely agree with your sentiment," I said. "It's just that helping a child overcome adversity is a long-term, continuous process. It requires lasting relationship commitments over the long haul and seems to work best when it occurs in a natural developmental context. As I understand the literature, a lot of what's being tried in the name of resilience, those pre-packaged programs we talked about in class, have little chance of succeeding. You can't just trot out a list of characteristics that resilient individuals are known to have and presume to 'teach' them to kids. I don't think it works like that. Resilience is as much dependent on the quality of relationships people have, and their transactions with the environment, as on their individual characteristics. In fact, there's still a lot of dispute about where resilience actually lives—within the individual, within systems that contain the individual, or in the transactions among the individual and important others in a variety of systems. It's not entirely clear."

"Yeah, I think that's really true," Cathy replied. "I've seen some of those packaged programs first hand in a couple of the schools I've been in. It doesn't seem like it works very well. It's like the concept of wellness; you have to understand the specific things that contribute to physical well-being before you can adopt a healthy lifestyle."

"Exactly," I said. "We know quite a bit about the broad factors that tend to be associated with resilience, but very little at this point about the specific mechanisms that tend to foster it. Once we understand the mechanisms, we should be able to make a lot of progress with prevention and intervention efforts. Trouble is, that's likely to take a long time. Knowledge in this area is probably going to accumulate slowly; but I understand you can't wait. You have a young boy and his family who need help now. You're between the proverbial rock and hard place, needing to proceed immediately but without a very precise map of where to go."

"So, are you trying to talk me out of this?" Cathy replied.

"No, no," I said. "I just think it's important to go in there with your eyes wide open. Cut yourself some slack, approach it experimentally, and be ready to make lots of adjustments as you go. I really have no idea what will happen if you approach it the way you've described, but like you said, 'What's the alternative?' Same old, same old, I guess. Why don't you give it a try and see what happens? Let's keep touching base every couple of weeks and you can let me know how it's going. Is that OK?"

"Yeah, that would be great," Cathy replied. "See you in a couple of weeks. Well, actually I'll see you in class next week, but I'll plan to talk with you about James the week after."

The following is Cathy's account of what transpired over the next several months as we continued our bi-weekly collaborations.

Resilience Applied: Cathy's Tale

My first impression of James was that, unlike many children who "learn from their mistakes," he was not able to profit from such lessons due to his impulsivity and lack of strategies for coping with difficult social situations. Because attention shifts were so common and frequent, James' experiences were not internalized in a nice, coherent fashion, and he had difficulty making sense of them. He also lacked consistent adult models who could coach him through many of these difficulties and help him begin to understand the cause/effect nature of his problematic behaviors.

Much previous research regarding AD/HD has shown significant long-term sequelae, including comorbid diagnoses of Conduct Disorder, Oppositional Defiant Disorder, Learning Disabilities, substance use or abuse, increased contact with the law, troubled interpersonal relationships, academic underachievement, increased risk of dropping out of school, peer rejection, and development of antisocial behavior patterns (Barkley, Fischer, Edelbrock, & Smallish, 1990; Gittleman, Mannuzza, Shenker, & Bonagura, 1985). James' long history of failure related to the disorder also made him vulnerable to depression. His social relationships were inconsistent and at times volatile. He had trouble forming long-term attachments with peers, finding it difficult to modulate his behavior with friends.

James' most immediate challenges were in two basic areas: impulsivity and attention problems. James' attention difficulties were twofold. He had sudden shifts of focus and would articulate both relevant and irrelevant information on any given topic. At other times, James would "zone out" so completely that he would appear to be in trance. He often didn't know why his mind would wander or what caused him not to be able to concentrate. Stimulant medications were tried with limited success. He experienced side effects of prominent weight loss and insomnia that led his parents to stop the medication. In addition, the administration of the medication was sporadic and inconsistent, making it difficult to evaluate its effectiveness.

In addition to working on self-monitoring and self-control strategies with James in our individual counseling sessions, I had him participate in a boys' group with four other fifth-grade boys. He never missed our weekly sessions and would often come to the group with pressing problems, mostly relating to girls. Though seen as troublesome by many of his peers, James was also friendly, outgoing, and sensitive. At times, however, he would appear cautious, resigned, sad, and flooded with emotion. I asked him what he knew about coming to see me. He told me that he was one of the "dumb kids", but later retracted that and said that he came to have me help him with his problems. As James became more comfortable with me, he would often seek me out as a mediator between him and his parents. James wanted me to help make his parents understand that he wanted to be more responsible and in charge of his own life. This included being responsible for his homework. James was quite articulate and capable of relating feelings and facts. He said that his parents just didn't understand him and that there was too much yelling in his house. He also had a growing sense of a connection to his surroundings saying, "What you put into the world, you get out of it."

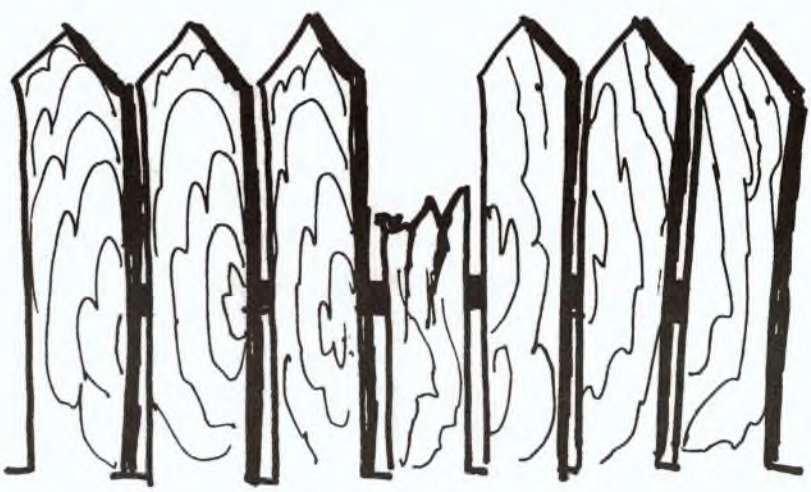
James seemed immediately to sense my empathy for and understanding of the difficulties he was experiencing. During our group time, I utilized a structured approach to social skills training; however, at times the boys preferred using the time to "just talk." Often I would begin our sessions with, " I've been thinking about what it must

be like to be in fifth grade and like some girls but not know how to talk to them...." and from there the boys would take over. James was one of two boys in the fifth grade getting into somewhat promiscuous interactions with girls. It seemed to me to be related to his problems with self-organization, having difficulty with boundaries, and controlling his impulses. In many areas, he struggled to maintain a sense of independence while holding an expectation that others would be critical and intrusive. He often expected that he would disappoint others.

During our group, we often used role playing of social situations to facilitate skill building and reading social cues. With some coaching, James demonstrated considerable skill in this area, often being the first to volunteer to participate. After a short time, the other boys in the group began to request that James be their partner "because he was the best." It wasn't long before the boys would say, " I wish I could act like you, James." By midyear, with my encouragement and that of his resource teacher, James began participating in plays in school. During the school lip sync concert, James, along with another boy, performed a rendition of the song "Don't Worry, Be Happy." He created ingenious costumes along with a smiling and frowning face, which he would move along with the lyrics of the song while dancing. All eyes were on James due to his compelling stage presence. Not surprisingly, he relished opportunities to perform and the positive attention it brought—and he continued to get better at it in subsequent plays and concerts during the school year. This allowed James to find a niche in school, particularly among his peers. He also started to participate more fully in class (at least when working with the resource teacher) and was more eager to learn. In short, the confidence that James gained from this achievement spread to other academic, emotional, and social realms in a highly beneficial way.

Working with James' Parents

The focus in treatment with James' parents was to help them acquire parenting skills and to provide relationship strategies and activities that were age appropriate and developmentally attuned to James' needs. While working with his parents to help them become better at developing a more positive relationship with James, following through on consequences for unacceptable behavior, and encouraging of more pro-social behavior, I also continued to work with James on self-control and better compliance with rules and demands at home. It should be mentioned that both Michelle and Dan had experienced difficulties in their relationships with their own



parents and had not acquired the capacity for protective parenting (e.g., their failure to intervene in James' running away). Running away appeared to be a desperate attempt to make an impact on his parents. These bright and very verbal parents seemed to lack the instinct for action that would interrupt potentially unsafe behavior on James' part. Both Dan and Michelle were invested in James but needed help in

understanding how best to help him and improve their relationship with him.

During our year together, I was struck by the nature of their struggles with James. Often Michelle would fight with him as if he were a peer or a sibling, turning to Dan for validation. In this area, Dan and Michelle would become openly argumentative. At one point during the school year there was talk of separation, with James stating it was his fault, and Michelle claiming that it was her and Dan's inability to find common ground about parenting. There were three meetings outside of the regular conference schedule and weekly conversations consisting of examples of how difficult it was to set limits for James. Often they would sit quietly, listening to suggestions, and then politely respond, "We've tried that." The initial tendency was for Dan to abdicate his role as parent/disciplinarian and allow Michelle to act in this role alone; yet Dan would become highly frustrated with Michelle's lack of ability to set limits. Communication often deteriorated to loud arguments, with threats of leaving or separation.

Dan, Michelle and I worked hard on developing skills to avoid verbal threats and engaging in power struggles. I taught them strategies to recognize impending power struggles and how they might intervene before a situation escalated. Michelle needed help in becoming attuned to what was motivating James' behavior. She also needed to allow him to make more autonomous choices. Dan and Michelle had always attempted to be direct and set firm limits for James but had difficulty following through with them once set. Michelle would state her belief that James was a good person with a good heart but in the next breath ascribe negative attributions to many of his behaviors. As a result, James formed the opinion that his parents were more critical and controlling than supportive and caring, and that he was a failure and source of disappointment rather than pleasure.

My work with Dan and Michelle included helping them to understand what wasn't going to work—no amount of cajoling, punishing, berating, arguing, or yelling was going to make James listen or learn—as well as what might. At times, there was no way of knowing what was sinking in. They used the principles we discussed to positive effect one week, then would lapse into "the old ways" the next. This disjointed dance between James, Dan, and Michelle created a great deal of friction between Dan and Michelle because of their frustration with James' seeming lack of compliance. I talked with them about recognizing when James was capable of focusing and talking with him at those times. Michelle was immediately able to identify when it wouldn't be effective to talk but struggled initially to recognize the times it might.

Because Dan and Michelle became so easily frustrated with James, we talked at length about how to communicate most effectively with him. We worked on deliberate strategies to increase positive interchanges and decrease negative ones. We also spent a great deal of time focusing on how best to use natural and logical consequences with him to help him understand the outcomes of his actions. It took a great deal of time and energy on my part to help Michelle and Dan see the importance of following through on sanctions for James' inappropriate behaviors while still maintaining a sense of encouragement for better behavior next time around. I felt it very important to impress upon them the undesirability of perpetuating his perception that he was a "bad boy" who constantly disappointed. Yet, he also needed the firm consistency of discipline and a system of external rules to help him manage his behavior. It took us the better part of the

year to arrive at the point where I felt Michelle and Dan had actually begun to change their behavior and means of relating to James, but it was a change I think well worth waiting for and working toward.

Mark and Cathy's Reflections on the Case

As noted in Cathy's narrative, several things changed for the better during the course of this intervention, and specific outcomes can be identified which support this contention. First, the relationship between James and his parents became visibly more positive. Incidents of shouting, verbal attacks, and threats were measurably reduced as Michelle and Dan learned more effective methods of dealing with James' behavior and communicating with him about their concerns. Similarly, instances of James' noncompliance with house rules and routines diminished. In fact, instances of running away or staying out beyond his curfew had dropped to zero by the final two months of the year. The causal pattern of these outcomes is not clear; however, we tend to see them as mutually regulated. That is, improvements in James' behavior likely influenced the more positive relationships his parents were able to form with him as much as their more positive ways of relating to him encouraged his higher rate of compliance. We are of the opinion that this is how lasting change most often occurs, making it vital in intervention to address both individual and contextual aspects of problem situations within the developmental systems in which they occur.

James' relationship with Cathy was also a highly positive and productive one, an influence we also believe was related to desirable outcomes. Having a warm and caring adult in the school system with whom he could confide and rely on to help him mediate problem situations was no doubt beneficial in a number of ways. Through Cathy, James learned better strategies for self-control, increased the number of friends he had, gained a measure of confidence in his ability to succeed, became interested and engaged in a number of pro-social activities, and increased his feelings of self-efficacy and self-esteem. To a lesser extent, his relationship with the resource teacher and principal of the school also became more positive. He demonstrated a better attitude in the classroom, had a higher rate of homework completion, and received many less discipline referrals as the year progressed. Again, these outcomes were mutually regulated—changes in James' behavior seemed to covary in relation to important others' development of more positive relationships with him. You can't have one without the other.

There were as well many things that didn't change. This intervention was implemented over only the final six months of the school year. It would be naïve to think that problems such as those described above could be completely overcome in so short a time. It is also patently inconsistent with the basic notion of resilience, which does not assume that once a hardship is overcome, it will always remain so. Since resilience resides largely in the transactions between individuals and important others in their environment, much depends on the nature and quality of those transactions. A person can be resilient to adversity at some periods of life, but not at others. Failures to cope are not conceptualized as deficiencies within the individual, but rather depend upon a confluence of factors. It is vitally important, therefore, for key adults in children's lives to act in ways that continuously support their development.

In the case of James, problems within the family continued to persist. There is still conflict between Michelle and Dan, and James' behavior remains challenging in many ways. He is not, by temperament, an

"easy" child, and he continues to challenge his parents' authority. As a matter of degree, however, problems seldom escalate to the levels seen when Cathy first began to work with the family, and James appears to be developing a belief that he is cared for by his parents (and other adults as well)—that he's not just a troublemaker or nuisance for them.

James also continues to struggle with peer relationships. He still has difficulty modulating his behavior with peers, especially on the playground and in other less structured situations. He continues to have deficits in both his knowledge of social relations and in his social skills. He is by no means a well-accepted child at this point, but he has developed several reciprocal friendships that provide him a measure of satisfaction. Prior to the intervention, James was very much "a loner," lacking not only peer acceptance, but also the experience of having at least one close friend. This situation changed during the final months of the intervention, and James continues to affiliate with several boys in his grade who provide good models of pro-social behavior.

James' relationships with some of his teachers also never improved, nor did his performance in their classrooms. Cathy tends to see this largely as a function of their expectations, which revolve around rigor of academic standards. Some of his teachers had difficulty adjusting their expectations of James in the classroom, in spite of his diagnosis of AD/HD. Instead, they continued to insist on excellence of academic performance, with little or no regard for the characteristics of individual students like James. James' responses to such treatment are still characterized somewhat by defiance and belligerence, though he is beginning to show more tolerance for demands of the classroom in general.

Clearly, some aspects of James' problems were ameliorated during the six months of intervention, while others were not. Whether the changes we saw would have occurred if Cathy had worked with him exclusively on an individual basis in her office, apart from access to his parents and other key adults, is difficult to say. It is our feeling, however, that a more viable structure for change, and continuation of change, may have been constructed by working in this way. In fact, we both believe that this may be the central advantage to working within a resilience framework. It allows you to tap into the naturally occurring developmental processes within systems, such as families or schools, and to address problems in the immediate contexts where they have salience. It also allows you to more directly influence the multitude of factors that seem to contribute to the development of healthy or dysfunctional patterns of behavior, and to do this in a more integrated fashion. Cathy said it best perhaps: "I'm not sure exactly how much lasting change was produced, but I feel like I set up a better framework for change. The potential for change was activated, and it seems like a better process for sustaining it was developed. I feel like I can hook back up with James' parents and some of his teachers at any point and try to keep the momentum going."

Though satisfying in many ways, intervening in this way was not without its frustrations. Cathy reported: "It was time consuming and labor intensive. It definitely requires a major commitment for the long haul. You have to stay on top of a lot more things when you're trying an integrated approach like this, rather than an individual one. I also felt at times that Michelle and Dan were trying to keep me involved in their struggles more than they needed to by pretending to be less competent than they were. They were ready to apply their new knowledge but kept trying to convince me

otherwise. I had to be very careful not to let them be too dependent on me. I also got frustrated with the teachers who 'wouldn't get with the program.' Some of them just weren't interested in trying to redefine their relationship with James, though they could see the benefits from the resource teacher doing so. I'm still not sure what to do about that, but engaging others in a process like this seems to be critical if you want to create the conditions for long-term change. I know there's a developing literature on parental engagement, how best to engage parents who have difficult children in the process of change, and I wonder if some of the same work doesn't need to be done with school personnel. It would really help if everyone was on the same page, committed to the same goals."

In view of these frustrations, at our last meeting of the year, Mark asked Cathy: "So, was all that extra time and effort spent worth it in the end?"

Cathy said, "I think the only voice I want to consult on that is James'. On the last day of school, he made a deliberate effort to find me in my office. He came swooping in, with a big smile on his face, and said, 'I don't know how you got me through fifth grade, but you did it!' That's reward enough for me, at least for now."

For Mark, the rewards were also many. In addition to taking vicarious pleasure in James' improvements, the collaborative relationship itself was richly rewarding. It was both exciting and challenging to attempt to apply the general knowledge taught in my class to a specific case. It was also a delight to work with an energetic and committed student/colleague like Cathy, who constantly stretched the limits of our understanding of resilience. I was forced to rethink a number of my cherished views on the matter, in the face of her observations and experiences with James. We had many productive dialogues about "how this stuff really works," and I came away with both a more finely honed set of concepts I was trying to teach and a renewed sense of commitment to teaching them. And somewhere amid this process, too, it occurred to me I'd completely forgotten about my back.

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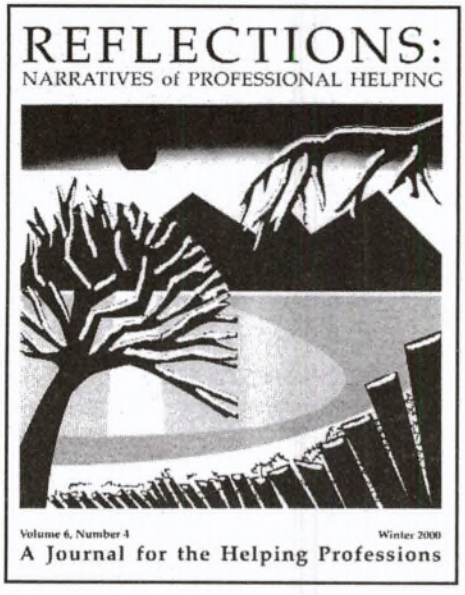

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