REFLECTIONS

NARRATIVES of PROFESSIONAL HELPING

Volume 14, Number 1 Winter 2008

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REFLECTIONS: NARRATIVES OF PROFESSIONAL HELPING (ISSN 1080-0220)
is a refereed journal published quarterly by the Department of Social Work,
California State University Long Beach, 1250 Bellflower Boulevard, Long Beach, California, 90840-0902
Periodicals postage paid at Long Beach, CA.
POSTMASTER: Send address changes to Reflections: Narratives of Professional Helping, Department of Social Work,
California State University Long Beach, 1250 Bellflower Boulevard, Long Beach, California, 90840-0902

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Volume 14 **Winter 2008** **Number 1**

Cover and original artwork: Dan Jimenez

PRINTED QUARTERLY BY **THE CSULB UNIVERSITY PRESS**

LETTER FROM THE EDITOR

Jillian Jimenez, Ph.D.

The political narrative is normally the most ordinary and least compelling of storylines. Most of the time there is no through line for Presidential primaries and even general elections are devoid of drama for all but the most committed political observers. Candidates sound more or less the same and the homogeneity of ideology is compounded by the homogeneity of demographics in the candidate field. The powerful sense of déjà vu that accompanies the political season (same arguments, same people) reduces interest in what is arguably the most important public decision Americans will make. If anything, the last eight years drives home the critical nature of the Presidential election – wars, soaring federal deficits, loss of support from other countries, war related deaths and casualties, programs denied, tax cuts for the wealthy, civil liberty issues – all are the legacy of the last 8 years of the Bush presidency. How could the stakes be any higher? Low voter turnout has been a sign that few share in the sense of moment embedded in Presidential elections.

This primary season a new, more dramatic and compelling narrative has been launched, galvanizing the interest of voters and the political classes alike: Barak Obama and Hillary Clinton are both viable candidates for the Presidency, and it is completely within the bounds of rational projection that one of them will become President in 2009. Examining the meaning of these candidates and their successes thus far reveals several braided narratives. Both candidates resonate with our history of oppression and discrimination and elicit our most closely held prejudices and hopes. They ask us to revise our narratives about political power and who can hold it in the United States. The job of President of the United States is not a token promotion or a prize born of special pleading. It is arguably the most powerful position in the world, made more powerful by the spread of nuclear arms, the conflagration in the Middle East and the rising inequality and health care costs that burden an increasing number of Americans.

It is truly remarkable that an African-American man and a woman are contesting for this role, and even more remarkable that one of them is likely to take it on. Something has decidedly changed in our narrative about who we are as Americans. Barak Obama's political rise constitutes the most spectacular apotheosis in American politics, solely because of our long history of deep racism and oppression of African-Americans. Fifty years ago some Americans would not have wanted to sit next to Obama on a public bus, much less voted for him to be President. For those of us who remember the Civil Rights Movement of the 1960s, Obama seems to represent a climax of long buried hopes that things can be different in this country and that the social construction of race and its ugly consequence, racism, can begin to fade from national life. Of course this has not yet happened; there is plenty of racial animus left and we are likely to see more of it as his campaign continues. But the fact of a high turnout of white voters supporting Obama is something many of us thought we would not see in our lifetime. Obama is the postmodern candidate, eschewing a race-based campaign, bridging political ideologies by reaching out to Republicans and Independents, seemingly forgetting the bitterness of our racial past. He refuses to embrace the political necessity of the Iraq project, as postmodernists might call our military engagement there. Yet he knows more than he puts in his campaign speeches, as indicated by his post-caucus speech in Iowa, when he obliquely acknowledged the importance to his candidacy of the Civil Rights struggle, alluding to Montgomery and Selma, Alabama. Obama is currently sending a coded message: if we don't mention the racial divide that has kept people like me out of political power, we can carry on as though it does not exist. Is this an agreement Americans are ready to accept? Does it promote social justice or drive bigotry underground to surface another day? The fact that Obama's own frequently mentioned biography includes a white mother and a father from Kenya perhaps protects him from the deepest discrimination reserved for those African-Americans who claim long roots in this country and whose ancestors lived through slavery and Jim Crow. Yet Obama is a recognizable African American man; his biography does not protect him the racism this fact can elicit.

Hillary Rodham Clinton's success as a Presidential candidate would be the most notable story of the campaign if it were not for the success of Barak Obama. In seriously considering a woman for President, the United States is behind other democracies that have elected women to positions of great power. The interesting question about her campaign is how much does she need to eschew traditionally feminine qualities to be successful in electoral politics? Since the nineteenth century the gender roles for white middle class women have been built on the qualities of piety, purity, domesticity and submissiveness; historians call this the "cult of true womanhood." Women were thought to be too emotional and delicate to vote until 1920, much less run for political office. Even after the woman's movement dismantled many of the expectations of femininity, hard edged, intellectual women continued to have difficulty in public life. The so-called double standard for women (assertive man is a leader; assertive woman is not welcome), meant that Hillary evoked negative feelings among people who felt she violated the socially constructed gender role she was born to fill. As political commentators have endlessly pointed out, Clinton's wincing "that hurts my feelings" at one of the debates and her eyes "welling up with tears" the night before the election were signs that an actual old fashioned woman lives under her organized, intellectual exterior and possesses the feminine delicacies, if not weaknesses that she is supposed to have. It was only after these "humanizing" (read feminizing) episodes that Hillary confounded expectations and won the day in New Hampshire. Confirming her femininity (do male candidates have to cry or do they disqualify themselves if they do, ala Edmund Muskie in 1972?), Hillary finally won the hearts of other women. It is a very odd thing that one's deepest ideological commitments and policy ideas can be trumped by a welling eye, but that is the game that Clinton has signed on for and seems willing to play. Like Obama's allusion to Montgomery and Selma, her tears and hurt feelings a coded message to followers: "I am a real woman." Shading Hillary's message even more, questions have been raised about the influence Bill Clinton will have on her Presidency—will he be the man she cannot be and do we trust her more because of her husband?

In any other year the main progressive narrative about this primary season would be the candidacy of John Edwards, a Democrat who does not claim the center as Bill Clinton did, but one who speaks of poverty and inequality. His quest was overwhelmed by the excitement many Americans feel at the new narratives we are writing: we can elect a Black man or a woman to the Presidency; yes we are a nation who has put our ugly racist, sexist past behind us. We will see.

The editor welcomes comments about this issue: jjimenez7@csulb.edu.

HOUSING WORKS, SHELTER KILLS!

An Oral History of Housing Works According to Keith Cylar and Charles King

Benjamin Shepard Ph.D., City University of New York

While first and foremost an oral history of a radical social service/social movement organization, "Housing Works, Shelter Kills!" is also the story of a broad impulse in AIDS and human rights activism. Housing Works was founded in 1990 to house a socially vulnerable population of homeless active drug users with AIDS – those usually turned away from other housing programs. Today, it is the nation's largest minority controlled AIDS service organization. The success of Housing Works can be attributed to an approach to social services built on combinations of fierce advocacy, client centered clinical care, rambunctious engagement, and community building. Through their re-invention of the Ghandian/U.S. Civil Rights repertoire of non-violent civil disobedience, Housing Works helped pave the way for the acceptance of harm reduction as a best practice approach to AIDS service delivery in the U.S.

Keith Cylar and Charles King were not the only founders of Housing Works, the nation's largest—and certainly most militant—minority-controlled AIDS service organization. (Attorney Virginia Shubert and ACT UP co-founder Eric Sawyer were also instrumental in starting the group). Yet over the years since the group was born out of the Housing Committee of the AIDS Coalition to Unleash Power (ACT UP) in 1990, Cylar and King came to embody Housing Works' belief in using direct action to "get the goods" for a population the rest of the world would rather have ignored: homeless, active drug users with HIV/AIDS.

Cylar, a gay African-American social worker and drug user, was the perfect counterbalance for King, a gay white southern minister who attended Yale's divinity and law schools, became the first (and only) white man to be ordained within the Connecticut Missionary Baptist Convention, and left his last parish when he refused to conceal his sexuality in the face of a looming AIDS catastrophe.

"*Silence Equals Death*" was ACT UP's warning to the world. Cylar and King were active members during the group's most active early years from 1987 through the early 1990's. Neither Cylar nor King could be silent about the fate of homeless people with HIV/AIDS. When ACT UP could not provide the advocacy and services necessary for homeless people, they moved to support their own entity that could achieve this end. In the decade and a half since the organization was funded, Housing Works has built on the power of the harm reduction and global AIDS movements to create permanent housing—and a community—for thousands of socially vulnerable people whose struggle with HIV/AIDS was complicated by histories of chemical dependence.

In interviews that follow, King and Cylar tell the story of Housing Works. The interview with King was conducted a year after Cylar's death from HIV-related cardiomyopathy in 2004. The interview with Cylar is the previously unpublished portion of a series of interviews I conducted with him in 2000-2001, some three years before his death (see Shepard, 2002, for the first half of this interview). The piece is structured so that the story of Housing Works' founding is provided by King, while its service and community-building model is detailed by Cylar.

Woven around King's 100-plus and Cylar's 50-plus arrests is the story of a radical housing model. These oral histories address the difficulties homeless people face and the creativity needed to turn despair into practical defiance which helped Housing Works thrive. The interviews also examine the uneasy trajectory from direct action into service provision. While many other organizations "bureaucratized" once funding became available, Housing Works was built so that it could be torn down if it became just another service provider. In the years since its founding, Housing Works has vigorously protested, lobbied, targeted its funders, lost funding, been exonerated, successfully sued mayors, and - more than anything else - built

King being arrested in 2005 during a zap at the bookstore of the Family Research Council (FRC) as part of the Housing Works/ Campaign to End AIDS. The protest was over the FRC's influential advocacy of abstinence-only HIV/ AIDS prevention approaches now adopted by Bush as the only means of preventing HIV/AIDS. (Photo Credits Housing Works)

homes and communities for those whose only other viable housing alternative was prison. The following is its story.

Part One – Charles King

Charles King began his interview by recalling his first organizing efforts:

CK: Actually, my first organizing was doing bus ministry in Huntsville, Texas – saving souls with small children (laughs ironically). And it all kind of grew from there. The bus ministry ended up becoming something very political because I was bringing African and Mexican-American children into an all-white church. It became quite controversial. And I would date my consciousness of racism and classism to that experience. Moving beyond that, when I was living in San Antonio, I was the Minister of Street Ministries at the First Baptist Church there. Then I started becoming involved in political efforts. It started out with anti-police brutality work, organizing against the death penalty, and that kind of led me into circles where I became involved with a sanitation workers' strike. So it was kind of interesting how the connections got made. Then when I was in Yale Divinity School, I was the graduate fellow at Greg Hall, which was the Center for Service and Social Action. I worked with undergrads on social service and organizing projects. Draft registration had just been reinstated, which became a campus issue, and the first Reagan Budget [was announced] with huge cuts for social services. The first demonstration I organized was around Reagan. We had a rally with 5,000 people. The first arrest I took was with a group of students protesting reinstating the draft.

INTERVIEWER: What brought you to your first ACT UP meeting?

CK: My first ACT UP meeting… It was my first year of law school. I had left my last parish and drove buses for a year trying to figure out what to do. During my first year I was here in New York at Cardozo [School of Law, Yeshiva University.] And I think I saw a flyer about a demonstration. Since AIDS had been the issue that had led me to leave the last parish, I decided to show up. And it actually took over my whole life for a few years there (laughs).

INTERVIEWER: How did the move happen from ACT UP to Housing Works?

CK: You know, there were several of us in ACT UP, somewhat separately, who had been passing homeless people in the streets. The late '80s was when you started seeing the cardboard signs that said, "Homeless with AIDS Please Help." I was a poor student, so when I passed someone who was homeless on the street, I would given them a quarter. When I passed someone who had a sign that said they had AIDS, I gave them a buck. But I really hadn't figured what to do with that. And then it sort of crystallized when we attended the [1988] Republican Convention in New Orleans.

Those of us who went spent the week hell-raising, and organized a New Orleans ACT UP while we were there. And some of the folks who became very, very involved in what we were doing—who were demonstrating with us all day, every day—as it turns out were two homeless men. When we got ready to leave, they asked if they could come back with us. And we were very cavalier about how, yeah, things were better in New York. When we got back here and tried to help these guys get things together, we realized that things were much better for people with AIDS who were housed, but if you were undomiciled you might as well still be in Louisiana.

So we organized the Housing Committee of ACT UP. We spent the next year and a half very aggressively challenging the city around homelessness and AIDS and its responsibility. [Activist attorney] Ginny Shubert had filed a lawsuit, *Mixon vs. Grinker*, to establish the right to housing. I like to think of it as the best lawsuit we ever lost. We worked that lawsuit for years. We won all the way up to the state Court of Appeals. We lost there, but basically it forced the production of almost all the AIDS housing that now exists in New York City.

Anyway, Ginny had started that lawsuit at the Coalition for the Homeless. The Housing

Committee of ACT UP actually did its first direct action in support of a plaintiff in that lawsuit, to get the city to file an injunction to take this person out of the shelter. So to fast forward, we saw [Mayor David] Dinkins as our great hope. Ginny had actually drafted his position paper on homelessness and AIDS. But as soon as he was elected, he repudiated his position and adopted a modified version of the [former mayor Ed] Koch plan, which was literally to create segregated units in the armory shelters- indeed, running a curtain down the middle of the shelter - with people with AIDS on one side and other people on the other. In January of 1990, we brought in the first Presidential Commission on AIDS and gave them a tour of homelessness and AIDS. They wrote a really damning report that had absolutely no impact.

Then, *Mixon vs. Grinker* came to trial and a city commissioner, a gay man who later died of AIDS himself, testified that all homeless people who were living with AIDS were either chemically dependent or mentally ill or both. And that they were better off in the congregate shelters where they were less of a menace to themselves and others. It was sort of devastating to hear this. I actually remember a meeting on a Wednesday night the day of or the day after his testimony, we met in an apartment on Eighth Avenue and 23rd street. People were just so discouraged. And we started talking about it and decided that if the people that we cared about were going to be housed, then we'd have to do it ourselves. The only thing that we agreed upon was that we were going to start this new organization. And that it was going to be called Housing Works (laughs).

INTERVIEWER: Keith said you guys got an arrogant streak, thinking "if no one else was going to do it, then we were going to do it."

CK: That would be a fair way to describe it. We talked our way out of depression and into action.

INTERVIEWER: I'm wondering about your point about what you do to keep moving and keep from being discouraged. Eric Sawyer (2002) described some of the housing actions, like putting couches out on the street and everybody sitting on the couches, following Martin Luther King's dramaturgical tradition. To what extent was a rambunctious creativity part of the spirit in which this group was born and part of its ongoing strategy?

CK: Well, to start off, the Housing Committee of ACT UP was amazing fun. I remember when we were trying to get [New York's HIV/AIDS Services Administration] HASA working, back then it was called the Division of AIDS Services. And they had a bunch of new hires - like 60 new employees - but hadn't given them any desks or workspace. So they were just spending their days sitting in a classroom. The union was picketing. So we organized this action. Eric actually drove the truck when we brought a bunch of desks and chairs and phones into the middle of Church Street in front of the HRA [Human Resources Administration] and handcuffed ourselves to them. I loved the chant. The chant was probably one of the best that we ever created: "The check is in the desk and the desk is in the mail" (laughs).

Our HPD [Department of Housing, Preservation and Development] action was another amazing one. On Gold Street they have revolving doors. We went around on a Sunday night and picked up a bunch of abandoned furniture on the Lower East Side. Monday morning we took it down to Gold Street and stuffed the revolving doors with furniture, trying to deliver it to furnish housing for people living with AIDS.

INTERVIEWER: So it was a blockade, too.

CK: What was actually cool about it was that we had been pestering Abe Biderman, the commissioner who had sworn that no HPD units were going to go to people with AIDS. He was very conservative. So we had been pestering him and we did that action. That very afternoon he issued a press release announcing that he'd established a commission to study whether or not they could identify housing for people with AIDS. That was in June. We waited until late August or early September, until right before the Dinkins/Koch primary election. Then we sent Biderman a fax saying we had another load of furniture to furnish housing for people with AIDS. "Where would you like it delivered?" That afternoon he issued a press release announcing that they had identified 60 units of housing for people with AIDS. Of course, they were going to turn the units over at a pace of 20 units per year, over the course of three years. They were going to do the pilot project to see if people with AIDS could live in their housing.

So, the actions were fun. The actions were creative. We saw success at the margins. But at the end of the day, the truth of the matter was that AIDS housing providers did not want drug users. Homeless service providers didn't want people with AIDS. And so even if the government had been willing to take on its part of the responsibility, there probably wouldn't have been providers who were willing to do it with the people we were trying to get housed.

I think the way we brought that spirit of creative action into Housing Works was in how we designed the programs. Take our first scattered site program. Housing contracts around the country had some preclusion about drug use, requirements around being clean and sober. We demanded and demonstrated for a contract that would require us to take people who were still using drugs. What everybody else in the country was precluding, we decided we would fight for.

INTERVIEWER: When I moved to New York in 1997, I had heard about your using noise-makers and crashing Bill Clinton's birthday party. There was always this audacious quality of doing all the things you were not supposed to do. While other providers and social workers were talking about collecting data and making arguments, you were protesting against your funders and challenging them to do the right thing. There seemed to be a real liberatory quality to your work.

CK: I want to emphasize that it also played completely into program development. So, for example, our Independent Living Program started out as a total scam on the system. The way the system operated, the state rental assistance program was in place. The way New York City interpreted the regulations, you had to have an apartment and be at risk of an eviction to be entitled to the rental assistance. There was no way somebody who was homeless could get access to it. So we started looking at ways to get around that. We started renting apartments on the open market. We would do a legal sublet with the client. We would move them in with a written promise from them to pay their broker's fee, security deposit, and first month's rent within 30 days of moving into the apartment. We would wait until 30 days passed, we'd serve them with an eviction notice, and they were now rent-stabilized so they could go down to HASA and apply for rental enhancement. We did this like 15 or 20 times. And that's when the city caught on to what we were doing and confronted us. But there was nothing illegal about what we were doing. Our response was, "We're not the ones who are acting illegally, you're the ones who are acting illegally. Set up a system so homeless people can prequalify and we'll stop doing this." And they ended up caving in and setting up that kind of system. Even then, in the scattered sites, the city-funded apartments, people would get up to a certain amount of rent and utilities were folded into the apartment's rent. So we started renting our ILP apartments utilities included. That got us our first DOI investigation.

The job-training program also started off as a scam. We wanted our clients—and most of them were active users—to have some safe space, so providing them with stipends to work around the office was a way to do that. But most of them, because it was so hard to get an AIDS diagnosis, were still on public assistance. Under the public assistance regulations, there was a dollar-for-dollar offset against your benefits. Ginny Shubert was actually the one who researched the regs and came up with the fact that expenses related to a job-training program were exempt from this offset. So we called it a job-training program. And our clients did not understand. We explained to them what we were doing and why we were doing it, but they were the ones who then turned around and said "but we want a real job-training program." And again, we went to every possible job-training program, public or private, and what we heard pretty universally - some were polite in how they phrased it, some said it just this way - "why would you spend money for people with

AIDS to work when they are just going to die anyway?" And so, going back to the idea of despair turning into the arrogance that allows you to take action, that solidified it for us. We were going to create a job-training program that worked for homeless people with AIDS, even if we didn't get a dime from anybody to put it into place. We were going to put it into place because the whole fucking world had said "you can't do this."

INTERVIEWER: I thought of that playing when I read the *New York Magazine* article on the group (Barasch, 1998). The story talks about you sitting around a table laughing, but you were playing with ideas. Everything was on the table. And that was the interesting thing to play with and think about.

CK: Actually, when we started out we opened an office with one desk, one phone, and five chairs. It was kind of an interesting thing. Now that desk, the reason we had that desk was it was too big for the tenant that preceded us to get it out of the space. So, it was this huge monster desk. It became our conference table. And I remember we used to sit around that table every morning for like problem solving. Then we'd have these weekly staff meetings. We were small enough to sit around this desk and do these weekly brainstorming things. And you're right, it did sort of help break out of the box and we'd think of wild and crazy ideas. And sure enough, one of these wild and crazy ideas would work. So, yeah being creative in the actions is important but it was also really important that we brought that same spirit of can-do playfulness, creativity to thinking about what programs would look like.

INTERVIEWER: Barbara Epstein (1991) describes a kind of pre-figurative politics framed within building community and the image of a better world within present organizing. The good news is now. The kingdom exists in this room. Such an organizing model is not unlike the idea of realized eschotology, the notion of building heaven's glory on Earth from Christian theology. This seems to overlap with the notion of pre-figurative community building referred to by many organizers.

CK: Right now, you're talking my language.

INTERVIEWER: The good news is we do live in the kingdom, to a certain extent. Let's show people that. It works, syringe exchange, we'll give clean needles out; housing active drug users really makes sense. Giving people housing is a good thing. And I think by saying we're building a community right here in this moment. Showing it within your protest, showing it within your programming, and then the funding following that seems to be part of the spirit.

CK: I think that that's a fair image. It's very interesting that we've spent a whole lot of time this last year—Housing Works is constantly going through change, but particularly Keith's death has put us through a wrenching change—and so we've spent a lot of time this last year not just talking about strategic planning and managing change but building community. And it was out of that whole community building exercise that we developed a whole values manual. I don't know how many organizations have a values handbook. And our senior staff meetings have been very dynamic conversations that have been on one level very disturbing because once we take the focus off the government as being the bad guys talking about how to stop the epidemic, we find that in this very diverse community, that there are a lot of prejudices and preconceptions that we've not turned to focus on. And so we've now started a series of discussions that are going to provide space for us to have those conversations in a way that's not just speaking out of people's prejudices but facts and informed positions kind of thing. I think that the community building work is kind of at the core. And I think sometimes we lose our focus on how central that is to what we do.

INTERVIEWER: That's a bit of my impression, of building a space for people who were not supposed to have a space, literally building them a home. A home is more than bricks and mortar.

CK: It takes a lot more than bricks and mortar for it to become a home. Our theory on that here at Housing Works has always been and it took me a while to persuade Keith that this was the right theory, he thought it was a little bit too religious, but he finally got there

INTERVIEWER: Keith was a member of religious communities, including leather (See Mains, 1984/2002; Rubin, 1997).

CK: Yeah, I know, I know. It was a notion that I brought with me out of the church because whether it was my own experience with the church or people who I worked with in the church, I always found myself working with the folk who the church tended to shut out. And it was so ironic because those were the people who the church should be reaching out to. I remember when I was working with homeless people in San Antonio, I did an outline for a book that will probably be never written but I had titled it *Members of the Community.* And ACT UP as Church within all of this. The idea of a church herding people together to minister to one another; and so the non-religious terminology that we've used for that is a healing community. And that a healing community is a place where everyone acknowledges that they have reasons why they need to be a part of this community. So it's not just us helping them.

INTERVIEWER: It's healing the broken parts of ourselves.

CK: Exactly. And it marginalizes people, whether they are marginalized because they are homeless, because they are victims of domestic violence or sexual abuse or they're addicted, whatever has shoved them off on the margins. Part of creating a community is not just offering them help but offering them a place where they can give help. That's really what it's about. If it's just about us-helping-them kind of relationship nobody gets healed. All you do is create dysfunctional dependencies that are mutual. We then need to keep the Medicaid money flowing so we keep them needing us so we can feel good about helping them and all those.

INTERVIEWER: You wouldn't want a cure because it would get in the way of all the pills flowing.

CK: Right, exactly.

INTERVIEWER: Keith talked about Martin Buber (1970) *I and Thou.*

CK: It was actually through that avenue that I got him to buy into the healing community.

INTERVIEWER: I can also think of Mary Magdalene, the patron saint of sex work, of Harm Reduction, and Housing Works. Who do you go to—from communion to community—it's not a long stretch.

CK: So actually where Keith was, where this was sort of his force, was in his attack on contemporary social work theory. Keith was absolutely the most insightful about the need to tear down existing social work structures. We talked a lot about breaking down boundaries. Boundaries are so important in social work. And how instead of trying to create the right boundaries what you needed to do was break down the boundaries that became barriers. You talk about fostering dependencies and how boundaries could actually foster that rather then preventing it.

INTERVIEWER: What do you mean by foster?

CK: Foster issues around transference. They create this false sense of divide that isn't real because we're human. We're connected.

Cylar being arrested at the hearings over John Ashcroft's nomination as Attorney General in 2001. (Photo Credits Housing Works)

Part Two – Keith Cylar

KC: The social service work we do is actually at the extreme of social service work because nobody knew how to treat an active drug user. No one knew how to deal with an actively using person who was dying from HIV and AIDS, and they didn't want to confront that. Users didn't fit within their nice, neat little models. And here we were saying, "Fine, everybody that you can't work with in your program, I want. I want to work with them and I'll find ways to move them." A lot of that just had to do with…first of all you had to listen. You had to listen to the people. And when they told you that they were hungry, then you needed to fuckin' feed 'em. And when they needed this and this and this, if you met them and did this and this and this, then, you know what? They would try a little bit to do what you needed them to do. Which meant that they might need you to go with them to the doctor's office. You had to sit there and you had to explain why the doctor needed to do their blood work and you had to explain what this meant and you had to talk to them because the doctors and the nurses didn't have time. And the doctors and nurses were looking at them and seeing them simply as problems. They were people. They were wonderful people and they had lots of stories. They had lots of life and they had lots of wisdom. And they had a lot to give back, but nobody ever valued them. Nobody ever loved them. So you became this great positive cathartic thing to them that gave them this opportunity to reclaim their lives (see Shepard, 2002.) Because it wasn't something that you were doing. It was something that they had to do. Anybody who does this work who thinks this is about them, they are stupid. They are misguided. And they should go maybe be a minister somewhere, I don't know (laughs). But it's not about me. It's not about you. It's about a framework that allows your clients to do really hard work. But you give them a chance to live and you give them a sense of hope. And we were all of those things.

INTERVIEWER: It's community development as much as anything else. It sounds like a community that you are developing.

KC: It is a community, and it's a healing community that allows people to heal from a lot of really negative stuff. And did I necessarily set out to build a community? I don't think so. I think what I set out to do was just in response to the reality of what I knew was good therapeutic intervention. I'm a clinician. I grew up in the milieu of hospitals and psychiatric hospitals and their models. I understand what it takes. It was no accident that I said it would have to be a positive cathartic experience that would allow them to move forward. I'm a humanist. I'm a whole lot of different stuff. So Housing Works represents a whole new way to do that therapy with this kind of population. 'Cause it isn't about how you treat people, it's about how you develop this thing that works for a large class of people. But the individual nuance of it is based on each individual's life and their history and their individual personhood. And so it isn't like you can have these common code-words. It wasn't really about that. It was about listening to the individual. And moving them, and helping them explore what works for them. And what worked for them was not whether they stopped doing drugs or not, what worked for them was whether or not they were going to live and whether or not they were going to die well.

And for me, the work we were doing was about helping people die well. That was really, really, really what it was about. Being about when they took that last breath, that they had made peace with themselves, with their families, and with god because they were going to die. And if they didn't do that kind of work or have that kind of energy about them, then they died really horrible deaths that were painful and really ugly. That was something I didn't want to see anybody go through.

INTERVIEWER: And yet Housing Works does so much, even welfare reform advocacy.

KC: Who better? Well, I actually hate the words "welfare reform" because when you say welfare reform, again you are talking about individuals' process of reclaiming their lives. They didn't want to be on welfare, they wanted the same things people like you want. They wanted a roof over their heads. They wanted to take care of their children. They wanted to be happy. I mean, we all want that. I hate the term "welfare reform." It isn't about reforming welfare - it's about creating opportunities for people to reclaim their lives. And welfare reform is baggage. It has such connotations about welfare recipients that people then lose who they are.

INTERVIEWER: So then, what do you think are the essentials of doing antipoverty work?

KC: First of all, the number one rule is that an individual has to have a stable place to live. And if you have a stable place to live and you have food and you have safety – the basics of Maslow's theory – if you have those components first, then you can start working on issues of education; you can start working on employment; you can start working on spirituality; you can start working on all those other issues that may lead to a decrease in negative behaviors that those people may manifest. Self-destructive behaviors – you can start labeling them all sorts of things, right? But we're talking about creating a safe space for people to change and to grow. And every opportunity is a chance to grow either towards the light or towards the dark. That's kind of the classic way that people like to look at life in this world.

So when you're talking about welfare reform or you're talking about poverty or whatever you want to call it, then you are talking about creating opportunities for people to enter into mainstream society and become employed and be able to manage an apartment and to be able to have the life skills to function. But the deck is stacked against them because they are black, they are poor, they may not know how to read. They may have come out of abusive family backgrounds with sexual abuse going on; they may never have had an opportunity to sit at a dinner table and eat in what most people would consider a normal fashion. And so when you talk about reform, you are talking about having to start off at very basic levels and move up over a long period of time to allow those people to gain skills that they may never have had or never have had a chance to get.

But hey, that's where we started. We started literally, in terms of a psychotherapeutic process, at square one – which was to give people a house. And then you hold people accountable, not for their drug use, but for the behaviors that they manifest. I didn't give a fuck what drugs or how many drugs you took if you behaved civilly. If you didn't behave civilly that was a problem. And then after you got to the point where you behaved civilly, then maybe I had to talk to you about making your doctor's appointments. And then I had to explain to you why you had to go to the doctor and what the doctor results meant. And then I had to explain to you what the interactions were between the HIV meds and your drug use and what was happening to you in a manner that you could understand. So sometimes what I was, and what Housing Works became, was a translator for this knowledge base - translating it back in a way that people can understand.

That's where the whole notion of peers came in. Peers were people who had listened enough so they could take that knowledge and translate it back to people who didn't have as much knowledge, but did so in a way which was in your language. They were the culture-bridgers between the dominant society and your own culture. That's how peers worked. They were role models. They gave you a sense of hope. If this person who had the same kind of background and the same kind of misery and knows what it's like to be locked down at Riker's Island could somehow or another get there, then maybe I can too. Maybe it's not impossible. Maybe there is some hope.

And those people who had made it could spot your game when you were trying to use, trying to get over, trying to rip off the agency. Then they clued me in: "This is where they are ripping you off. This is where they are taking advantage of you. They are not really doing the work." It also served as a bridge to help me see what was going on within my own agency. There had to be certain rules and regulations that were enforced from a loving standpoint, as opposed to a punitive standpoint. You don't help people grow by being punitive. You help people grow by having a clear sense of boundaries, by having clear rules, and sticking with those rules.

So it became a whole way in which you do social services. It became a whole way in which you looked at your clients. And it became this whole other philosophy. At the same time, the group of people who had to do this work had to support each other. And you had to become a support person. That means you had to work through your own shit about your relationship with your parents, your family, and how you were raised, because you were bringing that into the therapeutic relationship. If you didn't have that kind of clarity, you didn't understand what was pushing your buttons about this woman who reminded you of your mother, and why you wanted to get her off your caseload because she was reminding you of stuff in yourself that you just didn't want to face.

So you end up building a community and you end up moving into that without realizing that that's what you are doing. And it isn't until you've done it that you just kind of look back and people say, "You've developed this community." And you say, "No, I'm trying to allow people to die well, and I'm trying to make this government give me what I need and give them what they need so they can do that and do that well." Maybe that's the way it all came about? (sighs). I'm not sure.

INTERVIEWER: You know, AIDS has become such a part of anti-poverty struggles and the center of the global justice movement, but when you look at your life's work of helping put it there, what do you think when you look back?

KC: Well, first of all, I haven't gotten to the end, so I'm not sure. I don't know how to think that way.

INTERVIEWER: Do you have any final words of wisdom?

KC: What can I say? There's never enough time to fully flesh out what things meant or mean. I think that given an opportunity to just contextualize and communicate what it is that we intended to do - which doesn't mean that we're perfect at it, or that we haven't made a lot of mistakes, or that Housing Works today is all that I aspired for it to be, but I think it has begun a process to move people further along in a positive direction. At a certain point, you have to stop talking and start transcribing and say whatever it is that you are going to say, so maybe I should just shut up (laughs).

Afterword

On Monday, March 5, 2004, Keith Cylar died in his sleep. He had lived with AIDS since the 1980s. Charles King and this writer, like many in the New York AIDS activist community, had spent the previous Friday night at a funeral for Joe Bostic, an activist with the New York City AIDS Housing Network (NYCAHN) who had recently died of AIDS himself. It was the second funeral for members of NYCAHN in recent months. Another member, Joe Capestani, had died just two months earlier. At the end of Capestani's funeral, Bostic's knees buckled as he lost feeling in his legs. Cylar, who had been at the funeral with King, waved down a cab, paid the driver, and send Bostic back home to Brooklyn. Two months later, Bostic died of kidney and heart failure – both complications of his HIV (see Villarosa, 2004). The Rev. Charles King spoke at Bostic's memorial. He asked those in attendance to imagine the place in heaven - or whatever afterlife we believed in - for AIDS warriors.

Jennifer Flynn, the founder and executive director or NYCAHN who organized Bostic's memorial the previous Friday, send out an e-mail reflecting on Cylar's death.

> "While it is hard to imagine a place that could fit all of the incredible miracles that Keith brought to us, he certainly will be there and he certainly will be leading the chants and cheers when the rest of us figure out how to win and finally end AIDS. Without him, that too is getting harder and harder to imagine."

In Flynn's message, she included the statement from Housing Works, written by Terri Smith-Caronia, the Housing Works Director of New York City Public Policy:

> "We are sad to announce the death of Keith Cylar, the Co-Founder and Co-President of Housing Works. Keith had lived with HIV for over 20 years and was diagnosed with AIDS

> in 1989. In the last year, Keith developed cardiomyopathy, a serious enlargement of the heart. He died in his sleep early Monday morning of a cardioarrhythmia."

Keith spent the last 20 years of his life working as an AIDS activist and built Housing Works into the largest and the most militant community-based AIDS services organization in the nation. Because of this work, thousands of formerly homeless people with HIV and AIDS are living safely in their housing; hundreds have found jobs, and thousands more have received other vital services.

His fondest wish was to bring an end to both homelessness and AIDS and to ensure that nothing like these two plagues would ever devastate his people again. In his memory we continue the struggle.

Cylar's funeral took place in two parts. Part one included services and a rally in New York City. The words "Keith Cylar Keep Up the Struggle!" echoed through the New York streets where he had once walked. Part two took place later in May of 2004 when thousands rallied in Washington, D.C., and some 100 of us - including this author, Charles King, and many leaders of the AIDS movement - conducted the largest AIDS civil disobedience in Washington since 1987 (see Shepard, 2005).

The months of meetings needed to complete the interviews with Cylar took me from one hot spot in town to the next, where I selflessly drank vodka cranberries with the renowned AIDS activist. The final interview, featured above, was completed on Martin Luther King's birthday in January 2001 after watching a football game over pizza and beer. We'd been out interviewing and talking until all hours the night before, but it was worthwhile to complete the interview, the first part of a book about his life that Cylar hoped would be completed. There were so many sides to Keith, but a primary piece that I saw was the caring, playful spirit with which he went about his activism, friendship, fellowship, and communion.

A couple of weeks later, we both went to Washington for the protests surrounding George Bush's first inauguration where Cylar was arrested disrupting John Ashcroft's confirmation hearings (the photo is included above). A few weeks after that, Cylar and I met in the East Village for margaritas. After the fun of the drinks wore off, Cylar became emotional, a little sick, and tears flowed with grief for the friends he had lost during the first time the Reagan/Bush crowd had been in charge. He told me he had fought Reagan and the first Bush, and he could not believe America had elected another Bush, who was dead set on the annihilation of people with AIDS. Three years later, Cylar himself passed only months before Bush was re-elected.

Despite these losses, Charles King continues organizing, now as the reluctant sole president of Housing Works. Jawaharlal Nehru, who took over leadership in India after Mahatma Ghandi was assassinated in 1948, said that he felt like the light had gone out in his life and that it was hard to go on with the non-violent struggle after Ghandi's untimely death. (Blackburn, 1989) Many in the AIDS movement feel the same way after losing Cylar. Yet the power of peaceful resistance continued in 1948 with Bayard Rustin, the Quakers, and later Martin Luther King. The North American Civil Rights Movement built on the trajectory established by Ghandi. ACT UP, and later Housing Works, found inspiration in that same tradition. Cylar and King worked to create a righteous non-violent opposition to the AIDS crisis and the waves of homelessness that followed. Yet, as always with the story of Housing Works, loss turns despair into an audacious commitment to fight with creativity and care. Just days after Bush's re-election, King (2004) called for the entire AIDS community to dust themselves off and remember:

"It doesn't matter who is President or who controls Congress; if we can organize the grassroots in our country - everyone living with HIV and AIDS and everyone who loves someone who is living with this disease - we have the power to force change and to force our leaders to bring an end to this plague."

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I'VE GOT THEM IN MY BLOOD:
REFLECTIONS ON THE IMPACT OF COUNTERTRANSFERENCE ON THE PROCESS OF BECOMING A SOCIAL WORK RESEARCHER

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Poor minority women are the fastest growing group diagnosed with AIDS. As a seasoned social worker, the author conducted a research study that explored why a sub-population of these women, those in substance abuse treatment, continued to engage in AIDS risk sexual practices. Here, the author reflects on the impact their stories and experiences had on her. She learned that even as a seasoned social worker, knowledgeable in clinical countertransference, she struggled with her new role as a researcher.

Poor, primarily African-American and Latina women are the fastest growing group diagnosed with the human immunodeficiency virus (HIV) (DHHS, OMH, 2005). Most have been involved in drug use, though increasingly they are acquiring the disease as a result of heterosexual transmission (DHHS). Therefore, addicted women now enter substance abuse programs receiving not only drug treatment, but also AIDS[1]- prevention education services.

In the mid-1990s I became interested in minority women's risk for AIDS when running a 24-month substance abuse treatment program and, as a licensed clinical social worker, providing psychotherapy services for some of the program's clients. During that time, several of the women became pregnant, even though since the early 1990s the program also provided AIDS-prevention education groups for its clients. All were required to attend the groups at least monthly for the entire time they were enrolled in treatment. Nevertheless, within one 12-month period, some of the women became pregnant—a clear indicator of lack of condom use. Unprotected sex, of course, also increased their risk for AIDS and other STDs. In talking with these women, I was told that they wanted to get pregnant. This both shocked and pained me for several reasons. Most already had several children in foster care, for whom long-term arrangements had yet to be made. All of these women were having unprotected sex with partners who were intravenous drug users or engaged in other risky behaviors. Also, many said the reason they wanted to have another child was to "prove" they could have a baby born drug-free; none indicated to whom this needed to be proved.

As a result of what I was hearing from these women, I conducted two pilot studies involving five African-American women in recovery, some of whom were clients, and some of whom were drug-treatment employees. I discovered that during their recovery, ranging from six months to three years, a number of them had previously or still engaged in risky sex. One reported having unprotected sex with her husband whom she described as promiscuous. Another, clean and sober for 16 months, continued to prostitute, though not for the money. Two others, AIDS educators, were having unsafe sex. A former client, sober for more than five years, engaged in unsafe sex with a man whom she knew to be promiscuous and suspected of using drugs.

I wanted to discover what contributed to their risky sex behaviors and do something about it. I was concerned about the women I'd learned about and others like them. What they were doing alarmed me. Why, I wondered, would women who were seemingly taking control of their addiction risk contracting AIDS? I did not question my being alarmed; it seemed appropriate. In fact, the emotions these women generated in me motivated me to conduct social work research in the area of minority recovery women's continued AIDS risk. I had a clear purpose and goal; I knew I would not lose my way (Maxwell, 1996).

I used primarily quantitative methodologies to study an availability sample of 44 women in a variety of drug programs to address my global research question: What are the factors that contribute to the continued AIDS risk of minority women who are in recovery in substance abuse treatment? The qualitative portion of the study (not appearing in study's final version) provided personal, descriptive stories of their risky behaviors, detailing their relationships and the situations or contexts in which they occurred. In retrospect, I think it was the qualitative dimensions of the study that initially interested me. I prepared for the study while actively involved in clinical work with women much like the ones I planned to study, listening to their tragic and traumatic stories almost daily. By the time I began interviewing the participants, however, I was no longer working directly with women in recovery. As far as my clinical relationship with recovering women was concerned, I considered myself appropriately decathected; that is, I was clinically emotionally detached.

When I began interviewing the participants, I focused on them only as research subjects rather than as clients. I would still be of help to them, I thought, but indirectly, as a researcher. I would disseminate my findings to other AIDS educators who, in turn, would help them directly. It is clear I was deeply involved in these women's realities. It was, after all, my viscerally responsive concern that led me to immerse myself in this emotionally volatile arena. Being a researcher, however, was new to me. I didn't know the extent to which my inexperience and inadequate understanding in this new role would disarm me, causing me uncertainty in my old role as a direct practicing clinician.

My inexperience and lack of the knowledge and breadth of the researcher role led me to believe I would relate to the women only "objectively" as research participants. But, I began readily acknowledging the impact I would have on them (Mishler, 1986; Weiss, 1994). I knew I needed to remain aware of how and in what ways I was affecting them during the interview. Unfortunately, I left behind too many of my erstwhile clinical skills, neither giving much thought to, nor preparing myself for, how such interviews with highly vulnerable and traumatized women might impact me. Despite many years of psychodynamically oriented clinical social work, countertransference in the research interview process did not occur to me. I had no inkling of how these women, their stories, and their interview responses might force me to alter the course of my research. Only upon completing my study have I begun to think more deeply about the role differences between social work clinician and social work researcher, and to untangle the variety of experiences I had conducting this project. What follows is a narrative reflection on what was a difficult and complicated process.

The Social Worker as Researcher: The Future is Nigh

I mount the very steep steps of Harambi House, a woman's substance abuse treatment program, on a quiet inner-city street. The steps are so steep that I am convinced there cannot be physically handicapped women inside. I ring the bell and hear women's voices behind the door signaling my presence. I've already interviewed some women here, so they know me and I get in right away.

Mary* is waiting at the top of the stairs leading down to the interview room. We greet and banter with one another in an Afro-centric style that clearly puts her at ease. Mary is quite talkative and personable. Her affability belies, however, the evident toll that her life of drug abuse has taken on her body. She has scars across her eyebrows and several missing teeth, looking like a veteran undercard boxer, a look not uncommon on frequently battered women. The ravages of her hard life, like too many others I've interviewed, have left their permanent marks on her—she's only 35, but looks almost 50. I find that continually having to look at the results of these women's physical trauma is increasingly becoming hard for me to bear. Sometimes they are almost too hard to look at and to hear. Their stories are disturbing, the ones about their risky sex practices becoming ever more difficult to listen to. This difficulty flits through my mind, an as yet inchoate feeling that I find myself loathe to acknowledge. I watch as Mary completes

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*All clients names are pseudonyms.

her questionnaires and I ready myself to ask her open-ended interview questions. One of the first questions I ask Mary is whether there have been times in her life, including recently, when she has been in a relationship with a man and not felt in control of their sexual relationship. She replies that it was occurring with her current boyfriend. (At the time of the interview Mary had been in treatment for several months. She had been in this relationship with her boyfriend, though, for *three years* before she entered treatment.) "Yes, yes," she answers, almost eagerly. She continues, "I feel, first of all, I feel violated, helpless. It's like, it's because, I don't want to lose him. I'll do whatever I have to do. If he tells me to do something this way, I'll do it, not wanting to be alone, and that fear of being rejected. So whatever he asks me to do, I'll do it."

Listening, I begin to feel sad. Nevertheless, I listen to how Mary is using treatment and the support of the women's program to change the addict part of herself that she calls "stupid, gullible." I shift the conversation from her recovery litany—one I have heard from many of the women who have revealed that they continue to practice risky sex. For me the refrain has begun to take on an ego defensive doing-and-undoing motif, one that I believe must remain unchallenged by me, given my (lack of) understanding of what my quantitative researcher role must be.

I ask Mary what she thinks would help to alter her risky behavior. She answers, "I know, number one, I would have to leave him." Then, for the next 15 minutes, she talks about how she has trouble with this solution that she presented for herself. For her there seems no middle ground of asking her partner to wear a condom or wearing one herself. For her it's an all-or-nothing proposition: she must have risky sex with him, leave him, or watch him leave her. As she talks about her seemingly self-imposed dilemma, I am thinking that this has been an ongoing discussion for her, both in her head and with her boyfriend. She indicates the latter, that she's had this conversation with him by her response to my question about whether she uses condoms with him all the time. She says, "No," it was his idea they not use condoms. That, "...since I got it [AIDS] from him, his attitude is, 'What the fuck, we've got it anyway, so...'"

I did not ask the women their HIV status and did not ask Mary hers. Therefore, I have no idea that all the struggles around risky sex that she has been telling me have occurred in the context of both her and her partner being HIV-positive. I am, again, shocked. It takes all I can muster to keep from falling on the floor. I do, however, fall out of my researcher role, asking if they know they can become re-infected. She says they do. That means they know the deadly consequences of their sexual relationship. Mary goes on to tell me about the many conversations she has had with her boyfriend, her unhappiness with their risky behaviors, their constant arguing about it and other issues, and her feeling helpless to leave him. She says to be strong enough to break up with him "...is gonna take some time. Oh yeah, it's gonna take me some time. He's in my blood. I say that all the time." She laughs. "N*****, you're in my blood." "He is, literally," I say, wondering if she fully understood the depth and complexity of what she has just said. I repeat, "He is in your blood!" She says to me, "Yeah, he knows that. He don't like what I say. I say, if I wanted to get rid of you, I could not, 'cause I got the disease from you and you're in my blood." I am watching her smile as she says this. The metaphoric, yet very concrete, description she's just articulated renders me speechless. I think, though, that I understand where she's coming from. But, it does not feel like a good place and I do not like it. I don't want to go there; it's not a place I want to be: a place of perpetual trauma, of other- and self-destruction. But, as I was leaving I felt impelled to reflect on the context and history of how I had come to be in that place at that time.

The Social Work Researcher as Case Manager?

As I left Harambi House, I asked myself the same questions I had reflected on over 30 years ago, before I went to graduate school, before I became a "real" professional. Then, I was a case manager, finding myself on my knees alongside my colleague, a paraprofessional homemaker, sorting through a client's child's bedroom closet stuffed with dirty clothes and a couple of dead pigeons. Although I did not actually handle the dead birds, I nevertheless asked myself, why am I doing this? How long am I going to continue to do this? I never thought I would be asking myself the same questions again, more than 30 years later, in my newfound role of researcher. As I contemplated it, though, I realized that I should not have been surprised; I should have taken a hint two years earlier when I was preparing to conduct this research. Although I had been assiduously taught that skills gained in one helping role can—and should—be transferred to new ones learned, I didn't imagine that might include the role of researcher. Although case management skills, such as extensive and persistent outreach, are now recommended by social work researchers (Wu, El-Bassel, Witte, Gilbert, Chang, & Morse, 2005), I believed that they didn't include my old case management experiences.

For example, in one pilot research study, I interviewed several outpatient recovering women. I arrived early for one of the interviews and I waited for the participant. She showed up with a cab-load of children and groceries. I assisted her, but although I had incorrectly imagined "real" quantitatively oriented researchers never doing so with any regularity, I helped her unload all of the groceries, and then carried two bags and one of her toddlers up three flights of stairs. Her hands, too, were full with bags and "stair step" children, one of whom was groggy from sleep and stumbling. I took on my old case management role almost readily; it was not, after all, one that was new to me. And I did, of course, have my own agenda. If I do not have a clear purpose, according to Maxwell (1996), I'm likely "to spend my time and effort doing things that won't contribute to [my] goals in conducting the research" (p. 14). Quite honestly, I hoped that after carrying her toddler and a share of the groceries up the steep steps, and then helping put both children and groceries away, she would readily give me two hours of her time for my qualitative study.

Although I recognize today my erroneous thinking, at the time I thought, "This is only pilot research, not the real stuff." Back then, I had not read anything informing me otherwise. Reflecting on this now, it's clear I knew next to nothing either about conducting research or about the real-life adventures of researchers. I did not know what they had to do to get their research project accomplished. I had taken anthropology and sociology courses. I knew there were researchers who interviewed deviant people and sometimes were exposed to dangerous environments. That had always been my social work milieu, so I had not re-contextualized that knowledge. For me, that was not the challenge. I was hoping my research relationships would be contextually different, that I'd really decathect and increase the emotional distance between them and me.

When I began my research, I felt it was okay if I did not get as emotionally close to my research participants as I had to my clients. I was naive, looking forward to just showing up, getting information, and moving on. At that stage of my research knowledge, I hadn't read anything to the contrary. I wanted to go neither further nor deeper than the interviewee might want me to. I wanted to be able to relax, have more emotional distance, and I was willing to settle for whatever the participants were willing and able to share with me in a structured interview. I thought that was what quantitative research was all about, and why I opted to focus almost totally on that methodology. Of course there was also the need to fulfill course requirements, clearly *my* issues. In a sense, I was colluding with quantitative research, a methodology that apparently encourages distancing of the observer from the observed in its promotion of the notion of objectivity (Giami, 2001; Maxwell, 1996). Researchers like Giami and Maxwell, I now know, don't take this stance. But for me, it became my goal.

The Social Worker as Researcher: Cautionary Advice

Discarding some of my professional cautions had its advantages: I had completed two pilot projects and eagerly looked forward to being a researcher. Even after half a decade I was still interested in the intersection of AIDS prevention and substance abuse treatment.

Truthfully, helping recovering women by lugging their children and groceries was less emotionally draining than being a full-time case manager. I believed, partly because I wanted to, and partly because I did not (want to) know better, that research would take a lot less effort than what I had experienced in my old case manager role. Why I thought that, I don't know, but it's what I thought at that time. When sharing with a colleague some of what had happened while completing my pilot research projects, I said that my experience wasn't too bad, although I was glad that it was over, and I was ready to move on to the "real thing." He praised me for overcoming these hardships, but warned me about AIDS research, as he had studied AIDS victims' caretakers. He described his interview experiences and the emotions that he'd felt, trying to get me to hear and understand. My research could have even more serious consequences, he cautioned. I was studying a two-barreled problem: the deadly and devastating disease of AIDS, and the devastating—and sometimes deadly—disease of addiction.

Clearly, I heard him. I am recounting what he said, but I had not really listened. It seems that on the most important level I disregarded his cautionary story. He had studied persons with full-blown AIDS; in my narrow thinking, that wasn't my study sample. What I wanted to know was why they *risked* getting AIDS. I did not think I would be witnessing HIV-positive women telling me, either metaphorically or allegorically, that they voluntarily risked being re-infected or that they initiated sex with partners they knew to be HIV-positive. Sometimes even hindsight isn't 20/20.

The Social Worker as Researcher: Burnt Up or Burnt Out?

Despite denial, avoidance, and other defense mechanisms that become clearer upon reflection, it was not until my conversation with Mary that I felt the interviews begin to take their toll. About 25 of my 45 interviews occurred during the city's summer "dog days." Too many 100-miles round-trip commutes, too many three to four interviews per day, and too many steep steps—all in hot weather—appeared to be my psychological and physical softening agent. By the end of Mary's interview, walking down those steep steps I asked myself, was she serious? What did all of that mean? How do I feel now? For the first time I seriously questioned whether I could complete the 50 interviews I had planned. Mary was my 33rd interviewee; I had 17 more to go. It was just the middle of August. By then I was teaching full-time and had only three weeks to prepare for my fall courses. I had a lot of reflecting to do.

Unknowingly assuming another aspect of my old case manager's role—focused persistence—I redoubled my recruiting efforts since almost four weeks had elapsed before interview 34, the longest hiatus between interviews. My pace increased, but I moved slowly in other ways. Although never late for interviews, I wasn't arriving as early as I had. By interview 42, I was arriving just on time, women waiting while I set up. I felt worn out. I shared with a peer that I thought I wouldn't reach my 50-women interview goal; I didn't have it in me. I reconsidered why I was finding the interviews demoralizing. I'd spent years as a long-term psychotherapist of severely addicted women like Mary and the others, and my sample represented that clinical population. I wondered, what was the difference? Why couldn't I establish and maintain an emotional research distance like the clinical one I had worked so hard to achieve? These were my ruminations when I interviewed Luisa, number 43, a career -altering experience.

Luisa, who is Puerto Rican, lives on the third floor of a three-quarter house.[2] When I arrive, passing the resident manager in the front hall, I see Luisa on the phone. Covering the phone, she tells me to go on up. I walk into a bright, airy kitchen with the back door open to the warmth of a beautiful Indian summer day. It's good she's on the phone: I have the time I've now come to need to set up. Luisa is attractive, looking somewhat younger than her 30 years, and has been clean and sober for some time. She is quite open and friendly; we chat briefly before we begin. My first inkling that this interview is going to be different from any of my others comes with Luisa's response to an Addiction Severity Index (McLellan et al., 1992) question about how much she spent on drugs in the 30 days before entering treatment. I watch her thinking this question over. Her answer: $40,000, the largest sum given by anyone I'd interviewed. I am not shocked, though. Stories of multi-million-dollar entertainers and athletes going broke due to their drug addictions are legion. I sit quietly awaiting her version of this old, sad story.

She tells me the story of her husband and her coming into $40,000 and spending it all on drugs the month before she entered treatment. They bought drugs not only for themselves, but also for their many friends. Then, there's silence. With a pensive look she says, "Just think, all that money, and all I ever wanted was a family and a house with a picket fence." This, I think, is when my hard-earned, but thin, armor of objectivity begins to shatter. Before I know it, I retort, "Now the dealer has the house with the picket fence." She says nothing. She just nods her head seemingly lost in thought, looking into space as if watching the dealer drive away over a ribbon of black macadam, her house with its picket fence on his flatbed truck. I get myself back in control, my erroneously acquired researcher's façade firmly in place, and the next 45 minutes go smoothly while I am enveloped in a false sense of security.

Earlier, Luisa volunteered she was HIV-positive and had not practiced risky sex since being diagnosed three years earlier. Therefore, I am totally unprepared for her responses to the questions I ask to elicit stories about the context and situations surrounding the women's sex practices. I ask her one of those questions, and, in what I'm learning is her thoughtful and deliberative way, Luisa says that being asked about having unprotected sex makes her think about the phone conversation she was having when I arrived. It was with her boyfriend. She's been going with him for about six months. She says she told him she was HIV-positive, but that there were ways that they could have safe sex, if he were willing. He called to say he didn't want to have sex with her. She says, "He says he's still not ready."

Silence is between us again. She continues to look pensive. I, however, not being there in the moment, immediately begin to fantasize about Luisa becoming my poster girl for AIDS prevention. She's a sterling example of safer sex for minority women in recovery to emulate; she is a model of harm reduction (DesJarlais, Guydish, Friedman,& Hogan, 2000). The nature of fantasizing being what it is, I quickly move on to wondering about the likelihood of my being able to contact her for a "success story" interview. When Luisa suddenly begins to cry, I snap back to the here and now. First she cries quietly, talking through her tears in a voice much softer than she used earlier. I listen raptly now, paying close attention when she says, "This is the third time he says to me he's not ready to risk having sex with me." Then she cries harder, describing how conscientious she's been in telling her HIV status to the men she's been dating because she doesn't want to pass the disease on to them as her husband had passed it on to her "...totally without my knowledge," she'd said. Then, she completely breaks down, crying with loud racking sobs. Being attentive and mindful of the circumstances, as a good clinician should, I simply sit silently. I look at Luisa, her head in her arms on the kitchen table, crying. Already feeling I had overstepped my bounds with my previous remark about the dealer getting her house and picket fence, I'm wondering if, perhaps, in some way, my retort contributed to her crying in the first place. Given my uninformed, naively stereotypical notion of a researcher, I feel totally useless.

So, I just sit there, stroking her hand as it rests on a table now cluttered with research paraphernalia, in a sunny kitchen on a warm autumn day, and watch her cry. I sit there saying nothing. She pulls herself together enough to say, "I'm all right, now. It's okay for you to go." I get up to go. I still say nothing. As I pack, I glance at Luisa repeatedly to see what her body language tells me, because she, too, is silent. As I finish packing, I say to myself, in a new, different, and almost unrecognizable "researcher's" voice: thank goodness I followed Institutional Review Board protocol; program staff know about my research and that I am here today interviewing. If Luisa manifests any signs of continued distress, there will be help available. But merely following my naive impression of a research protocol is not enough psychological or emotional solace for me. As is the case with countertransference, this isn't as much about Luisa as it is about me and my falsely dichotomous notion about the differences between researcher and clinician; now I know that even as a researcher, I should have comforted her.

The three shallow steps that I walk down as I leave are, in an important sense, no different from the many steep ones that I climbed to see Mary many interviews ago. My dejection telescopes them. One interview slides into another; the last one seems like the first one, while the first seems just to have occurred. I wanted to tell Luisa she was doing the brave and the right thing, that the fact her boyfriend was still going with her, though he was uncertain about sex, said a lot about him, about her, and about the potential strength of their relationship. I did not say this to her, though, too wrapped up in my own dejection. I said almost nothing beyond good-bye. I just walked down that seemingly endless flight of stairs hearing her last phrases, echoing in my ears, "All I wanted was a family and a home. Was that asking too much? Will I ever meet anyone who will love me? Who would love a woman with AIDS?"

After Luisa, and with input from a colleague to whom I really listened this time, I stopped the interviews. I completed only those already scheduled. I interviewed a total of 45 women, not having it in me to do even five more. I had survived as a clinician working almost my entire career with women like Mary and Luisa because I perceived myself to be—and was—an active change agent in their lives. Helping people to change, and encouraging them to be active participants in the process, made enduring their traumatic life experiences tolerable. I liken it to the psychological defense mechanism of doing and undoing, but with the research I felt no undoing, just the experience of their doing. The undoing seems to be missing in the researcher's role (at least that is how I viewed it then) being the neophyte I was. I cannot imagine journalists who feed upon or intentionally generate Luisa's type of emotional drama. For me it was enervating, not invigorating. I have been open and forthcoming about my many contributions to the research difficulties in which I found myself during this process. Painful discoveries, I've come to learn, are part of the process of becoming a good researcher (Maxwell, 1996). I do not think enough is done, written about, and discussed to prepare new researchers for what they may encounter. Now that I've finally gotten it, I have a lot of questions that are, so far, unanswered. Therefore, I must reflect even more deeply, untangle my experiences, and figure out how to proceed.

The Reflective Social Work Researcher: If Not Countertransference, Then What?

Obviously, this tumultuous research process strongly and decidedly had its impact on me. Without exaggeration I can say that, besides the baggage I brought to this process, the experience was painful. I have used the time since completing my research to read and continue to contemplate my experience of these dyadic relationships. What, I wonder, would I have needed to do the 50 interviews? If I had seen five more women, schlepped to and from interviews with a heavy equipment bag, and just tried to complete the project, would the quality of my research have suffered? I can see an unspoken benefit of quantitative work: researcher angst is never its ostensive focus. This is less true with qualitative research, I believe, and others concur (Boylorn, 2006; Magnet, 2006; Wyatt, 2006).

As a long-time clinician, I often approach relationships from a psychodynamic perspective, using other psychological perspectives as needed. So, for me, in studying and reflecting on research relationships, countertransference is a familiar key theoretical framework for understanding these dynamics. Many psychodynamically oriented clinicians use countertransference as their stock in trade. It is something not avoided, but processed, understood, and—hopefully—used to accelerate therapy. Countertransference has both traditional clinical and contemporary research meanings that comprise my understanding of this complex notion. Traditional clinical countertransference involves the clinician's unconscious reactions to clients. The reactions relate to the clinician's internal conflicts projected onto the client. Countertransference must be constantly monitored and understood (Barker, 1997). Researchers can experience countertransference also. For them it is the "sum of unconscious and emotional reactions, including anxiety, affecting [their] relation with the observed subject and situation" (Giami, 2001, p. 10). I struggle, however, with using countertransference to characterize my research interview experiences.

Nevertheless, countertransference is my clinical stock in trade, too. My struggle is that it is my only lens and that it is a largely self-referential, wholly intrapsychic, one. Even as countertransference magnifies, it shrinks both perspective and dimension. Since I am writing from a first-person perspective, being self-referential is fair, but insufficient. The interviews, though presented from my perspective, were not actually *all* about me. The women interviewed said and did things *and* I experienced them. Countertransference addresses the latter, I believe. But, the concept is insufficient for understanding the "other," i.e., what the *interviewee* contributes that affects the interviewer.

Exploring interviewees' contributions necessitates broadening my conceptual framework to consider concepts that, along with countertransference, may provide more dimension and substance to my truncated research effort. This, after all, is a qualitative reflection on a primarily quantitative research study by a persistent clinician committed to understanding her new role and apprising others of this transition process. I believe more clinicians should do research. They must do so, as more and more of them, in this era of accountability, are being pressured to initiate or increase their research and/or evaluation efforts (Blythe, Tripodi, & Briar, 1994; Padgett, 2005). My exploration, therefore, continues.

As I came to realize, many of my interviewees revealed pervasive trauma. Sometimes it was evident in a woman's visage, as in Mary's case. Or sometimes in their stories, as it was with Sara, who described years of sexual abuse in foster homes in which she was placed as a result of her alcoholic mother's severe neglect and abuse. Whatever its manifestation, trauma always seemed to hover at the top of the steps, an enervating aura ready to overwhelm the inattentive in an amorphous haze. It was almost impossible to conduct interviews without becoming engulfed by an aura of trauma. How could it have been otherwise? Becoming ensnared in the women's trauma experiences was not about avoidance choices, but about naming, giving meaning to, what I felt was happening to me (Stamm, 1997).

Traumatology lacks countertransference's psychodynamic depth, but it focuses on knowing and doing more for *interviewers*. It is about being aware of how interviewers are impacted by interviewees, helping the former to work through and with the impact. Trauma, "an injury to the body or psyche by some type of shock, violence, or unanticipated situation" (Barker, 1997), was the aura of many of my interviews. Countertransference is only one aspect of trauma and the interview process. Three additional concepts now frame this discussion: compassion fatigue, secondary traumatic stress, and vicarious traumatization (Stamm, 1997). Virtually synonymous in their clinical contexts, they refer to a syndrome resulting from "exposure to a traumatizing event experienced by a client [that] becomes a traumatizing event for the therapist" (Figley, 1999, p. 11). According to Pearlman and Saakvitne (1993), vicarious traumatization generates compassion fatigue and secondary traumatic stress, having a *cumulative effect across clients,* pervasively impacting the *self of* the therapist (p. 250) [italics added for emphasis]. For traumatologists, vicarious trauma is the overarching concept under which countertransference, compassion fatigue, and secondary traumatic stress are subsumed. What they add is this: interviewers, including research interviewers, *will become vicariously traumatized when repeatedly* interviewing traumatized clients (Giami, 2001). I embarked on my first research effort with no idea of the extent to which the traumatized lives of my interviewees would traumatize me and, at the same time, was ill-prepared to use my clinical skills because of my uncertainty about my new role.

Learning about, and better comprehending, vicarious traumatization has led me to realize the inevitability of the negative impact of my interviews (Figley, 1999; Pearlman & Saakvitne, 1995; Steed & Bicknell, 2001). It was the natural result of being an empathetic social worker interviewing suffering people. As a clinical therapist steeped in empathy, interviewing recovering women who invariably had traumatic histories (Amaro, 1995; Amaro & Hardy-Fanta, 1995; Brown, 1995), I was a vicarious trauma victim waiting to happen! Given empathy alloyed and vicarious traumatization inevitable, I would seriously question the assertion "...that the methodology of the clinical interview, modified for research purposes, is an effective and safe way of obtaining data on human experience" (Bunin, Einzig, Judd, & Staver, 1983, p. 23). In this case, it seems the authors primarily focused on the safety of the interviewee. They did not go beyond countertransference to acknowledge what traumatologists willingly do: that what interviewees bring into a session can be unsafe for the interviewer.

From the researcher's perspective, how "safe" is safe? How is the social worker or other professionally empathic researcher protected? I would not have thought to be a *less* empathic researcher. I did expect to *do* some things differently (in fact, I eagerly anticipated it), but I did not expect *to feel* differently. I saw empathy, that principal social work quality, as an asset that contributed to decreased resistance and tension in interviews on sensitive topics (Lee, 1993), enabling *interviewees* to feel safe to discuss them with a greater ease and openness. It was a psycho-affective methodological process (Figley, 1999; Pearlman & Saakvitne, 1995) that facilitated my entry into 45 recovering women's desperate and unhappy lives. Now, Pearlman and Saakvitne are suggesting that the same empathy I honed and developed over the years—the emotional quality central to social work—was an "exposure liability," a trauma-prone characteristic. The concept of vicarious traumatization has made a valuable contribution to my reflection on my novice research experience. I know that if I continue research with this population, I can expect to be vicariously traumatized and that it is likely to worsen with the more women that I interview. I must protect myself. Despite its important contribution, I am still having reservations about vicarious traumatization as the conceptual framework to explain my response to this research experience. That is because many of its manifestations do not fit my experiences; they had other possible causes.

For example, workers experiencing vicarious or stress-related trauma have been described as having symptoms such as feelings of inadequacy or incompetence, burnout, intrusive traumatic thoughts, hyperarousal, and avoidance (McCann & Pearlman, 1990). I have had two of these symptoms: feelings of inadequacy and intrusive traumatic thoughts. The former I did not attribute to burnout, however. I thought it was related to my performing what I deemed a passive researcher role. Doing what seemed to be nothing to me clearly related to my feeling inadequate. I remember, on occasion, sharing with colleagues my feelings about being unable to say or do anything clinical in response to some of the things I heard in the interviews. They tried to assuage me by suggesting, as does Shamai (2003), that the research interview itself can be therapeutic. Subsequently, I've encountered those "aha," moments in research interviews. I have experienced what I believe to be change as a passive by-product of research. I do agree it's better than the nothing I felt I was doing. Nevertheless, I believed that being an active change agent would, to a large extent, have mitigated my feelings of inadequacy during that six-month arduous process.

Even if research interviewing can be therapeutic, reservations about vicarious trauma's explanatory efficacy, vis-à-vis my research experience, continue. Not because I don't believe I experienced vicarious traumatization; I am certain I did. I felt for Luisa. Her acquiring AIDS from her partner, drugging away $40,000 in the space of a month, and then finding herself unable to achieve an open, honest, satisfying safer-sex relationship, that's the stuff of traumatology. Luisa's story, however, was one too many of its kind for me. I wanted to avoid them and did, never reaching my interview goal. Vicarious traumatization isn't ineffective—it is insufficient in explaining how I experienced interviews such as Luisa's. That's because a large part of what I was feeling and experiencing in those interviews had to do with the ways the women were presenting themselves *while* I was interviewing them. I must reiterate that I first became interested in the issue of recovering women's risky sex practices when I noticed that some were becoming pregnant while in treatment, thus implying that they were not effectively practicing safer sex and thus were risking contracting AIDS. That was what concerned me at that time, not past traumas that may have contributed to their behavior, or simply that they were pregnant, which was their right. Typically, hearing this news I went toward the potential problem. I didn't avoid it. I'd meet each woman and ask her to share her thoughts and feelings about the pregnancy. I'd feel energized as a result of these conversations, wanting to know what was on their minds and in their hearts. I wanted to help, to allay, to the extent that I could, any potential for it to undo their sobriety and stability (Brown, 1995), both of which were needed for good pregnancy outcomes.

Psychodynamic clinicians do not just react to what clients reveal about their pasts. They respond to the here and now, and are proactive about what's going on during the interview. That is why countertransference seemed better than vicarious traumatization as a conceptual framework for understanding my research experience reactions. Though I struggled with it, countertransference does include clinicians' current emotional reactions toward comments and behaviors that clients present in sessions. Conceptually, vicarious traumatization's explanatory inefficacy is due, it seems, to its narrowness, asserting as it does that the basis of interviewer stress is the impact on the interviewer of the interviewee's relating of *past* trauma (McCann & Pearlman, 1990). Interviewers' traumatic feelings are viewed as generated by exposure to interviewees' memories *of past* experiences that have traumatized them (McCann & Pearlman, 1990). My focus is the trauma generated by my exposure to interviewees' *current*, apparently self-destructive, behaviors and experiences as they unfolded *during* the interview process.

The Social Worker as Researcher: A Witness "In" Trauma

One should remember that this is all hindsight reflection. At the time I was conducting my field research, I had not thought about how many times I would have to listen to, be exposed to, and be confronted with women's self-defeating and self-destructive behaviors. Not in the form of stories about traumatic pasts, but comments and predictions uttered in here-and-now interviews. Maybe the results would have been the same, but I was conscious of feeling inadequate because, while hearing the self-defeating and self-destructive conversations, I believed that I could neither do nor say anything outside of what I perceived as a narrow and prescribed research role. I was not a clinician. I wasn't even a participant-observer (Baker, 1994). I was merely an observer, eliciting and taking down information to be processed and analyzed later. It's almost akin to being a bystander watching a toddler wander into the street; you are frightened by the potential danger, but the toddler is oblivious. The child has no fear or anxiety; it's not the child's problem. All the negative, premonitory feelings belong to the bystander. As the witness of a potential accident, the bystander is *directly*, not vicariously, traumatized. Traumatization inheres in the witnessing of an event that involves a threat to another's physical integrity (APA, 2000). In a very real sense, as a cognizant witness, I am the one "in the trauma," not the unaware wandering toddler.

Teresa is an example of that high-risk toddler. At the time of the interview, she had been in recovery for about 18 months, and was still in outpatient treatment. She also was continuing to have unprotected sex with her husband who had a serious drinking problem and whom she suspected was promiscuous. Teresa said she had risky sex because that was the way he wanted it. If she didn't do it his way he might leave her. She needed him to stay to help financially and to baby-sit their four young children while she went to play bingo. Several months after the interview, he was arrested. Their youngest child was found wandering the streets. Her husband had gone out and left the children alone. Another, Barbara, in recovery for over two years, revealed she was prostituting (she didn't call it that) because her SSI check didn't cover the cost of cigarettes and snacks. Then, there was Jane, six months into recovery. She told a story about her drugging days during which time her boyfriend had thrown her out of his apartment, where she'd lived with him for several years, because she refused to have sex with him. However, during her interview, she revealed they'd become engaged and would marry shortly after both had completed treatment. They were relating not only traumatic past events, but also describing here-and-now self-destructive situations. I was traumatized *in* those interviews because I was witnessing women discussing behavior that was threatening their stability and even their lives and, for Mary, the lives of others. What was most distressing about interviews with women like Barbara, Teresa, and Jane was that they seemed, if not pleased, then satisfied with themselves. They focused on, and talked convincingly about, how much better their lives were.

Quantitatively speaking, being in treatment was a confounding variable in my AIDS risk study. From Mary's perspective, for example, she *was* doing better. From a harm reduction perspective, by being monogamous she had lowered her AIDS risk. For some of these women the fact that either they, or their partners, had AIDS or were still on drugs or were in a residential program and, therefore, had no idea what their partners did when they weren't around was not betrayed by their demeanors. Their seeming obliviousness was what was traumatizing. *I* was the one shocked by what they were doing or saying. *They*, however, did not seem to be. Often during interviews I asked pointed questions, such as, "And you did *what?*" or "He's *still* an active heroin user?" or "*You* didn't *want* to use a condom?" It was like working with a caseload of suicidal clients, not vicariously traumatized by their stories of having attempted suicide, but traumatized by sitting in their presence as they talked convincingly about preparing to commit the act. Except, as a researcher, I wouldn't be their clinician and able to have give-and-take discussions or draw up anti-suicide contracts. Instead, I would merely listen, observe, and maybe find out later if they were successful. (This example is for analogical purposes only.)

As an observing researcher, I am traumatized, but not vicariously as a listener to past experiences. I am a witness to their presently hurting themselves or, as in Luisa's case, being hurt by someone else. It was more than being an empathic interviewer. Pearlman and Saakvitne (1995) do not adequately explain my experience by suggesting that I "understood" Luisa's experience or that I "felt" her pain. It was more than that: I had pain that was my own, pain generated by what was going on during that interview, by having to be there with her. The aura of traumatic pain was in the room that we *both* shared. She was not merely telling me *about* having cried because she was in despair about never being loved. She cried and was despairing in my presence, and I was in the trauma as I witnessed grief threaten her emotionally and psychologically. I was horrified and pained in the space I shared with Teresa (the interviewee who prostituted herself) when I learned that she was virtually risking her life for cigarettes and soda. I felt fear because Teresa, unlike Luisa, did not appear to care about her risk. I think my feelings solidified into traumatic ones because in Teresa's situation, for example, and as in Mary's and others, I felt bad, but they didn't seem to. I was observing, through my flawed researcher's window, a heavily trafficked street teeming with unattended toddlers, experiencing overwhelming feelings of premonitory dread. The way these women blithely talked about their self-destructiveness made my trauma direct and primary, not vicarious and secondary. My struggle with vicarious trauma theory, therefore, isn't about its inappropriateness as a theoretical framework. Rather, it's about its inadequacy when deconstructing my research experiences. It doesn't go far enough in explaining the negative impact interviewees like Mary, Barbara, Luisa, and Teresa had on me, a neophyte social work researcher. The bottom line is this: vicarious traumatization is bad, but witnessing or being "in the trauma" is worse, much worse.

The Social Work Researcher Objective: "Good Distance"?

Qualitative research writing is replete with discussions about the impossibility of achieving real objectivity. The intra- and inter-subjectivity of this methodology may be all there really is (Denzin & Lincoln, 1994; Giami, 2001; Mishler, 1986; Weiss, 1994). The objectivity sought by quantitative researchers is a mirage; according to Giami, it is impossible. What one has to do, he instructs, is to find the "'good distance,' according to one's research objectives" (p. 23) It's something I had never considered. That I hadn't might explain the all-or-nothing approach with which I tackled my research. It seems that accomplishing this good distance was easier for me as a clinician than as a researcher. If I were to do this research project again, I think a "good distance" for me would be *closer* to the research participants, even though it might have necessitated revising my research objectives. Even though it is likely I would have suffered some vicarious trauma while interviewing a number of these women, I believe a lot of direct traumatization would have been avoided. The distance between the women and me needed to be titrated; I was too close to be out of range of the many negative emotions they generated in me. Yet, I was too far away to respond to them more naturally, actively, and helpfully. Though they were clean, clinically, many were in very deep denial about the dangers they were courting. I believe that my newness as a researcher and my "oldness" as a clinician account for much of my inability to find Giami's (2001) good distance.

Overall, though, the research project was a good piece of work, I believe. And although I have not had any subsequent contact with any of the women I interviewed, I have been in contact with staff from their programs and know that they were in no way harmed in the process. It appears, though, that I would have done a better job, or at least not have felt so bad in doing it, had I given more thought to the study's objectives and the potential sequelae of its processes. I believe it would have been better had I approached it *more* clinically, not less. Had I done so, it is likely I would have considered potential countertransference and trauma consequences earlier on and secured support and guidance then.

Clinical countertransference, the quality of interview relationships, and reflecting on their processes have methodological and research implications. To some extent choosing a quantitative methodology is also at issue. Without "therapizing" research (Berger & Malkinson, 2000), qualitative researchers are much more likely than quantitative ones to consider interviewer-interviewee relationships and the distance between them in the research process thoughtfully (Bunin et al., 1983; Giami, 2001; Mishler, 1986; Shamai, 2003; Weiss, 1994; Wyatt, 2006). Getting closer to research subjects (Giami), rather than getting farther away; looking at interviewees more clinically (Shamai), not more objectively; and adopting a more clinical role and less of a "scientific" one, might have kept me safer and, perhaps, made me a better and more helpful interviewer (Shamai). The implications of these qualitative research components are fraught with ethical and other dilemmas (Shamai). That, however, is for another paper.

My motivation for writing this paper and sharing my experiences of Mary, Luisa, and others was born out of a need to practice my clinical training. I felt compelled, as a good social work clinician, to examine and analyze my research experience in light of the fact that it did not turn out as I had planned, even though I risked exposing my extreme research naiveté and my sometimes less-than-generous feelings and thoughts, both about clients and my mistaken quantitative research beliefs. Considering countertransference as my primary theoretical framework, I examined the confluent impact of countertransference, roles, traumatization, subjectivity, objectivity, distance, and research objectivity upon me as I reflected on the entire research process. By contemplating and analyzing my painful and not-so-stellar, but enlightening, experience I have come to grips with what happened and why. It was difficult, but the compulsive desire has been assuaged.

The process has also been rewarding. I am left with a genuine appreciation for the research process and have concluded that a qualitative approach to my research study would have yielded better results—both for the study and for me. Based upon my personal experience, I actually have come to believe the contention of Bunin et al. (1983) that there is an affinity between research and clinical interviewing, even though they do not discuss qualitative research specifically. I guess that was left to me! What I would like to add to their model is the need for more training and support (not just debriefing sessions) for qualitative researchers, particularly for those (new to it or not) studying "matters concerning experiences, opinions, and feelings that people find painful or embarrassing to discuss" (Bunin et al., 1983, p. 31). This training, as I envision it, would define Bunin et al.'s "people" as including both the interviewee and the interviewer. Some budding researchers need help in creating and maintaining a "good enough" research distance. Psychotherapy for researchers involved with self-destructive participants, such as some that I interviewed, should also be strongly encouraged, as it often is for clinicians working with traumatized populations. Having gone into therapy upon completing this project partly explains my courage and ability to return to it for a better understanding of what I did and didn't do and has given me an objectivity I did not have then.

Though I may have sounded offhanded in the recounting of my interview with Luisa, please note that I was aware of the presence of counselors onsite when I visited her. Prior to beginning this project, all program directors, staff, and prospective participants were advised of the risks inherent in this study. During recruitment, and included in the consent form, prospective participants were not promised confidentiality in this context because of the study's inherent risks. As stated earlier, no staff advised me of any negative consequences generated by my interviews. I'm convinced I was the one who left interviews with bad feelings, not the participants, perhaps with the exception of Luisa. Did I make mistakes? Yes, many. But none that were detrimental to others. Many of the programs' directors knew me and had confidence in my clinical skills, and I believe their confidence wasn't misplaced.

My reflections are at an end here. But, a somewhat intrusive afterimage lingers: I believe that Luisa really is, or could be, a poster girl for good, responsible safer sex. However, I don't want to interview her again. I don't want to plumb the depths of what leading that "good" life would be or feel like. I would hate to think, though, that Mary is her alternative. Somehow, despite my reflection, intellectualizing, and insight, it is a bit too much for me. I have yet to find my good enough distance from them. I'm still way too close—I've got them in *my* blood, and what remains before me is the rest of my social work life (Herman, 1992).

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[1] The term AIDS will be used for HIV and HIV/AIDS throughout.

[2] Transitional residences frequently used by those who have problems with alcohol and/or drug dependence, who require some minimal professional support (Barker, 1997).

Call for Papers:

SPECIAL ISSUE ON HUMAN-COMPANION ANIMAL RELATIONSHIPS

The Fall 2008 issue of *Reflections* will be devoted to narratives about human-companion animal relationships. We are interested in articles about the importance of animals in our and our clients' lives: the nursing home cat who comforts dying residents, the woman who would not leave a domestic violence situation due to worry about her dog's care, services designed to enable older and/or chronically ill people to maintain their pet(s), the dog who lives in the emergency shelter for abused children, a horse riding program for developmentally disabled adults, a vocational program on dog grooming for incarcerated men, the special pet who helps you cope with challenging client or personal situations, and many more. Articles describing cruelty to animals will not be reviewed.

The deadline for submissions is June 30, 2008.

Please send submissions to:

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Department of Social Work
California State University, Long Beach
1250 Bellflower Blvd.
Long Beach, CA 90814

Questions may be addressed to: mpotts@csulb.edu

This special issue will be dedicated to all animals described by the authors and to Bobby, Goldie, Diana, Susan, Jerry, Tippy, Skipper, Buttons, Penelope, Clara, Marley, Amelia, Ezekiel, Johnny Cougar, Janice Joplin, Buster, Sparkle, Sushi, Kiko, Snookie, Pookie, Rosie, Sweet Pea, Missy, ChiChi, Ishi, Jack, Crackers, Bull, Bulldozer, Maurice, Oliver, Fluffy, Bear, Cosmo, and Inyo.

KILLING CANARIES: A BIRD'S-EYE VIEW

Erlene Grise-Owens, Ed.D., Spalding University

This article interweaves a personal narrative with feminist, experiential, and justice-focused educational tenets. The author's individual story occurs in the collegial context of educational efforts to address significant social issues—particularly racism—connected to Hurricane Katrina. A critical "canary" incident of oppression provides an avenue for exploring universal dynamics of sexism and interlocking isms.

Three weeks after Hurricane Katrina wreaked havoc in the Gulf Coast, I participated in a meeting enjoining three educational institutions. Representatives from three universities met to brainstorm about how we might collaborate on educational efforts related to Hurricane Katrina and the social issues to which that catastrophe brought attention—most specifically race. Seven of the nine participants, including myself, hold administrative or faculty positions at local universities; two were students. Two private universities and one public institution were represented.

Canaries, Context, and Characters

Early in the discussion, I mentioned that I see the disenfranchised people who bore the brunt of Hurricane Katrina—in death, devastation, and displacement—as the "canaries" of our culture. I elaborated that miners used to send a canary into a mine to test whether the air was safe for them. If the canary did not return, the miners knew the environment was dangerous and they would likely not survive working there. I drew the comparison that the environment of our world is becoming dangerously deadly—in myriad aspects, including ecology, social policies, political structures, cultural values, and so forth. The most vulnerable of our community are the canaries of our culture. They warn us that we are creating an uninhabitable world. If the canaries cannot live in this environment, no one can ultimately survive. None of us are really free to live until it is so for all. As West (1993), declared, "We have to keep track at any social moment of who is bearing most of the social cost" (p. 4).

I did not anticipate that in this meeting I would have a canary-like experience. Here's my story, told from my bird's eye view. I have changed names to provide a degree of anonymity and to protect my rights to free speech. My perspective is that of one individual; but my story is universal to what many experience. As an older feminist, I realize at deep levels, both experientially and intellectually, that sexism is perennial, persistent, and pandemic—even, and perhaps particularly, in academia (Grise-Owens, 2002). So, I thought I was inured to these type incidents. But, this canary experience left me newly incensed and airless.

First, let me introduce the context and characters in this story. The meeting was held on a Sunday evening in the home of a black male, Luther, and his white female partner, Gloria. Both Luther and Gloria are administrators at a private university—with teaching roles, as well. The only other black participant was Matthew, an undergraduate student at the same private university. Other than Gloria and me, the only other female was Guiselle, a white graduate student at the private university where I teach. Guiselle's spouse, Alex, also attended; he is a white male administrator at the other private university. Three other white males attended. Damien teaches philosophy and Joe teaches history at the public university. Paul teaches in the same School of Social Work where I teach.

To my knowledge, all participants identify as heterosexual. Also, it appeared that no persons with disabilities were present. I make these observations because I will be describing who participated in this meeting. However, I have learned that it is just as essential—and oftentimes more significant—to note who is *not* at the tables of discussion.

Voices Heard...and Hidden

As we arrived, Luther and Gloria graciously welcomed us all. Throughout the evening, Luther's eloquent refrain was that we must change the discourse—specifically about race. Luther continually and collaboratively called for us to "do something different." I must say up front that Damien and Alex seemed to genuinely attempt to be collaborative contributors. They creatively and constructively engaged and respectfully disagreed in the conversation. While Alex and Damien subtly benefited from white male privilege— e.g., in how readily their ideas were received—they did not engage in overtly dominating behavior.

Guiselle spoke infrequently and, though she offered good ideas, her tone often seemed conciliatory or hesitant. Matthew, the only other black voice in the room, was largely silent. Of course, the power differential of Matthew's and Guiselle's position as students in a roomful of professors impacted the dynamics. The two students also appeared to be the youngest persons in the room; so, their student role, minority status, and age placed them in the least privileged positions in the room. The vast majority of the airspace was taken by Joe and Paul.

As the discussion evolved, we began to sketch out a plan for a one-or two- day community forum on Hurricane Katrina. As we talked about identifying our audience and establishing a format, Gloria, who had been in and out of the room (serving food), suggested a four-phase agenda for the event. Paul, in a badgering tone, attacked Gloria's idea. He verbally hammered her about the logistics being unrealistic. Gloria politely attempted to clarify that she was simply making suggestions and the specific time frames would need to be worked out later. Paul overrode her voice. After loudly blustering and blistering for several minutes (taking up air space without really saying anything and causing general discomfort), Paul said, "Oh, I'm not disagreeing with you." My interpretation: After administering a verbal smacking he said, "Oh, I didn't mean to hurt you." Abuse dynamics are similar, regardless of the context, relationship, and level of engagement.

At some point during the evening, Paul defended some "fact" by declaring, "Well, two and two is four!" I interjected, "Yes, but it could also be twenty-two." Paul, derisively said, "Well, you knew what I meant."

Yes, Paul, I knew what you meant because I have learned in order to survive that I must speak the language of male dominance, which claims absolute, measurable knowledge as its unquestioned birthright. I have learned through extensive tutelage about male dominance, which cuts off any alternative interpretations with: "Why should I try to know what you mean, because what I mean holds priority of power? And, how dare you challenge my purview by voicing another view?" I have learned that the masculine voice of rationality, rules, and objectivity is seen as "real," whereas the feminine voices of relationship, dialogue, and multiple realities are silenced and "hidden" (Weick, 2000).

Amongst the many ironies of this evening, my proposal to discuss the intersection and interlocking of *isms* (Andersen & Collins, 2001; Van Soest & Garcia, 2003) was met with a range of hesitation, resistance, and avoidance. The masculine perspective of needing to consider things in singularity, isolation, hierarchy (e.g., Schriver, 2004) seemed to dominate. Similarly, Joe and Paul (and perhaps others) seemed intent on the primacy of giving the audience "expert" knowledge. I had the distinct impression that Joe believes it is imperative that he tell students all they need to know and lecture is his primary (sole?) mode of teaching. I know from his communications within our School that Paul believes that teaching is "about the teacher being the expert" and the classroom is "not a democracy": hierarchical, disempowering notions.

Any singular, hierarchical way of knowing is limited. As I point out to students, DWMs (Dead White Males) are the primary purveyors of knowledge valued in our culture. I clarify that I am not saying we should discard all DWM knowledge—much of that knowledge is valid and valuable. But, I emphasize that white male dominant knowledge is a mere fraction of the multiple ways of knowing—and some of the dominant "reality" is oppression and disempowerment cloaked in sheepskin-sanctioned "knowledge." To continue to uncritically accept hegemonic knowledge as whole knowledge keeps oppressed individual's and group's knowing as invisible, inconsequential, marginalized, and powerless (Davis, 1990; Minnich, 1994; Saleebey & Scanlon, 2005).

Ways of Knowing/Teaching/Learning

Myriad ways of knowing makes for more diverse, complex, complete learning (Goldberger, Tarule, Clinchy, Carter , 1996; Belenky, et al., 1994). For example, I learn about oppression and dominance through my lived experience as a white female (who grew up poor) in this culture. I learn about "isms" through my conversations and relationships with those who share their experiences with me. Disenfranchised persons who seek empowerment must use multiple perspectives for our learning. Otherwise, we remain disempowered by believing that his-story is normative and singular (Friere, 1971).

Nevertheless, during this brainstorming meeting, I spoke the masculine lingo in ways to legitimize my input for my primary audience—by citing experts, specifically a primary text that I use in social work practice classes. I suggested using the core concepts articulated in Finn and Jacobson's (2003) *Just Practice* framework—i.e., power, history, meaning, context, and possibility—as a way to frame our discussion about Katrina. Although one of the males murmured verbiage that indicated minimal interest, this idea was not pursued by anyone else in the group. Because the *Just Practice* framework was unknown to them, I conjecture that the men assumed it must not be "real." After all, these experts (i.e., Finn & Jacobson) were not expertly identified from the males' expert expertise about experts—but that of a woman's experience.

As a feminist, criticalist social work educator, I believe the best educational experiences are empowering and engaging (Belenky, Clinchy, Goldberger, & Tarule, 1997; Dore, 1994; Figueira-McDonough, Netting, & Nichols-Casebolt, 1998; Maher & Tetreault, 1994; Nichols-Casebolt, Figueira-McDonough, & Netting, 2000). I advocated for interactive, shared learning as part of the event we were planning. I suggested we call the experience a "Learn In" rather than a "Teach In" (which, one male participant had suggested, was reminiscent of the 1960s). For me, Teach-in connotes a more "sage on the stage," let-us-tell-you-what-you-need-to-know lecture approach, whereas, "Learn In" connotes a "guide on the side," shared, facilitative process. As Goldstein (2001) said, a teaching model for education is "…didactic, deductive, 'top-down'. In contrast, a learning model is experiential, inductive, and 'bottom up'" (p. 8).

My approach to any educational endeavor—particularly with adults—is that it must engender dialogue (Vella, 2002). Any significant, life-impacting learning is not just about the dissemination of expertise and information. Transformative, socially responsible learning engages and encompasses personal experiences, diverse ways of knowing, social constructions, and spiritual connections (hooks, 1994; hooks, 2003; Saleebey & Scanlon, 2005). This synergetic, criticalist learning approach not only challenges oppressive, unjust structures, it shapes social change and creates communities of justice and wholeness. For me, to collaborate on an educational forum on the Katrina catastrophe's connections with ingrained oppression and injustice, and not plan an event using this approach, would be a further travesty. As too often happens in education, we risk recapitulating the very dynamics that conscientious education seeks to eradicate.

A primary way that transformative, synergetic learning occurs is through engaged, critical conversations. So, in our brainstorming session, I used language such as "having a conversation," citing Phyllis Wheatley's writings (2002) about how "all social change begins with conversation." Notably, this idea of conversation was one of the very few times that Matthew spoke. He suggested that we have follow-up, ongoing cyber-conversation as follow-up to our Sunday conversations. Perhaps this avenue seemed a more likely way for Matthew to have his voice heard.

I also suggested that we incorporate action steps into the experience—i.e., not just talk about these issues, but plan what we were going to do about them. The idea for action steps seemed to be well received. However, the ideas about interactive learning were largely met with trepidation. White male participants expressed concerns that we could "lose control" during that interactive element.

Hives, Hitting, Hegemony, and Humor

At one point, I suggested using a specific interactive exercise to engage the audience in understanding the intersection of isms, privilege, and dominance. In response to my advocating interactive learning, Joe said, "That gives me hives." Being well-trained by our culture to be a caretaking female, I tried to diffuse Joe's pain and his apparent repulsion with this idea. I playfully walked toward Joe—in my mind I was simply trying to separate the growing gulf between us by taking steps toward him. Joe recoiled, putting up his hands defensively, saying, "You are not going to hug me!"

No, Joe, I do not want to hug you. Furthermore, I apologize—to myself. I am sorry that I fell into old patterns of feeling responsible for your hives. I am not responsible for your hives or hurts. You can go to a doctor and get treatment for your hives. However, remember that even male-dominated medicine is finding that as much as we try to protect ourselves from "having hives," soon our bodies develop immunities. The proliferation of medications is becoming problematic in itself. So, wise health advocates tell us to address the systemic causes of our "hives" rather than hiding them through quickfixes. Otherwise, the medications can actually weaken our abilities to deal with some of the hurts and hives that come through living. So, when a really big bug (or bird) bites—not just an uppity feminist flea that gets under your skin, unsettling your controlled world —we get sicker and sicker, and deader and deader.

Truthfully, as this encounter with Joe and Paul progressed, I was reminded of the story my friend Donna tells of picking up her daughter, Sarah, at daycare and learning that Sarah had been hitting her preschool peer, Jack. Donna corrected Sarah with a preschool-size "talk" about how it was okay to be angry but that Sarah needed to use her words to express her anger. Sarah listened earnestly, nodding her head in apparent agreement. Donna, the proud parent, thought, "Ah. Problem solved. Preschool war averted." That is, until Sarah quietly, but emphatically enunciating each word, asserted, "But, I don't want to talk to him. I want to hit him!" Like Sarah, I did not want to talk to, much less hug, Joe or Paul. I wanted to hit them. But, being a pacifist lover of language, I made a valiant effort to overcome my preschool proclivity. I attempted to use my words—when I could get some air space.

During this male-dominated discussion, I am sure that I probably began to sound "shrill" at times. Women are oftentimes characterized as "shrill" when they do not speak in soft, uncertain, appeasing tones but dare claim their voices. It was no accident that Howard Dean being characterized as "shrill" was the death knoll for his presidential bid. There are few more condescending connotations for a man than being "feminized." Women are shrill and emotional; men are forceful and assured. As Valian (1999) documented in synthesizing numerous studies, males exhibiting "feminine" behaviors are often perceived negatively, e.g., as less competent. However, Valian noted that females are often placed in lose-lose positions: If a female acts "feminine" she is dismissed as weak or incompetent; if she behaves in a "masculine" way she is penalized for being "unfeminine."

Later in the evening, Joe characterized the different threads of discussion as, "Well, we have those who want to focus on content and those who want to do touchy-feely stuff." I attempted to refrain from being defensive about having my ideas dismissed as "touchy-feely." I attempted to convey that I believed in order to change the discourse, we must look at both form and content. I further conjectured that perhaps part of the reason the content had not been "gotten" by our intended audiences was because we needed to look at different forms of engaging the content.

At this point, Joe yelled (dare I say, shrilled!), "That's bullshit..." Frankly, with that outburst, I had had it. The rest of Joe's words (in my head) went something like: "blah, blah, blah, blah, brotherhood; blah, blah, blah, blah, brotherhood." I know he said something about the brotherhood and bringing the brotherhood together. Exasperated at the impenetrable sexism, I simply said, "Well, at least when we talk about the brotherhood, could we talk about the sisterhood, too?" And, I went to do what any good feminist knows to do when in these situations: I found a sister to talk with….

I escaped to the kitchen (still a familiar habitat for most females). There, Gloria was bagging up leftover chips and sandwiches. Joining her, I observed to Gloria that I found it hard to stomach that four white guys were primarily setting the agenda for a discussion about race and at the same time a woman was cleaning up the kitchen. Gloria smiled and told me a story of when she was a young sociology major. She was one of only two women in the class of a renowned male sociologist. This teacher said to the women that in his sociological estimation they belonged in the kitchen. Wryly, as she laid out dessert, Gloria noted, "We really haven't come very far." Adding insult to irony, Gloria also revealed that the idea for this collaborative endeavor was generated by two women. Gloria and the female spouse of one of the males had been casually talking, came up with the idea for the three universities to collaborate on this topic, and shared the idea with their respective spouses.

At an earlier point in the evening, Joe had declared that the event we were planning must have at least 300 attendees or it would "be a failure." I said, "Are you serious?" (I really did wonder if he was being humorous and felt a slight tremble of anticipatory hope. Humor can be a great equalizer and stress reliever.) Joe clarified, "Yes, it has to be at least 300. I have at least that many in my classes each week." I half-heartedly attempted to offer a balance to the perennial masculine perspective that bigger is better—except for female body size. I offered, "I think thirty people with synergy can accomplish more than 300 people who just come and sit." Luther, with astute diplomacy, said, "Well, I'd like to have 300 and synergy!"

But, in that crystallizing moment, I realized that we had come to the crux of this meeting's purpose: to get the "Joes" and "Pauls" a bigger audience for their hegemonic "knowledge." Been there! Done that! And, it didn't even get me my tenured tee-shirt! I had to learn to sew my own.

Reflections on the Experience: Common Canary Narratives

As I struggled for airspace in this airless mine of white hetero-male dominance, I had a stark vision of our culture's "canaries" of color; canaries with disabilities; LGBTQ, poor, female canaries—and anyone who was not like the majority of privileged birds in that room—gasping for air. Meanwhile, the hegemonic hawks and eagles continued to opine: "We tried to teach them. Too bad they never learned."

Some would criticize that I was "being sensitive" to the dynamics I named. They are right. But, when did it become a negative to be described as sensitive? Like the "shrill" characterization noted earlier, "sensitive" is viewed as feminine, and, thus, a negative in our canary-killing culture; however, "objective" is viewed as masculine and, hence, a positive attribute. Of course, I'm sensitive! I'm a canary! I'm saying, "Stop killing the canaries—for all the birds' sakes!"

Yes, this canary experience sucked the air right out of me. Yet, I still hold hope that the birds of a feather will flock together (i.e., synergy of the disenfranchised) with the ally eagles and hawks who are willing to be partners (rather than just Flapping Big Birds). I still believe that we really can collectively, collaboratively, and—yes, dear, Joe—experientially create a new world where canaries and birds of every feather and color can live to sing new songs. And, there can even be a place for turkeys like Paul and Joe, but, only if they learn not to gobble up more than their airshare and they change their unharmonious solo tunes.

As for this particular bird, this experience unsettled and angered me; it has continued to be a critical incident for reflection. A few days after the incident, I meandered through a bookstore in Providence, Rhode Island. I was still seething, and seeking resolution to my canary experience. So perhaps it was, indeed, providence (and past experience in having read some of her writings) that drew me to pick up bell hooks' (1995) *Killing Rage: Ending Racism*. Here's an excerpt from the first paragraph of the first chapter, "Introduction—Race Talk," of that book:

> *When race and racism are the topic in public discourse the voices that speak are male...Cultural refusal to listen to and legitimize the power of women speaking about the politics of race and racism in America is a direct reflection of a long tradition of sexist and racist thinking which has always represented race and racism as male turf, as hard politics, a playing field where women do not really belong. It presumes that the business of race is down and dirty stuff, and therefore like all male locker rooms, spaces no real woman would want to enter. Given these institutionalized exclusions, it is not surprising that so few women choose to publicly 'talk race.' (p. 1-2)*

Reading hooks reminded me that I am not a lone canary. I was reminded of the power of sharing "canary" views. This canary did not return to the airless mine dominated by Paul and Joe. The planning continued, a forum was held, and it was a "failure"—using Joe's measurement. When I was younger I would have thought leaving was defeat and probably would have persevered. As an older (and hopefully wiser) feminist, I have learned that sometimes it is more productive to leave a battleground and, instead, seek places of common ground. So, I continue to have fruitful conversations with individuals from the group (other than Paul and Joe). I seek healthier avenues for collaborating on addressing the Katrina phenomena. For example, I collaborated with other faculty to integrate/adapt assignments related to Katrina in our Social Work curriculum.

My canary story does not compare to the intensity of the Hurricane Katrina victims' experiences. However, the complex dynamics of oppression are similar—regardless of intensity and context. I hope that my bird's eye view can encourage other canaries to realize the legitimacy of their views, claim their voices, and tell their song-stories too. As Weick (1994) noted, "Stories are a form of knowledge and, some would say, the only knowledge we have" (p. 222). Our narratives inform, empower, and construct realities. As the purpose statement of *Reflections—Narratives of Professional Helping* articulates, our narratives "shape social change." And, as Wheatley (2002) contends: "All social change begins with conversation." The powerful wake of Hurricane Katrina brought a flood of narratives about oppression and desecration. In the aftermath, let's use the Katrina crisis as an opportunity. Sister and Brother Canaries, let's sing our stories. Let's call ourselves to conversation. Together with allies, let's shape social change by addressing

oppression and revitalizing hope. Let's use our narratives to "restory" equity and common good.

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THE TEACHER'S TASK: EMPOWERING THE STUDENT

Paul Johnson, D.S.W., and Brandi Fairchild, D.S.W., University of Maine

A key element in teaching is creating an environment in which students are taught how to learn. Rather than being fact oriented, it should be a setting in which one thinks about ideas. In many respects, teaching is a dialogue between teacher and learner. Yet, for this dialogue to occur, one needs to provide an environment that fosters students' abilities to think conceptually and critically about social work. Hence, teaching at its core is about engaging others in the great adventure of learning. It is an ongoing journey in which one is always looking to provide a setting in which one can take risks, engage in dialogue with one another, and have fun. The classroom should be a place where students look forward to coming and creating an environment that is collaborative and supportive. Ultimately, students are in charge of their own learning.

Introduction

In 1999 I wrote an article entitled "What a Long Strange Trip It's Been" (Johnson, 1999). The paper attempted to examine and reflect on my experiences of being a beginning social worker and teacher. In many respects they were painful experiences fraught with disappointments, frustrations, and, at times, loss, sadness, and anger. The article also addressed some of my fears, anxieties, and apprehensions. Yet, several years later I find myself no longer as preoccupied or concerned with making mistakes; rather, I am more cognizant of what I am attempting to achieve in my classes and how I can best go about ensuring that happens. According to Ambrose and Bridges (2005), research has shown that mastery or expertise in any domain takes at least ten years. Now with over ten years experience in higher education, my understanding of the profession and the importance of dialogue between students and faculty is vastly different.

In all of my classes, I have two central objectives. First, I want students to learn and second, I have to provide a setting in which this learning can occur. The intent of this narrative is to look at these two objectives and discuss how I believe they can be achieved.

According to the Council on Social Work Education:

> *"Social work education combines scientific inquiry with the teaching of professional skills to provide effective and ethical social work services. Social work educators reflect their identification with the profession through their teaching, scholarship, and service. Social work education, from baccalaureate to doctoral levels, employs educational, practice, scholarly, interprofessional, and service delivery models to orient and shape the profession's future in the context of expanding knowledge, changing technologies, and complex human and social concerns"* (CSWE, Educational Policies & Accreditation Standards, Preamble, 2001).

This statement connects well with current trends in education, from a rejection of the traditional transfer of knowledge model, to a greater emphasis on the integration of the scholarship and practice of teaching. In doing so, I believe, a more student-centered conceptualization of education that places student learning in the forefront occurs (Barr & Tagg, 1995; Hutchins & Shulman, 1999; O'Leary, 1997). In other words, andragogy is central to the approach for such transformation, as teacher and students move together from the known to the new.

In many respects, teaching is essentially a *dialogue*. Derived from ancient Greek signifying a "word with, through, by means of, or among," the word is replete with the philosophy of teaching's essence. It evokes a reality of conversation within a community. As such, it bespeaks an art of communication and it is this art that I identify as the essential philosophy of teaching. It is an art which integrates knowledge and know-how communicating and sharing with others. While I accept that knowledge, proficiency, and experience are necessary, I would also assert that teaching requires one to be able to engage in a dialogue between teacher and learner. Such dialogue rests with an imaginative connection being made between learning context and content. In this respect, the objective of teaching and learning is not directed towards pure information but, rather, transformation.

Excitement for Learning

I love to teach and take pride in the fact that I am a licensed social worker. I convey this through enthusiasm for what I am teaching. In my Introduction to Social Welfare class, I get excited about presenting the historical component of the course. Frequently, students have stated that they thought social welfare history would be "uninspiring" and not relevant to what was happening today. However, through many of their assignments, students have been able to make connections between what we have discussed in class and contemporary social welfare issues.

Examples include papers on individuals or events that are of particular interest and concern to students. Some of the subject matters are Martin Luther King, Malcolm X, Rosa Parks, Jane Adams, Dorothy Dix, Janice Joplin, and Bob Dylan, and legal rulings such as the Civil Rights Act and Roe v. Wade. Regarding Roe v. Wade, many students refer to the current debates on abortion including the possibility of the present Supreme Court overturning it. Students also discuss a woman's right to choose and look at some of the reasons why women are forced to make this difficult, personal decision; in other words, students are driving the process. My goal is not for students to listen passively but to develop critical thinking skills by questioning assumptions.

Relevancy of class material is helpful in creating dialogue. I have students break into groups and ask them to respond to the following:

1) A time in their lives when they personally experienced or witnessed discrimination.
2) A time in their lives that some significant event touched them personally.
3) What it must feel like to be poor.
4) A time in their lives when they stood up for something they believed in.
5) How they wish to be remembered after they die.

The objective of this exercise is to engage students in a dialogue with one another. It also reinforces the fact that the material is not abstract, that it has meaning, significance, and personal implications. This class assignment provokes, prods, and animates the students. When providing specific examples of personally experiencing or witnessing discrimination, many of the younger students will talk about an event in high school where they observed a classmate being humiliated by a school official. Students with more life experience talk about personal experiences of being discriminated against at work; for example, female students overlooked for promotion based on gender.

Regarding a time in their lives that some significant event touched them personally, older students recall the assassination of John F. Kennedy. They remark that they can remember exactly where they were when they heard he had been shot. This leads to discussion of other tragic national events such as the 1986 space shuttle explosion and the events of September 11, 2001. These conversations bring the subject of social welfare to a place less abstract and less dry, making it real and significant to the student.

Service Learning

In the last few years I have incorporated service-learning into my Introduction to Social Work class. The intent of service learning is to connect classroom learning to real life applications in the community. Also, service-learning projects are designed to benefit community organizations as much as students. By integrating service learning into the curriculum, educators do more than give students opportunities for hands-on experience. They are providing opportunities for encountering competing definitions of the common good, diverse viewpoints on the root cause of social problems, and questions about who and what knowledge is for. Courses that include service learning encourage students to ask the larger questions that lie beyond the bounds of most traditional courses.

Since incorporating the service-learning component into my class, I have been impressed with the passion, richness, and insight of class presentations. Several of the students stated that they wanted to declare their major as social work. They also talked about what a profound impact many of the clients/consumers had upon them and acknowledged that with this component, the theoretical material being presented in class was far more meaningful.

There have been a number of examples over the last few years that have impressed me. One student was very interested in volunteering at the Center for Grieving Children, which offers a multicultural program for children who have come to live in the Portland area because they had fled their own countries due to war and civil unrest. This particular student talked about how much he had learned from these children. For his presentation he put together a wonderful Power Point that displayed the children's art work and provided information about the Center. I have continued to keep in contact with this student who is now in his senior year in the program. He continues to volunteer at the program, and the Center has utilized his computer skills to put together presentations for possible funding purposes.

Some of my students had no initial interest in social work. One woman was taking this class because it fit into her schedule. However, several weeks into the course she inquired about possible agencies in the community that offered some flexibility. Another student who took the class with me last semester volunteered at the Preble Street Resource Center, a program that provides services for individuals who are homeless. I was absolutely amazed by this student's presentation. She stated to the whole class that when she had started volunteering at the program, she had some negative and stereotypical ideas of what homeless people were like. However, she explained that this volunteer experience had completely changed her perception of social work. The staff had been very welcoming and she learned a great deal from the people who utilized the program. In addition to these two specific examples, a number of students have volunteered at Big Brothers Big Sisters, Camp Sunshine, the Special Olympics, and programs for the visually impaired. At the beginning of the course they had been extremely nervous about the class requirements but found the service learning to be one of the best components of the class.

Facilitate Learning

In order for the aforementioned to occur, I need to provide an environment that facilitates learning. One of the resources that I utilize in the ongoing process of learning is humor. I strive to make my class settings a learning process that is fun, one where students are not afraid of failure and are willing to take chances. I also believe that using humor has numerous benefits. It creates community, relaxes students, and helps student engagement and retention. When I use humor I am consciously utilizing something that everyone can relate to.

The University of Southern Maine is predominately a "Red Sox nation." You only have to mention the New York Yankees and everyone has an opinion. Twenty seven World Series, the curse of the Bambino, Bill Buckner, Bucky Dent—mention any of these names and almost everyone has something to say. In class, many students will come in and tell me how the Yankees lost last night, or have I had a look at the box scores or standings that morning. In fact, many students will bring in the *Boston Globe* or the *New York Times*. Now, here's my opportunity! "Hey did you happen to read that article in the paper about social security, health care, homelessness, elder abuse, the high cost of prescriptions, or foster care and adoption? That would be a great piece to incorporate into your paper."

I'll also tell them how I can relate to their years of woe, how for countless years I have watched the English football team, cricket team, or rugby team be defeated in a major competition. In soccer it was usually the Germans who dashed our hopes. In cricket, it was Australia or the West Indies that beat England. In rugby, the numerous defeats were handed down by Wales at Cardiff Arms Park.

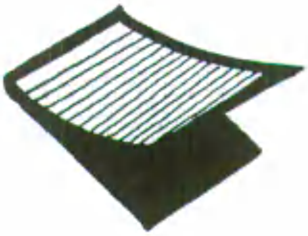
In addition to sports humor, I enjoy using music as a teaching aid. I will say, "I'm sure you remember the Beatles or the Rolling Stones." At that point I will burst into a brief rendition of one of their songs. Immediately one of my students will reply, "I wasn't even born when they recorded that," or "Hey professor, keep your day job." Yet again, from this terrible rendition, we are able to make a connection with what we are discussing in class. Hence, going back to a previous rationale for my social welfare classes, students are able to make connections between what we have discussed in class and contemporary social welfare issues.

In my Introduction to Social Work class, when we are looking at empowerment and human diversity, I ask the class to share stereotypes of the English. Some of the favorites include: we are stuffy, drink tea, bad cooks, talk funny, drink warm beer, eat fish and chips out of newspaper. I then turn the tables on the students and proceed to tell them how people in England view Americans: loud, overweight, rude, pushy, aggressive and always saying "have a nice day."

You can see that some students are somewhat taken aback by this. A discussion follows about how we formulate these fixed mental images of members belonging to a group based on assumed attributes that reflect an overly simplified opinion about that group. The outcome of this discussion is that our fixed mental images do not result from our personal experiences, but are socially constructed based on what we have heard family members say, seen on television, read in the newspaper, seen in a movie, or heard on the radio.

I then turn the issue back to my own experiences of living in America. I state that I have made numerous friends here and that I have found people to be extremely kind, generous, warm, and loving. In other words, the preconceived notions that were based on secondary sources have been proven to be unreliable and inaccurate.

Research



Another class I enjoy teaching is research. However, many students are afraid of research and feel a great trepidation about taking this class. I show them that what interests them or what they are doing in their field placements or their place of employment is all researchable. It's as if their whole perception about the subject changes. Rather than being based on fear and trepidation, it becomes real, manageable, and perhaps even enjoyable.

I have had students who volunteer or work with the elderly. One was interested in the importance of socialization programs in nursing homes. She started researching this and by the end of the first sequence had completed a wonderful literature review and had formulated several hypotheses. I also had this student in the second sequence where students operationalize ideas and analyze data using SPSS 13. My nursing home student's project was outstanding. Despite her initial fear of the class, she realized that the project was driven by her own interests and that it was not abstract or meaningless but real and relevant to her work.

Fieldwork Seminar

In my fieldwork seminars, the learning goal I attempt to incorporate is to provide students with a forum in which they can share experiences and take risks. In this environment I see myself primarily as a group facilitator. The richness of the class comes from the students themselves when they are willing to share their successes and failures with their peers.

At the beginning of the academic year there is a great deal of apprehension, and the students talk glowingly of the agency and of their supervisors. Gradually they start to question the agency's philosophy, how they observe their supervisor dealing with particular individuals, or why the agency does things in a particular way. The other intent of the fieldwork seminar is to provide the students with a forum in which they can draw on material from all of their social work classes, in other words, connecting theory and practice.

I am the first to admit that this does not always go smoothly. Students will often assert that the social work program stresses a strengths perspective, but their agency seems to be working from a deficit model. Another topic is social workers in the field not utilizing the theories and concepts that the students are talking about in their classes. There appears to be an inconsistency here. In addition, students encounter a wide discrepancy in placement settings. Some students are placed in very traditional settings while others are placed in agencies where social work is secondary.

Here, I introduce the concept of parallel process. I mention the fact that if they perceive the agencies in this way, then might many of the clients/consumer members feel. This I believe takes one's thinking to a different level. Students no longer talk about the agency, but start talking about their own practice and what they are doing.

An Empowered Voice

Brandi: As Paul's student for two years and three classes—Introduction to Social Work (200 level), Research I (300 level), and Field Seminar (403/404)—I can speak to some of his teaching tasks and styles and their outcome as they pertain to my growth from student to professional social worker. I can also, from a student perspective, link academics to a real world context.

When I returned to college after fourteen years, I was anxious about what to expect. Paul's syllabus for Introduction to Social Work talked about andragogy. Andragogy? I wasn't sure what this meant but was surprised and pleased to know that a teaching style existed that put the responsibility of learning on the student, assuming there exists a certain level of self-concept, experience, readiness, orientation, and motivation for this learning (Knowles, 1998). There also exists a connective piece wherein the instructor is responsible for establishing, nurturing, and monitoring a learning environment, the crux of what Paul discusses above.

My development began with the introductory course and included the basics of social work: key concepts and policy and history of the profession. Values, ethics, empowerment, and self-determination were discussed as a group and taught through peer presentations. Paul's use of humor helped create a casual and comfortable learning environment, which in turn helped students develop relationships as well as the strength to question and critique material.

Research seemed daunting primarily because I had no interest in "doing" statistics. Fortunately, Paul's knack of explaining things simply, as well as technological advances in data analyzing, enabled me to visualize my project with less distaste. His enthusiasm for the subject matter was infectious and, because of this, I successfully managed to incorporate an issue of interest into a working research hypothesis. Though I am not a baseball fan, Paul's playful banter encouraged camaraderie, resulting in a positive learning environment.

Fieldwork and its accompanying seminar was, for me, where all the substance of the social work curriculum lay. Earlier coursework was necessary, but for social work students, leaving academia and incorporating theory and ethics into one's practice on the "outside," is the ultimate educational experience. Early seminars included discussions on professionalism, boundaries, and agency philosophy. After a few months, the dialogue shifted more towards placement dynamics and personal experiences in the field. This shift began the essence of peer interaction as well as interaction with Paul.

The seminar is the stage for risk taking, both prepared and unprepared. Through much discussion with a trusted peer on levels of standards and discrepancies in theory and placement, we decided it was ethically imperative to question the actions and behaviors of our peers as well as to question Paul's facilitation techniques. Frankly, I thought that there needed to be more guidance through the initial phase of placement integration. This part of the social work curriculum is unique, and I strongly believe that we are all responsible to each other to uphold the standards of the profession, student and teacher alike. I questioned Paul's absence in certain discussions and asked him to become more involved with ethical issues. Some groups may not have needed such support, but the dynamics of my seminar were such that this support was vital.

The integration of academic learning into professional skills was challenging until I became comfortable using my natural skills in a professional setting. I interned in a local nursing home that housed over one hundred residents, primarily elders diagnosed with dementia. It was apparent early on that my observations would bear fruit with regard to advocating for residents. I discovered an unacceptable gap in services that affects our elder population nationwide: oral hygiene. I used my energy and skills to promote a link to services and after months of research, meetings, phone calls, and letters, I was able to secure a non-profit oral hygienist organization to visit the facility twice a year.

I believe my advocacy skills interfaced with seminar discussion in upholding myself and my peers to the ethical standards our profession embraces, as well as the ethics we as individuals profess to hold. Basically, we created an environment where support and critique of our new skills was welcomed. One of the factors that made this possible was Paul's use of humor in the classroom. Humor clearly relaxes individuals, allowing for an easier transition into risk taking. I appreciated Paul's knowledge, humor, and unwavering support throughout my academic journey.

Conclusion

Teaching, at its core, is about engaging others in the great adventure of learning. It is an ongoing journey. I am looking to provide a setting in which one can take risks, engage in dialogue with one another, and have fun. I want my classroom to be a place where students look forward to coming to class and together we create an environment that is collaborative and supportive. Ultimately, I believe that students are in charge of their own learning. My role and responsibility is to provide them with an environment that enables this to occur.

In many ways I see myself as a conductor of an orchestra. For me, being in the classroom is like having all these different instruments. Some of the students are like trumpets, others are like percussion instruments, and some are like string instruments. My role is to get everyone to play together and ensure that each one is heard.

At times that is frustrating and difficult. Some weeks we make mistakes but by the end of the semester, when everyone gets to present, all the rehearsals and practices have been worthwhile. Everyone has something profound and significant to offer the entire class and everyone gets a round of applause. There is no greater accolade than being acknowledged by your peers.

In summation, I believe the following poem by Lonnell Johnson (2003) captures my teaching philosophy. It reinforces and validates many of my own experiences of teaching.

* * *

The Teachers Task

The smallest spark can kindle a desire
Ignite a fire to stir and warm the heart,
And through the years the embers from that fire
Will glow with light inflamed from that same start.
In the dark of night should a doubt arise,
A question of the road less traveled by,
Recall that same glow in a student's eyes
Shall dispel the chill of questioning why.
You who labored in the classroom have learned
That report with student, colleague and friend
Offers recompense beyond wages earned.
You who loved the teacher's task we commend:
May joy warm your heart and sustain you yet,
With memories of success and no regret.

(Lonnell Johnson)

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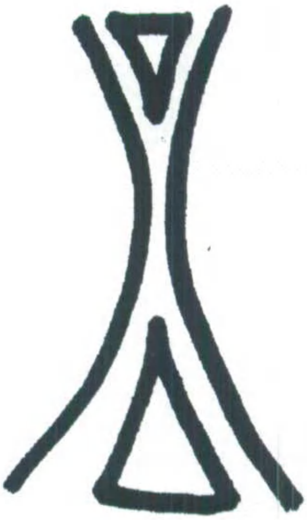

LACING UP FOR MY TURN: ONE SOCIAL WORKER'S RECKONING WITH DEPRESSION AND FAITH

Michael S. Kelly, Ph.D., Loyola University, Chicago

The following narrative describes the author's battle with a "bully:" the clinical depression that disrupted his personal and professional life for what seemed like an eternity.

Clinical depression doesn't always lend itself to precise descriptions, even when you're the one feeling it. Here's the best I've come up with based on my own experience of depression: it was like a big bully sitting on my chest, his big frame weighing on me as I tried to go about my day. All the while, the bully was casually telling me that he's happy where he is and isn't going anywhere. He tells me, sometimes in a voice that almost sounds affectionate, that he was meant for me and knows that he is home now. To protect my chest and all this weight I'm feeling, I gradually clear out the things I have in there: my lungs, my guts, and my heart. I move them to undisclosed locations in myself and visit them only periodically. All that's left in my chest is a dull ache that feels like a feeling sometimes but mostly just feels like the bully's weight. Meanwhile the bully just stays and stays, and the more tired I get, the more comfortable he seems to get with his surroundings.

The bully wants to say something: Damn right I'm comfortable sitting on you. This is what I do; I spread out and get comfortable. You can't really blame me, I've been living here for a long time. I just decided to make my presence felt more now. Besides, don't mind me; just keep on fixing other people, social worker man. I'll be here.

I am writing this narrative six years after I suffered a major depressive episode, and I still shudder at my keyboard remembering this time. Depression has a way of doing this to a person. Despite the memoirs of people battling depression (including some prominent therapists like Kay Redfield Jamison and Richard O'Connor), despite the very happy state of mind I am in most of the time these days, there is still the reality that I, along with an estimated 15 million Americans, have had major depressive episodes in a given year (NIMH, 2006). Though some people never recover from their depression and even take their own lives, the overwhelming majority of people with depression make it back from the edge (Keller et al., 2000). Most people, like me, recover and get back to their lives. Some of us turn to therapists and medication to get back on track. Others pray to God and ask for divine guidance. I did all three, and it was therapy, meds, and God (definitely not in that order) that allowed me to lace up again and return to the living.

The bully again: Ok, so now's your big chance to make sense of these things in your head. For you and the people reading this, got it? I guess you should be able to do this; you've had these things clanging around in your head all your life. And besides, you're a social worker, or a therapist, or something, right? You make sense of the things in other people's heads for a living! This should be easy. Talking to these people about your depression—no problem.

Christmas 1999: My Reckoning Begins

December 1999 was busy but completely normal for my normally hectic life as a school social worker and part-time family therapist. My school entered December with minimal upset, my private practice clients had no major flare-ups, and I was going to San Francisco for a vacation with my wife to visit her family in the Bay Area. Before we got to San

Francisco, the only indication of the bully's presence were my persistent headaches that I had been popping ibuprofen for, despite not having any cold or flu symptoms. In the usual blur of clinical work, I had assigned these headaches to regular holiday stress and had pressed on.

In San Francisco, my darkness was thrown into starker relief, with the natural beauty and easygoing vacation time all around me. I had no work stress to blame my headaches on, and now I was waking up early, usually between four and five each morning, groggy and a little frantic. It was too dark to go outside and do my regular five-mile run, so I slipped down to the hotel lobby with a book and eavesdropped on the friendly night receptionist talk to his insomniac friends. (I didn't talk to him much myself; like a lot of people in depression, interacting with others just felt like too much work.) When the sun started to fight its way into the sky, I would lace up my Asics and run around the streets of San Francisco. Just me, the bully, and people who were either sleeping in the streets or coming home from work.

San Francisco: Crying Out for Something

One morning during that trip, I found myself running into a Catholic church doing an early morning service called the "Liturgy of the Hours." I lunged in from my run, sweaty and feeling slightly less burdened by the bully and took a seat towards the back. In front of me sat five parishioners, and at the altar three priests who were quietly reading the prayers aloud.

O God, come to my aid.
O Lord, make haste to help me.
Glory be to the Father and to the Son and to the Holy Spirit,
World without end.
Amen. Alleluja (Universalis, 2006).

The word "broken" occurred to me in this church and my own sense of feeling as if I was broken. My soul felt like it was creaking under the weight of the bully, as though I had been smashed under his weight and had stopped growing and feeling things in any normal sequence. How can a person feel mangled without any outward physical signs? I never knew until that day, but that morning I felt gnarled and misshapen on the inside, with little hope that I would ever feel any different.

Faintly, I felt something stir as I listened to these men say such beautiful, restful prayers so early in the morning. I couldn't say these prayers in my own heart, but I appreciated someone else saying them for me. Depression can impose its own reality on events for a person who has depression; things that should be moving and beautiful aren't, even though around you others seem to be feeling the appropriate emotions. And even though my bully was ever present, he seemed to really excel at moments like this, allowing me to float above and around others' emotional connections, just to remind me that I couldn't connect, that I couldn't hope to feel what they're feeling.

The three men continued praying in a cadence that was so comforting to some distant part of me that I started to cry. Crying in church wasn't unheard of for me; I'm usually not dressed in running clothes and bleary-eyed to begin with, however, and I'm usually not anywhere near a church at sunrise. Or maybe this morning was a more accurate reflection of my inner faith life at that time than I wanted to admit. My inner and outer soreness was there for me and for God to see: bleary-eyed and spiritually aching blurred together, and I wasn't sure who or what I was crying for.

O God, you are my God, I wait for you from the dawn.
My soul thirsts for you, my body longs for you.
I came to your sanctuary, as one in a parched and waterless land, so that I could see your might and your glory.
My lips will praise you, for your mercy is better than life itself.
Thus I will bless you throughout my life, and raise my hands in prayer to your name; my soul will be filled as if by rich food, and my mouth will sing your praises and rejoice. I will remember you as I lie in bed, I will

think of you in the morning, for you have been my helper, and I will take joy in the protection of your wings (Universalis, 2006).

◆

To this day I want to refer to my church service in San Francisco as a turning point for me, as a reaching out to God and anyone else to tell the bully to stop pinning me down. But it wasn't a turning point; it was more an acknowledgment that someday I might make such a plea to God, but not yet.

I was after all, a social worker. I was one of the healthy, one of the normal, one who helped others with messy things like depression. I wasn't there yet, but soon I would reach the nexus between my clinical work and my own depression. Until then, I remained pretty much detached from myself.

To some extent, this detachment is helpful for a therapist. Nobody wants to go to see a therapist who reacts emotionally to everything you tell them—you're there to cry if you need to, not to hold the therapist's hand. In a way, my depression made me well-suited for clients who needed heavy emotional lifting. I had always considered my own feelings to be like interesting museum pieces: pretty, under glass, and to be handled only under special circumstances. To not feel things organically and unmediated is one of depression's great tricks, because it is ultimately the distorted thoughts and feelings that we do experience that makes depression so debilitating.

But this experience of having detached or distorted feelings is also one of psychotherapy's occupational hazards, as well; practicing therapists are in so much daily contact with emotional pain that it becomes necessary for a good therapist to manage his or her own feelings in order to put the client's needs first. The emotional self-protection required to do therapy well carries with it a fair amount of selective repression, an ability to notice feeling states in oneself and to postpone the full experience of those feelings until they can be shared with a supervisor or a trusted colleague.

Bully: Well that's tidy, isn't it, you getting to chalk up your depression to your chosen profession. If this is true, then why did you choose to do therapy anyway—to fix yourself? To make yourself feel better by comparison to your sorry clients?

Being Horribly Awake

There was more early morning waking upon our return from San Francisco to Chicago, and I was feeling more unsettled and despairing throughout the entire day now. This was clearly Depression 101, but I still clung to the curious idea that therapists don't just "get" the stuff their clients have, even though I had often told friends that the best part of being a therapist is that it makes you deal with your own emotional problems. My second semester at school started conventionally enough, with a full roster of kids in conflict and teachers knocking on my door. My sleeping was down to four or five hours a night, but I was so thoroughly caffeinated at that point in the school year that I was able to soldier through, even telling myself that I felt some kind of jetlag coming back from the Bay Area. Late in my first week back I realized that I wasn't getting even four or five hours of sleep anymore, more like two or three, and my wife was getting worried. I was starting to affect her sleeping too, keeping her up late and talking in increasingly weary, disconnected sentences about the things I had to do the next day.

Many great writers from Shakespeare to Dickinson had insomnia (Spaar, 1999), so I'm not sure I can top them in trying to characterize how serious my sleeplessness was for me. But I have to try, because for my depression there was nothing more damning or frightening than the early morning waking I was experiencing. To go to bed relatively unencumbered emotionally and to then wake up a few hours later painfully alert and aware of everything that's wrong is one of the true horrors of depression. To be so wrongly awake and to know that everyone else I loved was snoozing or dreaming made me feel cosmically alone. I usually sat in our big chair, teary and yawning, trying to find a book that was soothing and that would somehow make me sleepy again. I finally settled one night on the *Arabian Nights*. It was a book that had the advantage of being written in short bite-size bits but that also had a dreamlike narrative that swept me away for a few precious moments. If I couldn't be asleep and dreaming, at least I could try to imagine some magical dreamworld while I was awake.

I want to say that there was one night, one moment, when I knew that I had to stop this depression from getting any worse. No chance. Though looking back, it's probably good for me that I can't identify one moment that turned everything around, and instead have to acknowledge that it was a process that forced me to rely on God and my family and friends to help me. My depression is one that has black-and-white thinking as its foundation. I wanted to feel one hundred percent better, no space for difficult depressive feelings. So in keeping with my depressive thinking style, I should have had a road to recovery that started with one big "rock bottom" moment, followed by a big move to health again. No, the bully didn't get up off me that way.

Bully: Sorry my friend, there's no miracle story here. I've been here too long for you to get rid of me that easily. Besides, when you think about it, what would you do without me?

Running and Aching

It was 3:59 a.m on a January, 2000 morning, and I was lacing up my Asics running shoes to go outside and run. I had slept exactly one hour and 15 minutes, and had lain on my couch consumed by a mixture of outer and inner soreness. The outer soreness was easy enough to describe; I hadn't slept more than three hours a night for the last month and my body was aching and creaking in response. My eyes had a caked glaze of pressurized pain, my arm joints felt like I had torn something lifting too many weights, and my legs churned with the lactic acid that I usually experienced after running a marathon. At times I was speaking in voices and tones that I didn't recognize: low rasps that hinted at how exhausted I was, and fast, clipped sentences that often spiraled into vagueness and outright incoherence. All the time my throat hurt, like the words I was speaking hurt to say or even to form in my mouth. What was happening to me? The inner soreness was harder to place. I just wanted the soreness to go away.

During those awful nights in January 2000, I do remember hearing myself tell God out loud that I was broken and that I needed to be cared for. I had put down *Arabian Nights* and was trying to find a comfortable spot on our big living room chair. I was really trying to find another kind of comfort that night, too. I felt teary inside but the tears had stopped a few days ago. Instead it was just me, audibly mumbling to no one else that I wished that God would make sense of this for me. I didn't hear anything back, but maybe I wasn't listening.

I went back to school the next day, and it was one of those arctic January days that Chicago specializes in. I wore a spring coat without thinking about it and got several puzzled looks from friends at school. I joked about my spaciness but I knew the real reason: I felt so cold inside of me already that no winter could make it worse. I had to make the cold and the soreness go away. I had to do something.

I remember the call to my primary care doctor vividly. It was the closest I've ever come to an out-of-body experience. I saw myself dialing the phone, saw myself tapping my pen as I waited for the doctor's receptionist to put me through. I heard my voice and felt detached from it, as though I was listening in on someone else's conversation. I recited my symptoms to the doctor, casually without feeling, as though I was dictating a patient note to her. I asked her to put me on an antidepressant and to authorize me to go see a therapist in our managed-care network. I looked at myself in this out-of-body way, seeing somebody hunched over his desk, making a decisive move towards getting better, but feeling no pride, no relief, nothing. I must have been persuasive, as she didn't ask me many questions. Or maybe I was just one of fifteen patients she needed to talk to that morning. She told me that a prescription for a daily 50 milligram dose of Zoloft would be waiting for me at the local pharmacy that evening. She also authorized me to go for therapy, and I made an appointment to see a therapist the next day.

Zoloft. Here I was becoming a patient. I didn't even call my own clients patients, and here I was about to go on medication like a psychiatric patient. This whole experience of going on meds turned out to be less of a watershed moment for me as a therapist than I had feared. Unlike many therapists I worked with, I neither revered nor scorned medication for my clients. I had seen it help plenty of people in my practice, and while I was concerned about our tendency in schools to overmedicate kids, I knew that medication had shown some good results for adults with a variety of DSM diagnoses. I also knew what the research said about meds plus therapy being the best treatment for adults with depression (Keller et al., 2000). Now I was about to find out if this treatment was going to help me.

Being that I was essentially self-diagnosing and treating myself at this point, I had neglected to ask my doctor about when to take the Zoloft. Unthinkingly I settled into a routine of taking the Zoloft with dinner, as the bottle's instructions said to take it with food. I remembered the doctor saying it would take two weeks to kick in, so I hunkered down and waited for the meds to work. I made a good connection with a senior therapist at the local community mental health center and, as with so many of our clients, having the chance to be heard in a safe place already made a difference to my depression. The only problem was that while the therapy was immediately helpful to my mood, the Zoloft at night was making me even more sleepless, so I was even more exhausted than before. Now I had two reasons to be sleepless, and the intense energy boost the Zoloft gave my brain made me even less coherent as I tried to cope with my insomnia.

Bully: Oh those were the days. All day and all night, having free reign over you. Tell them about the weekend in January when you really lost it.

6 a.m.: " It's not your turn"

A week after going on the meds and starting therapy, the bully in me took his punishment to a higher level. Jealousy and envy exploded in me and, combined with the self-loathing that I already had underway, made it hard for me to function.

The jealousy episode was triggered by an article in our local newspaper. A dear friend of mine since childhood had just published a huge article in the paper on a project he had worked on for months. I knew the article was coming out, and our circle of friends had cheered him on through the many revisions he had completed. I was so deep in my fog that I forgot about the article until I saw it on the front page of our Sunday paper. I traipsed downstairs to get the paper, read his headline, and a part of me collapsed inside. I stumbled upstairs, my eyes aching from no sleep and my mind blazing with incoherent, half-finished thoughts.

The Bully said: You are nothing. You're nowhere. This article is just one more sign that you're lost and not coming back. Just forget trying. Blah, blah, blah. Thinking about getting yourself out of this is a waste for you. Just accept that you'll never be anything.

This blizzard of mental debris had come before, but never as fiercely. By all rights, I should have felt thrilled for my friend, not filled with envy and self-hatred. This was a great day for him and for his career and was definitely not a day about me. But depression has a way of making me fixate on things as though they are about me, if only to just confirm that life isn't going my way. And won't go my way again. Ever.

Research on people who commit suicide shows that some who actually succeed in taking their lives kill themselves as they are emerging from a deep depression (Klein, Schwartz, & Rose, 2000). This research had always intrigued me as a clinician, this idea that people could feel so depressed that killing themselves seemed like too much work. Only in beginning to feel better could some suicidal people muster the energy to end their lives. Now this Sunday morning I instantly felt this to be true in my bones: this morning had confirmed for me that there wasn't anything left to live for, but I couldn't imagine doing anything about it. The bully wasn't going to let me leave him, even if it meant my dying in the process.

So I did what I often did at these moments, somehow: I laced up my Asics and ran. January in Chicago is hardly good running weather, with icy sidewalks and bitter winds that chapped my face. I didn't care. I just knew that if I could run for thirty minutes in a row some small part of my brain would tell the rest of me to feel good for a few minutes. Those few minutes were all the good that I could count on, and I needed to go get it.

The running route I had chosen reflected my constricted view of life. I simply ran around the block clockwise, angling for all the dry sidewalk patches and trying to avoid people getting into their cars to go to church. I didn't always succeed at avoiding pedestrians; a few times that day I got so foggy that I nicked people going to their cars and was too overwhelmed to do anything but yell "sorry!" as I plowed past them.

It was the longest thirty minute run of my life. The chill of the wind bore itself into me, making me run faster to try to warm up. Each step hurt, each turn at the corner felt like I was farther away from my home. But even during this run, I noticed a small fire kindling in the back of my mind, warming a small part of me. I knew the fire was there, but I couldn't feel its warmth yet.

During the final approach to my house, my body felt turgid and empty, but at least I had started sweating. The thirty-minute trail around the block had given me some endorphins and hopefully a few non-miserable minutes, but what else? Would it mean the bully would be back even stronger? Would I get reassurance that everything wouldn't be this numb and awful forever? Some sign from the divine being that might have been on call that morning?

It was a few minutes after I returned to my apartment, as I peeled off the layers of running clothes from my arctic run, that I got the divine sign. This wasn't the distant call and presence I sensed at the church service in San Francisco; this was unmistakably coming from somewhere new. The sign was for my envy, for the crippling sense that I had that things weren't going my way and wouldn't ever work out. I looked in the mirror, looked down, and felt compelled to repeat in my mind this thought: It's not your turn; I have something for you. I felt strangely reassured by this message, as though all the severe deprivation I was feeling had finally given way from the bully to this spiritual presence, if only for a few moments, if only for me to get this thought, this curious gift.

It's not your turn; I have something else for you. My hard work was just beginning. I loved the peace of this message but I had no idea what it meant. And the bully in me was happy to talk me out of analyzing the message: he promptly reasserted his presence and I spent the remainder of that Sunday moving from couch to chair to bed, trying to keep myself awake so that I would sleep that night.

Though I was sleeping no more than two hours a night and must have looked like hell, my clients and colleagues didn't seem to notice. If anything, I did some really good work, more than I thought was possible. One of the most perverse aspects of being a therapist with depression is that for at least a while, I could actually engage certain clients better because I felt terrible. The teens that stared off into the distance in my office didn't seem to know that I was staring off into my own distance. They just seemed to appreciate that I was quiet and with them. And because it was taking so much effort to think and process my own thoughts and feelings, I was making very clear and concise statements to my clients that seemed to make sense to them. But this might be happy hindsight; during that month, I remember worrying constantly about messing up my clients. Oh yeah, you were worried about your working with your clients, and with good reason. Were they getting, what, like thirty percent of you each time you saw them? (I had the other seventy percent.) No way that they couldn't have known that you were out of it.

But the crazy thing is that a lot of people close to me *didn't* seem to know. Though I was in a private practice with four other experienced therapists, and in a school with a number of good friends and caring people, none of them once asked me about how I was doing and whether I was okay. I don't want to sound bitter about this, because it reflected who I was at that time: a therapist who was seriously vested in maintaining my veneer of stability and optimism. What's remarkable is that I wasn't even trying to put on an upbeat front at this point; I was just numbly getting through my days. Because my depression didn't involve lots of crying or overtly erratic behavior (I just looked terrible and was thinking awful thoughts about myself), I was able to draw on a reserve of benign goodwill from my colleagues. I wasn't asking for help, and they weren't offering, because why would they? I could handle myself, I always had…

Art Appreciation from the Inspiration Café

I somehow did my job that month, largely because of my wife's stable presence and love and my runs around the block (I was never running more than thirty minutes—I was too tired to run any farther).

I made it also because of a lesson in art appreciation that saved me. My art instructor and spiritual advisor was Carl (not his real name), a man who was homeless that I had met at the Inspiration Café. The Inspiration Café was a social service agency-restaurant in Chicago that served gourmet meals to the homeless and offered job training and other social services to help get them back on track. My wife and I started volunteering there in fall of 1998 and had met Carl our first day there.

Carl was a striking, middle-aged, African-American man with a thick head of hair and a beard with a few distinguished dollops of gray. And distinguished he was: he spent his time at the Café holding forth on his many interests, mostly art, biology, and politics. He was a former small businessman who had lost his family, his work, and his home to drugs and alcohol abuse. Though he told me that he had been sober for a year, he had so many financial problems that he still hadn't found housing. He also had serious anger problems that had produced violent incidents with his girlfriend and with some other homeless people in the neighborhood. I never saw his violence, just his wit and piercing intelligence. He loved to read and was always telling me about a new article or book he had just read. Eventually I was bringing him last month's *National Geographic* and staying after our volunteer time to talk to him about the latest political gaffe in the news.

Bully: Oh no, not the Carl story! He was one that I couldn't touch. He really did take you away from me.

At my therapist's advice ("take this time slow and be good to yourself"), I took a day off of school and went to see some art. I felt called that day to go to Chicago's Art Institute and to spend some time basking in the glow of the blue Marc Chagall stained glass windows. These windows are so warmly blue, and so lovingly constructed, that I knew that viewing them would be enable me to get some relief from the turmoil in my head, if only for a few minutes.

The Chagall windows comforted me. They always had. Staring at the myriad of people and American icons portrayed in the stained glass, I remembered all the times over the years that I had sat looking at these windows. When I was a child, this was where my parents would stop after all the excitement of entering the museum to get us organized to go see other exhibits. Then in college, the windows became a place to take girlfriends, to try to impress them that I knew something about art (I didn't know much really, but I hoped that the beauty of the place would somehow earn me some points anyway). Now as an adult and a practicing therapist, I made five or six pilgrimages to these windows each year, to recharge myself and to meditate on a particularly challenging case.

Today the meditation wasn't going so well; maybe it was because this time I was "the case." The few minutes of muted joy I had hoped for at the windows soon dissolved into self-loathing. I suddenly felt so self-indulgent that I had taken a "mental health day" to go look at art, especially when I knew that I was going to be exhausted all day, fall asleep at ten, and be up at midnight for the rest of the night. The bully had a point, as much as I hated to admit it; what good was this doing my mental health if I still couldn't sleep?

Then Carl came over to me. That day he was with other Inspiration Café clients, taking a field trip to see art. He wasted no time in dispatching the bully. "Hey there Mike, you love these windows too?" I realized that even in all my fog, I was staring in wonder at the glass, smiling.

"Yeah, this is my favorite place in the whole museum," I said, forgetting that I might want to actually say hello first and acknowledge him.

"Well, I have to say Mike, it's one of my favorites too, but I've got something else for you," Carl said.

"Huh?"

"I said, I have something else for you. Come on with us upstairs." This was the same phrase that I found myself "saying" a few weeks earlier as I finished my run. I lurched forward off the bench, nearly slipping onto the ground.

There have been times that I sat in church and heard the scripture passages talking about how blessed the poor are, how closer to God they are, and how much Jesus loves them. I have often felt that Jesus was either kidding or at least working the crowd a bit for support. I didn't feel that now.

Carl took me by the shoulder and guided me up to the wing with all the Impressionist paintings. We stood in front of Van Gogh's painting of his room at the mental hospital in Saint Remy, "The Bedroom" (1889). It's a simple painting, especially for a Van Gogh, relatively unadorned with his trademark swirls and blasts of yellow. The painting has four pieces of furniture in it: two chairs, a table, and a twin-sized bed. The painting's perspective views everything in the room from a distance and a bit on high, as if Van Gogh had knelt down on the floor to paint the scene. There are paintings on the walls, but nothing of note, as Van Gogh is more interested in creating the overall comfortable effect of this modest room. This is the room that Van Gogh stayed in during one of his many battles with mental illness.

It was the next-to-last hospital stay of his short life. He would be dead of a self-inflicted pistol wound in July of 1890, roughly a year after he painted his room at Saint Remy. The art critic Uhde (1998) wrote that Saint Remy gave Van Gogh peace one more time, and it's clear from this painting what he means. There's nothing special in the room, but enough there for it to feel like a home.

Carl stood next to me, looking at the picture, intensely, reverently. He spoke softly to me, still holding my shoulder. "This picture is what I imagine for myself, when I get real down. I think of having a room of my own again, and I look at this painting and I just know it will happen. I can do it, if I just keep trying." He gripped my shoulder tighter.

I stared at this beautiful colorful room of Van Gogh's, tears building inside of me, trying to think of something to say. I didn't have any words to say, but for the first time in a long time, neither did the bully.

Carl wasn't finished talking. "Look at the colors. The chunks of paint, look how badly he wanted to paint this. I *love* this painting."

Carl was right. Van Gogh's swirls and colors had always made me love his work, but today I was feeling the thickness of his paints, the ways that the colors insisted on their own presence and dignity. The colors had purpose and confidence and power. I felt myself absorbing their energy, as Carl went on praising the picture.

Minutes, or maybe hours, went by. Carl and I didn't look at any other paintings. For the first time in six months, I wasn't aware of time because I was finally feeling present and alive. The meds would kick in sometime in the next week (I had finally stopped taking them in the evening), and I would start sleeping through the night. But that day I made my real move out of the dark. I knew that I was going to make it even if the bully still lived near me and came over to bother me sometimes. He didn't live in me anymore.

Someone from the Inspiration Café came and told Carl the group was leaving. He shook my hand, smiled, and said seemingly out of nowhere, "Thanks for all that you've done for me." I never saw Carl again. The next week he was ejected from the Café program for relapsing into drinking and threatening a staff member. I walk around Chicago hoping to see him again and praying that he has found his own room at Saint Remy.

Meanwhile as the meds started to work for me, and I began to finally sleep through the night. The long dark days gave way to days that had small pockets of light. I told my therapist that I was finding "daylight" and that my feelings of being broken and lost were fading. It took about six months before I felt like myself again, but I never felt the bully as fiercely as I did for those two months at the turn of the century.

My reckoning with depression wasn't over, though. I had just begun to set some new terms of engagement with the bully, terms that were more favorable to me as a social worker and as a person. The bully was still hanging around in the corners of my mind, eager to snicker at me and push my buttons. Only now he didn't have my full attention; he had to work hard to get me to notice him. I was too busy seeing all the colors in my own room. It was my turn now.

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FACE-TO-FACE WITH DISABILITY AND POVERTY IN CENTRAL AMERICA: LEARNING FROM AMPUTEES ABOUT SOCIAL SUPPORT AND RESILIENCE

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Working as a program evaluator of a human services program in Central America, the author was confronted with her conceptions of disability, resilience, and social support. She presents three stories of amputees, each with a unique story of survival. As the stories unfold in this reflective discourse, lessons of acceptance and even forgiveness emerge as central themes.

Background

When I heard that there was a short-term contract opportunity to complete a program evaluation of a human services agency in Central America[1], I could see that it was a wonderful opportunity to return to and work in the region. The job would require work in some difficult and impoverished conditions; we would be making home visits to interview clients in urban and rural settings. On the face, "difficult conditions" did not intimidate me because I had worked as a Peace Corps Volunteer in Belize and as a community health technical trainer for Peace Corps in Guatemala, one of the poorest countries in the region. I thought that I understood the conditions of the people of Central America, though I now realize that in the past I had only scratched the surface of the multiple realities of people living in poverty.

A Basic Description of the Individuals That I Interviewed

With the aid of a translator, another social worker and I completed semi-structured interviews. We conducted ten interviews in three days with three women and seven men. Their amputations occurred due to a variety of factors, including diabetes, traffic accidents, and landmines. With the exception of one interview with a diabetic patient, which took place in a hospital, all the other interviews were completed in the subjects' homes. Three individual stories are presented as composites for the purpose of protecting confidentiality and honoring human subject standards.

Learning by Hearing About Life and Disability in "Difficult Conditions"

I realized that even though I had lived in Central America for several years where extreme poverty was a daily reality, my understanding of the human condition of disability in this environment was actually naïve and uninformed. In fact, these interviews raised my level of consciousness in such a way that I was forced to contemplate my superficial understanding of disability in a developing nation. And, in each interview there was a story or a unique lesson about survival, social support, and resilience. Each interview was a powerful experience. The following three composites are presented to "tell" the story of limb loss in a developing country.

Lessons From Carmen

Carmen was a married young woman in her early twenties. We arrived to interview Carmen at her modest apartment and began the interview in Spanish. She quickly responded in an almost accentless English and suggested that we could conduct the interview in either language. For me, this was intriguing because she clearly had a strong command of the English language. We proceeded in English, and she told the story of how she lost both of her legs in a train accident.

As a young woman, Carmen, like many other young people of her village, made the northward migration to the United States looking for work. In the past, she had been successful crossing the border and finding work. She would periodically return to her country to visit her family and bring back money. Because she was young and strong, she viewed crossing the border as a challenge that she, her husband, a group of friends made periodically. The following excerpt from the interview is how Carmen described the last time she attempted to cross the border when the accident and amputation occurred.

> *"We were in Mexico and the Federales (Mexican police) were chasing us. They always used to chase us and we would laugh because they could never catch us—they were too fat. We were running towards a moving (freight) train and I had to jump quick. I thought I had my grip, but I slipped. My legs fell under the train and it happened. At first I couldn't believe it, but I could see that my body was in one place and my legs in another. I was bleeding real bad and the Federales stood over me talking about what to do with me. I laid on the ground for over an hour—I think they left me to die. But, my husband and my friends stayed with me and argued with the police for help. I knew that I would bleed to death if I didn't get help and I could feel my heart beating—pulsing. Because of my will to live, I told my heart to slow down. Finally, I was taken to a hospital. The Mexican hospitals are pretty good. I stayed there for a few months and then they deported me back here. The care here* [in her country] *is pretty bad compared to Mexico."*

As I listened to Carmen describe the trauma of losing both of her legs in a train accident, I was struck by how she laughed about the "fat" Federales whom she essentially described as incompetent and completely uncaring. She made this description as a matter of fact, touching on the age-old tension between the Mexicans and the lesser developed nations to the south in Central America. She talked about how she ultimately survived the accident because her husband and friends stayed with her and because of the outstanding care she received in the Mexican hospital. She also talked about how she would have died in a hospital in her own country because the equivalent level of care is just not available.

I thought I understood resilience, but Carmen was truly an inspiring character. Not only did she slow her heartbeat and manage to survive the initial trauma, but she succeeded with rehabilitation and learned to walk again on prostheses—no small feat for a double amputee, especially in an underdeveloped country. She talked about how the prosthesis fit and her desire to get "new legs" because the equipment had worn out and was in need of replacement. Carmen shared that she currently had difficulty walking because of blisters on her stumps, but she continued working every day, teaching English to young people.

As a social worker, I found it difficult to hear about Carmen's need for new prosthess without much hope of that need being met. She was lucky to have prostheses at all—there were many people waiting for such services in her country. As a privileged citizen of the United States, I felt a sense of guilt that I had never before felt. I was able to walk out of Carmen's home and continue on my way, eventually boarding a plane and flying back to a country where our citizenry is guaranteed basic disability services, such as prosthesis care.

Because it was not relevant to the program evaluation, I did not ask Carmen about regrets. I did not ask her if she "had known she would lose her legs—would she have taken the risk of jumping on the train headed north?" I feel pretty certain that Carmen would have said "yes." I believe this because with the exception of her leg loss, Carmen was a strong young woman. She had hopes and dreams like any young person and the northward migration was a reality for her and her family who were subsistence farming and living in poverty. Working in the United States and sending money home is a way of life for many young adults of her country and the dangers of crossing the border are a necessary reality.

Sadly, in the aftermath of the accident, Carmen shared that her family had essentially washed their hands of her. Originally, it was planned that Carmen and her husband would take over her family's small farm once they saved enough money from earnings in the United States. However, with the loss of her legs, her brother had taken over that role and subsequently ostracized Carmen from the family. Carmen shared this with a sense of irony because her brother had the more invisible disability of alcoholism, making him an unreliable farmer. Looking forward, as a resilient person does, Carmen found a great deal of support and the important sense of family in her relationship with her husband, and she took on the professional work of teaching English. This new role as teacher was ultimately a more appropriate occupation given her amputations.

Lessons from Maria

Maria was a single woman in her forties. I will never forget the trek to Maria's home as it was the most rural setting of all ten interviews. We climbed a steep hill to reach her modest, one-room, cinderblock home that she shared with her two young sons. The home sat beneath a forest and one could not easily find it except by following a narrow trail.

When we arrived, Maria was resting and she wiped the sleep from her eyes. She was clearly happy to see friendly faces and had been expecting our arrival. I could see immediately that our visit was special to her because with the exception of her family, who lived close by, she was socially isolated and visitors were rare.

Maria's amputation accident was a tragic story of a young woman caught up in war as a member of the resistance forces. Recounting the history of how she was recruited by the militia, she talked about how her family was fleeing their dangerous home area and traveling across the countryside for safety. In their travels, the family had stopped for rest and received food and water from "the guerillas." When she was a young teen, Maria became entranced by the rhetoric of the militia leaders who she described as "charismatic." She became excited and decided to join the movement even though her parents pleaded with her to continue with them on their journey to a refugee camp. She resisted her parents' pleas and took up arms with the guerilla movement. At the age of fifteen, Maria stepped on a landmine and lost her entire left leg and two fingers.

Upon rehabilitation, Maria talked about how the militia leaders held her up as a symbol of heroism, valor, and strength. At first, she felt the support of that militia community and her comrades came to her comfort. Of course, with time, she was forgotten because she was no longer of value to the group as a fighter. Eventually, Maria left the opposition movement and reunited with her family. In the post-war years, Maria worked in a factory, or *maquiladora*, but her health was fragile. She complained of constant stomach pain that prevented her from working. The doctors told her that she had stress ulcers, and Maria described to us some of the physical symptoms of Post-traumatic Stress Disorder from which she suffered.

As we interviewed Maria, we learned how her family was caring for her needs of food and medicine. Her young, school-age sons were clearly a source of joy. In addition, we were introduced to three different pets that kept her company during the many hours that she spent alone on that Central American hillside while her family worked and her sons attended school. During the interview, Maria had two small dogs that sat at her feet the entire time. The dogs were friendly and did not respond to us as threats—however, it was obvious to me that Maria's companions could be fierce protectors in the face of danger.

The most interesting feature of the relationship between Maria and her dogs was that they mimicked Maria's movements. For instance, when Maria looked in a particular direction, the dogs looked in the same direction. When Maria stood up, one of the dogs stood up on hind legs while leaning the front paws on her leg. While I've heard that dogs and owners begin to look like each other, this was the first example that I had ever witnessed with such obvious *behavioral* patterning. Of course, Maria and the dogs spent so many uninterrupted hours together with few outsiders, they undoubtedly saw Maria as a part of their den—sharing sleeping quarters and what little food the family had. Clearly this was an important relationship for Maria that served some of her social support needs in otherwise isolated conditions.

Finally, just as I did not ask Carmen about any second thoughts or regrets, I did not ask Maria if she had any regrets about joining the resistance forces. However, the way that Maria talked about the guerilla leaders in hindsight with such disappointment in her voice, I can't help but think that an older and wiser Maria would have refused to join the militia.

Today, I think of Maria, as a symbol of youth who take up arms for a fight that they firmly believe in, often under charismatic leadership. They find themselves actors in a war that is always fueled by energy and the principles of freedom and liberty. During the interview, Maria focused more on the immediate and her survival in the face of her ongoing health problems. Now as Maria sits on that hillside and no longer identifies as a soldier, she has countless hours to contemplate how her personal freedom has been changed forever.

Lessons From Miguel

Miguel was a married man in his early thirties. When we arrived to interview Miguel at his home, we were greeted by a group of curious children who were playing in the yard. Four of the children were Miguel's and the other two were a niece and nephew that were living in the care of Miguel and his wife. It was immediately obvious that this was a cheerful, close-knit home.

Miguel's amputation was not as severe as the previous two cases. In fact, Miguel's disability was comparatively minor because he had only lost a hand in a factory accident. However, after the accident the supervisors at the factory ostracized Miguel because they no longer regarded him as a viable worker. In the face of the adversity of losing his hand and his livelihood, Miguel had to look to alternative employment, and that story revealed some new insights for me.

As we interviewed Miguel, his wife stayed close by his side; they were clearly a team. In the home environment, we could see that there were several micro-enterprises operating there. The two businesses that the couple talked about were car tire repair and t-shirt screen printing. Miguel had always been good at repairing tires, and after the accident he received a small grant to assist him with developing a small business. Miguel used this seed money to buy additional tools, and he hung a sign for his business. He was quite skilled at this craft and had become known in the community for this skill.

With that business underway and profitable, Miguel and his wife began to explore other opportunities. During the interview, Miguel excitedly showed us a t-shirt that he had printed with the image of the Christian cross. He talked about how he had learned to make the basic screen and then print onto t-shirts. He had received one large order from a local church for the t-shirt and he and his wife were excited about future possibilities.

While Miguel showed us the screen print and the t-shirts they had made, he often referred to the process saying, "I did" instead of "we did." However, in conversation he admitted that his wife had been instrumental in teaching him how to craft the screen for printing. At that moment, I began to understand that Miguel's wife was also quietly his business partner. She clearly did not need to be acknowledged officially. When it came to the t-shirts, she let him do the talking about that aspect of their micro-enterprise—even though it had become clear that the concept was conceived and initiated by her.

In an environment where *machismo* is a dominant aspect of Latino culture, the relationship between Miguel and his wife was interesting. I knew that often men will do the talking for the family in Latino culture; however, the dynamics in this interview were different. Miguel's wife talked during the interview, but she also deferred to her husband when he spoke about the t-shirt business. It seemed to me that in her wisdom, she understood that Miguel needed to reclaim and demonstrate his sense of himself as the breadwinner as he transitioned into a new workplace—their home, which had previously been her domain. On the surface, I could have just viewed this dynamic as simple *machismo*, and there may have been aspects of this dynamic. However, Miguel's wife was an important source of support while he built a new identity as father and husband, and she did not appear to need acknowledgement during our interview.

Final Reflections

Although I've shared three stories with you, there are countless other stories of disability, resilience, and social support throughout the world. As I finished my interviews with amputees, I reflected on my new and deeper understanding of resilience, identity, and sheer survival. Carmen, Maria, and Miguel all found sources of social support and new identities after their amputations.

While I knew that social support was one of the most important variables to adjustment to limb loss and disability in general (Ferguson, Richie, & Gomez, 2004; Rybarczyk, Edwards, & Behel, 2004; Williams, Edhe, Smith, Czerniecki, Hoffman, & Robinson, 2004), I now have a deeper understanding. I also could see how all three of these amputees would have benefited from knowing each other as an opportunity for mutual aid. Unfortunately, there was no such support group existent in the country. This was a missed opportunity—an intervention that I strongly encouraged the human services agency to consider implementing. I know that Carmen and Maria, in particular, would have benefited from being able to talk with each other about adjusting to prosthesis, phantom pain, and the other physical and emotional realities of adjustment to amputation.

Also about social support, I was reminded not to underestimate sources of emotional support. Maria's pets were clearly as much her companions as well as her guarantee of security in an isolated location. Other interviewees, not presented here, also had important relationships with dogs and cats—often petting the animals during the interview and even introducing the animals as important members of their family. While this may not seem unusual for an American reader who identifies with a pet-friendly culture, this was particularly unusual in a Central American country where dogs and cats are often viewed as additional mouths to feed in an environment where malnutrition is rampant. As a result, cats and dogs are treated more like "animals" than pets in the region. However, these companions were clearly important pets and they looked well-fed, especially compared to the dogs and cats that we saw in the streets.

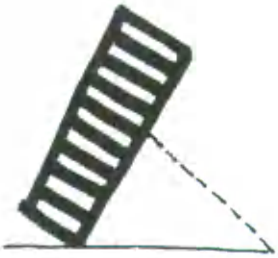
Another important lesson was the idea of identity and disability. For those of us who have not experienced "disability," it is easy to underestimate how we define ourselves as "able" bodied. Of course, it is natural to take it for granted that we have all of our limbs. However, that could change rapidly for anyone—especially with the rise of amputation associated with Diabetes in the United States (Zimmet, Alberti, & Shaw, 2001). Since I have a history of diabetes in the family, I could not help but put myself in their shoes and wonder how I would cope. Would I be able to learn to use a prosthesis effectively? Would I have a sufficient social support system? Would I be able to overcome the depression that must occur post-amputation? How would I personally reconstruct my "identity" as a "dis-abled" person? Certainly I would be resilient because I have the benefit of living in an industrial nation with the benefit of health insurance and quality care. At least I *think* I would be resilient. Of course, I make the assumption based on the belief that I would be afforded quality care—however, in the U.S., I am not absolutely guaranteed health insurance. As such, quality care is not a guarantee.

It was not lost on me that the amputation rate of military men and women serving in the

Global War on Terror is very high (Gawande, 2004; Noe, 2006). I wonder about their adjustment to amputation, especially with the accompanying Post-traumatic Stress Disorder (Friedman, 2005, 2006). Of course, they would have some of the best medical care afforded to amputees, but the human element of adjustment "disability" is relatively universal and inevitably difficult. Will they have the social support of their friends and family as they transition back from a war zone? Will general society be supportive of their experience and special needs given the fact that this war is highly unpopular? Or will they return, just as the Vietnam Veterans did, to an unfriendly community that treats them as suspect and damaged? What about their resilience as they must find new employment? I do not know the answers to these questions. Only time will tell.

As a social worker, I am accustomed to people sharing their personal lives, sometimes the most intimate of details. This was the first time that I felt some shame, almost like a voyeur, as I grappled with my own feelings of shock related to the descriptions of trauma during and after the interviews. Hearing the stories of the actual limb loss, especially the train accident and landmine explosion, was the first time I have actually experienced secondary trauma as a social worker. I now know that I had totally underestimated the idea of secondary trauma, even though I have specialized training in critical incident stress management with military personnel. My role as a specialized and impartial military social worker—an observer—shifted to a role which made me emotionally vulnerable. That role was less "detached" and the most human of all—I put myself in the shoes of another and came just about as close as one can to understanding limb loss and amputation without actually physically experiencing it.

My final thought about the amputees that I interviewed is ultimately the most important lesson. Survival of an extreme trauma in a developing nation, where health care is poor and infection rampant, makes them, by definition, resilient people. Also, as all of the survivors of amputation talked about their experiences, they were thankful to be alive and when they had been further wronged in some way, such as being ostracized, I often sensed that they had arrived at some place of acceptance and even forgiveness. And I am reminded that Desmond Tutu wrote, "To forgive . . . is the best form of self-interest . . . forgiveness gives people resilience, enabling them to survive and emerge still human despite all the efforts to dehumanise them" (Tutu, p. 35, 1999).



Footnotes

1. I have chosen to identify the region of Central America rather than the actual country in an effort to insure confidentiality of the agency and the individuals that I interviewed.

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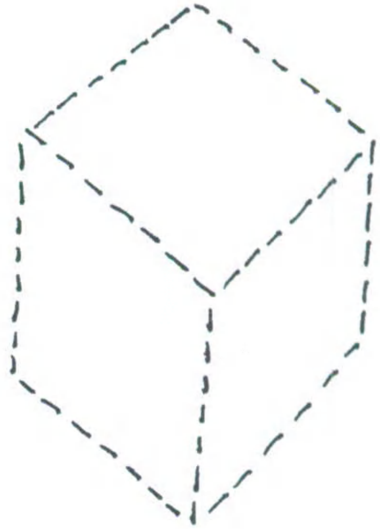

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Narratives may address but are not limited to:

- How did/does both the challenges and liberations of your coming out process impact your professional life?
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- What critical incidents encapsulate your inside-out narrative?
- How and why do you choose to share your identity/experiences with clients, constituents, colleagues?
- How do you interpret your personal "inside" vis-à-vis your professional "outside?"
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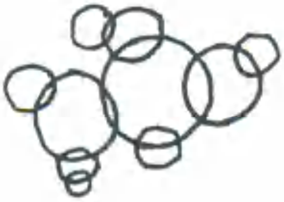
LESSONS LEARNED AS A LESBIAN CLINICAL SOCIAL WORKER: IMPLICATIONS FOR SOCIAL WORK STUDENTS, PRACTITIONERS, AND THE PROFESSION

Emily L. McCave, M.S.W., University of Kansas School of Social Welfare

Despite social work's consistent efforts to dismantle unjust systems that oppress individuals, we have not yet been able to eradicate all discriminatory practices within our own social work institutions. In this narrative, the author reflects on practices that present obstacles for those that are gay, lesbian, bisexual, transgendered, and questioning (GLBTQ) as they specifically relate to social work students, practitioners, and clients. Through her own narrative, the author illustrates situations in which she experienced and witnessed overt discrimination of GLBTQ individuals as well as subtle barriers within social work settings. The implications for social work students and practitioners as well as the profession as a whole are discussed, and recommendations for changing these conditions are made. If we are to speak truly for those whose voices are silenced, degraded, or ignored, we must remain open to criticism from within our own profession so that all voices continue to be heard.



Introduction

As a new social work doctoral student, I am constantly engaged in conversations about how our profession is responding to the needs of the oppressed, particularly during these difficult political times. Conversations also focus on remaining open and accepting of diverse clients. During these dialogues, I often find myself reflecting upon my experiences as a mental health therapist. Contrary to what my experience has been in graduate school, both at the master's level and now at the doctoral level, I was surprised by how similar conversations with other mental health therapists and administrators often left out the needs of the gay, lesbian, bisexual, and transgender community (GLBT). As a feminist lesbian practitioner, I find this very disconcerting. Even more disturbing are the more overt obstacles that I faced as a practitioner trying to advocate both for the GLBT community and for me.

In this narrative, I will illustrate the difficulties that I faced as a lesbian practitioner as well as my struggles in trying to advocate for GLBT clients in social work settings. While I am critical of how the profession is attempting to meet the needs of the GLBT community, I am also optimistic that this article will foster insight and dialogue on this issue. If we make experiences such as mine visible, we can take action to stay in line with our profession's mission. Moreover, I hope that this article will reach social workers who are currently facing similar difficulties and remind them that they are not alone. Finally, I wish to illustrate how our profession continues to struggle to meet the needs not only of diverse clients but also of diverse professionals.

Leaving the Safe Zone and Entering the Field

During my days as an MSW student, I was very impressed with the amount of support available for GLBT students as well as various educational and social action opportunities for straight allies. The GLBT student group was particularly active and supportive of individual and collective concerns. Walking through the hallways, I could see pink triangles in some of the faculty members' offices. GLBT students would talk in our courses about their struggles of deciding whether to be "out" at their practicums, with their clients, and with their colleagues. It was during this time that I began questioning whether I might be bisexual or gay. In hindsight, I believe the high visibility of the GLBT community within the school prompted deep introspection and provided a sense of safety for exploring this new identity.

Shortly after I graduated with my MSW, I came out to my friends and family as queer.

As an aside, I refer to myself as any of the following: queer, bisexual, lesbian, and gay. I often use the word "queer" because of the fluidity it allows, since, while I consider my overall orientation to be bisexual, I have chosen to be in only lesbian relationships since coming out. It was during this same period that I accepted my first clinical position in the northeast. Looking back, I think I was so excited about this new personal and professional journey, as well as being still somewhat naïve and idealistic, that I did not even consider that being queer would be an issue in my new job. Unfortunately, this was not the case.

A few months into my position, I realized that my assumptions about the organization were seriously misguided. I was providing counseling to youth in a residential facility, some of whom disclosed that they had been "caught" experimenting with other youth of the same sex. I did not self-disclose that I was gay because I did not feel it would be beneficial to them at that juncture; however I did explore their feelings about their experiences as well as ask about how their staff had responded to them. I was startled to find that the non-clinical staff in charge had given them consequences because they had engaged in "immoral" behavior. Notably, those youth who engaged in heterosexual experimentation also received consequences; however, the label given to those youth was that of "defiant" rather than that of immorality. I was even more confused when both my clinical and administrative supervisor dismissed my concerns, asserting that the behaviors of the youth were clearly inappropriate for that particular time and place while minimizing the remarks made by the staff regarding the morality issue. Both negated that the youth might actually be lesbian or bisexual and rather indicated that the youth were sexually acting out because of their past trauma experiences. Other social work colleagues concurred and encouraged me to let it go, stating that while they acknowledged that some of the non-clinical staff had particular feelings about homosexuality, it really was the behavioral issue of the youth that needed to be addressed. Consequently, I dropped the matter.

About a month later, my partner and I ran into a group of my clients who were on an outing in a nearby community. I immediately dropped my partner's hand and tried not to engage with them as a way to protect their own identities as clients as well as my own identity as a lesbian. I remember feeling confused and anxious, wondering why I was scared to let them know I was gay. I was also preoccupied with thoughts about whether they suspected and how this might come into our therapy sessions. As I expected, about a week later, one of my clients began asking me pointed questions about my wall posters, suggesting that they all had "rainbow" coloring, and finally asking me about my "friend" who had been with me that night. Because this client was notorious for trying to find ways to deflect attention away from herself in therapy sessions, I did not feel compelled to disclose or even address her questions, other than to ask the motivation behind the questions. However, this interaction did let me know that the youth did know or at least suspect that I was gay.

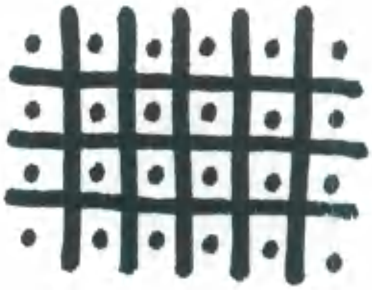
Consequently, I took this problem to my clinical supervisor, a social worker, and asked what she thought I should do in this situation. She minimized the situation, suggesting that the youth would move on to something else soon enough. I did not find this response particularly helpful. Therefore, I asked her what she thought would happen if I either self-disclosed to those clients where I thought it might be beneficial or addressed the issue in a less direct way, such as bringing my partner with me to a facility function, one in which residents, staff, and their spouses or significant others would also be attending. My clinical supervisor told me in no uncertain terms that she did not think either choice would be wise because there would be some in the organization who would not support it and that I would be taking a risk professionally by coming out. She advised that I give it some serious consideration, but that she would support me in any way she could, which I found reassuring.

About two weeks later, I received a message from my clinical supervisor saying that she and my administrative supervisor, who was a psychologist, wanted to meet with me during my usual clinical supervision time. Although she had not stated the reason for this change, I was immediately apprehensive. At the scheduled time, I went to my clinical supervisor's office where we often held our meetings. She informed me that instead we would be meeting in my administrative supervisor's office. I have to admit that within a matter of minutes I became very emotional and began to cry. My administrative supervisor told me that I was walking a very scary and difficult path, and that if I chose to disclose my sexual orientation, either by self-disclosing or showing up with my "friend" at a function, I would be "let go" from the agency. The part that still enrages me is that she justified this decision with a clinical rationale. She stated that if I were "out" at work, my clients, all of whom came from abuse and neglect situations, and most of whom had experienced some form of trauma, would become even more traumatized and therefore more likely to engage in risky behaviors. She claimed that the youth were not "ready for this kind of diversity." Thinking back on it, I believe I said nothing during the whole meeting. My clinical supervisor had sat there and offered no support of any kind. I remember leaving feeling very humiliated and very alone.

The next day, I handed in my two-week resignation. I knew that despite working in my chosen area of interest with other social workers, I did not belong in an organization that could allow such oppressive policy structures and administrators to exist. I felt very guilty, as if I were abandoning my clients and letting the organization "win" so to speak. I felt frustrated and let down that while my social work colleagues privately affirmed that they disagreed with what was happening, none of them would speak out against the administration. My partner told me that she was not surprised by this level of passivity. She gently reminded me that after all, in this state, as it is in many states, it was not illegal to discriminate on the basis of sexual orientation in the workplace. I had no viable recourse.

Through all struggles come growth, and through this particular ordeal I became very aware of where my line was in terms of what I was willing to do and who I was willing to "be" in the workplace. I came to realize that I could no longer ignore how central my personal identity as a feminist and as a lesbian was to my professional identity as a social worker. At first, I was concerned that I did not know how to *be* a feminist, lesbian clinical social worker. After some reflection, I understood that it meant that I could be present and authentic with my colleagues, my clients, and myself.

Following this experience, I disclosed in interviews with potential employers that I was a lesbian and informed them that I needed to be at an organization that would support me as a lesbian practitioner. Fortunately, every agency I interviewed with was very open and affirming. They all reassured me that they encouraged professional diversity in their organizations. I was happy to land at a community mental health center with an incredibly supportive administrative and clinical staff. It was a completely different experience from my first position. My identity as a lesbian was embraced and celebrated, as were the gay and lesbian identities of the agency's clients. I also allowed myself to let go of some of my guilt from leaving the last agency. I did this by retelling my story to others and to myself in a way that removed self-blame and placed the responsibility on the administration and how they conducted themselves.



Advocating for GBLT Clients

I became more cognizant after my initial negative experience of how social work organizations were responding to the needs of GLBT clients. When I relocated to a different social work setting in the Midwest, I became aware of a particular gap in the service provision of my organization. When I specifically asked team members about GLBT clients, they admitted that there was a gap in service provision for this population. Yet my impression from various clinicians and supervisors was that there was no one ready to initiate the necessary changes within the agency. After considering the social and political milieu of the agency, I decided to be the one to take the first step.

I spoke with my colleagues and my supervisor about starting a processing group for youth that were gay, lesbian, bisexual, transgender, or questioning (GLBTQ). I received positive feedback and was encouraged to submit a proposal for the group to the clinical director. My understanding was that the process for starting a new group was very informal, in that the administration usually reviewed the proposal quickly and on most occasions gave full support to proceed. In this case, the process turned out to be more challenging than I expected.

The clinical director responded to my proposal, indicating that in order to proceed with the group, I would need to present my proposal, along with current research supporting the benefits of a GLBTQ youth support group, to all of the upper management staff as part of their regular committee meeting. Their request was surprising; I had assumed that the administration was familiar with the multiple risk factors (i.e., increased risk of suicide attempts, substance abuse, homelessness, physical and emotional abuse, and harassment) as well as the protective factors (i.e., reducing isolation via group processes within school and community settings) associated with GLBTQ youth. (For a thorough review of this subject, please refer to the Suggested Readings list.) I vented my frustration to my clinical supervisor, who told me that this was about politics and not about research or efficacy. He encouraged me to stay committed to my goal of getting the service approved.

Heartened by my supervisor's support, I went to that meeting nervous but determined to secure the service for GLBTQ youth. I answered their questions, most of which centered on how I would take the necessary precautions to draw as little attention to the group as possible. They also wanted to know how I would involve parents with the group to minimize the likelihood of any parent becoming angry at the agency for providing a service that the parent did not approve of for his/her teen. I reminded them that for all of our services, individuals aged fourteen or above could consent to their own treatment. I also reassured them that I would take referrals only from clinicians who talked about the group with the client first and then if appropriate, discussed the group with the parent or guardian to ensure that all parties agreed. The staff asked me what I would do if people came and picketed the organization. I responded that I would ignore the picketers but that I was highly doubtful that our group would bring about so much attention. I tried to be as low key as possible, often replying that I would address any difficult situation in a similar fashion to how we would handle other groups. I also emphasized that I had the support of my supervisor and that I would utilize him throughout the process. Finally, after what seemed like a very long hour, they were satisfied with my presentation and gave me permission to proceed with the group.

Although I felt elated after the meeting, I also felt indignation at the whole process. From talking with other clinicians, such a rigorous and lengthy process was unheard of to them. Still, I went ahead, assuming that the path in front of me was clear. Considering that our agency served some 3,000 youth, I was discouraged that after a month of trying to get referrals, I had fewer than ten names given to me. It appeared that many clinicians either were uncomfortable broaching the subject with their clients or were not tuned into issues around sexual orientation. I saw this as an opportunity to reach out to clinicians and encouraged colleagues to engage in dialogue with their clients and speak with me if they had any questions or concerns. On the positive side, I received a few encouraging emails from both the clinical and non-clinical staff who said that they were happy to see someone taking the initiative and that GLBTQ youth were in desperate need of attention and services.

I finally decided that I would proceed with the referrals I was given, knowing that it was the beginning of a bigger process. I had never facilitated a group with this particular population, so I chose to work with a co-facilitator who had conducted several groups within this agency. The co-facilitator was a young, bisexual female of color who brought enthusiasm and knowledge on this topic. Together we had an incredibly challenging and rewarding experience. All of the youth brought their own stories of frustration and confusion as well as excitement and joy. Our group went through the typical stages of group development (for more information see Garvin, Gutierrez & Galinsky, 2004). We had power struggles and periods of silence and awkwardness in the beginning, with a shift towards the middle and end of the process of speaking honestly and openly about issues related to coming out, sexual discovery, risky behaviors, and dealing with oppression in their families, schools, and communities. When I asked them what they liked best about the group, they all said that they were glad to have a place to come where they were not labeled as "freaks," but just kids hanging out with other kids who were like them. Building a sense of community for a few hours a week at least gave them some breathing room to explore their growing identities.

Implications for Social Work Students and Practitioners

Illustrating my experiences creates an opportunity for self-empowerment, for validating other similar experiences, and for reflecting upon and understanding implications for the social work profession. There are important lessons to learn from my experiences regarding the implications for GLBT social work students and practitioners and for the social work profession.

GLBT Social Work Students and Practitioners

For those of us in social work that are GLBT, there are certain issues that we must face whether we do them as students or as practitioners. As students, we may face these issues together or we may face them alone. There may be supportive structures and individuals to promote the formation of a GLBTQ and allies group, or the environment might be too stifling for this to occur. We may have opportunities to choose a practicum with a GLBT emphasis, or there might not be any practicum options available with that focus. Faculty members who are GLBT and "out" serve as valuable support systems to GLBT students. While I support GLBT faculty members' rights not to be out, they should be aware that by doing so, they close off valuable support systems to students.

Despite best efforts, social work educational institutions are still at risk for maintaining heterosexist structures and cultures. We must recognize the subtle yet oppressive nature of assumed heterosexuality in what we presume about our classmates, our professors, and our clients. We need to examine closely whether what we read, discuss, and agree on is free from heterosexism. As GLBT students, we must prepare ourselves for the possibility of interacting with students who have few opinions about gay issues because of having little to no exposure to GLBT individuals. There may be students who are uncomfortable with GLBT populations but are trying to grow more tolerant. And there will certainly be straight allies who will walk with us in our journey. Connecting with staff, faculty, and students who are supportive and who take part in social action opportunities and dialogue groups can be reaffirming.

Making the transition from a student to a professional is a large step. As a doctoral student, I talk freely with my professors, colleagues, and fellow students about my partner and about being queer. The ideal situation would be that moving into a professional position would be little different. However, as my experience illustrates, this is not always the case. In hindsight, I wish I had considered two main issues. First, how do I address my needs as a lesbian when deciding where to work? Second, how do I deal with self-disclosure with my colleagues and clients? The first seems clear to me now that I have been through several interviews for various social work positions, consistent with the perspective that during an interview not only being are we being interviewed but we are interviewing the organization as well. It is imperative that we ask questions relating to the organization's policies and culture pertaining to GLBT staff and clients. Before accepting a position, I would recommend inquiring about their non-discrimination policy in hiring and firing; asking about partner benefits; posing how they support GLBT staff around issues of harassment; soliciting information on how they foster a queer-friendly culture within the agency; and finding out how they provide targeted services for GLBT clients and their specific needs.

The second issue around self-disclosure with colleagues and clients is more subjective and situation based. Regarding self-disclosure to colleagues, again I think we must consider that not all of our social work colleagues will be aware of GLBT issues or will feel comfortable working with GLBT individuals. To some extent, we have an obligation to educate these individuals on what it means to have a GLBT identity as well as salient GLBT issues. Some may ask, "Why must you share or impose your beliefs onto others?" My response is that social workers make a commitment to improve the lives of minority individuals who are oppressed and with that comes an implicit acknowledgement that there is a willingness to learn from others on how to better understand and work with people who are different from themselves. However, we must also consider protecting our own needs. If it appears that self-disclosing and entering into dialogue might cause conflict, it is important to take into account our current position. For example, new employees might rely on colleagues for referrals, for connections, and for support. I would recommend waiting on these discussions until getting settled in with support systems. In other situations, we may have to work closely with colleagues on clinical cases that involve GLBT clients or issues. In such instances, it is imperative that there is a common agreement on what the goals are and how to reach them; it might be helpful to self-disclose at that point if the colleague is missing key insights. Notably, it is not helpful to engage in ongoing heated personal and/or moral discussions to the extent that they take a priority to the client's needs. If this situation arises, it is essential to bring supervisors into the discussion.

In self-disclosing to clients, I believe the decision is best made on a case-by-case basis. As practitioners, we need to be cognizant of how self-disclosure may affect our clients. I rarely disclose that I am a lesbian to clients. As a practitioner, I worked mostly with children and youth along with their families. Clients frequently asked if I was married or if I had a boyfriend, to which I could answer "no" quite easily. In addition, I have had clients, particularly children and adolescents, ask, "Who is that?" when they see my partner's picture on my desk. I feel most comfortable replying that she is "my best friend." Most children and teens can relate to this open affection towards best friends and willingly accept that answer. I have had a few occasions where a parent will be present and give me a questioning look; however, I tend not to respond to such nonverbal cues at that time to avoid disrupting the therapeutic process that is ongoing with the child or youth. In one instance, I did have a client whose parent expressed a very uncomfortable look at this remark; unfortunately, she did not bring her son back to see me or return my calls.

Finally, I have self-disclosed with clients who have confided in me that they are gay, lesbian, bisexual, or questioning. It appears that self-disclosing has enhanced the therapeutic relationship by increasing the clients' sense that I accept them and it allows for openness regarding specific instances of discrimination that they face. I can then present similar experiences of my own, which serve to externalize their experiences. A caveat to remember is that we may encounter GLBTQ clients who have difficulties with emotional and physical boundaries. Self-disclosing may make it more difficult with such clients who are struggling with boundaries. It is essential that we maintain empathy yet stay firm on our boundaries with clients, particularly with youth who may be confused and seeking nurturing and support.

The Social Work Profession

Undoubtedly, the experiences of GLBT students and practitioners vary greatly and while I cannot speak for others, I do see salient implications for the profession. Within the structure and culture of the social work profession, there still exists oppressive barriers that prevent GLBT students, practitioners, and clients from getting their needs met. One of the challenges our profession faces is living up to its high standards of being inclusive and respectful of human diversity in all situations. Through our social work education, we have prioritized the need for students and faculty to build cultural competency skills as well as to maintain a commitment to social justice issues. However, the unfortunate reality is that within the hundreds of accredited social work schools and programs, not every student, staff, or faculty member will be at the same level in regards to his/her skills and ethical position around working with GLBT individuals. Moreover, it may be that some individuals choose not to acknowledge or address their heterosexist and/or homophobic attitudes and behaviors, in which case it is likely that GLBT students, practitioners, and clients will encounter such individuals while either receiving services or working within a social work setting.

The solution is not a simple one; however, I do offer three recommendations for addressing this problem. First, we must continue to place emphasis on developing cultural competence in all areas of social work practice, education, and research. In particular, it is important that social workers who are committed to cultural competence seek out administrative positions, as they will be in a position to support GLBT youth and staff within organizations. We can also do this in minor ways, such as being conscientious about addressing clients who use the word "queer" to describe someone as "stupid"; this has been particularly common with adolescent boys. Just as I would with clients who make sexist or racist remarks, I question the basis for their comment and ask them to consider whether it is helpful to engage in such language and discuss the implications of their remarks on others.

Second, within our social work education programs, we must continue to integrate material into mandatory coursework that includes scholarly writings about and by GLBT social workers and helping professionals. Having an isolated GLBT or diversity course is not sufficient. Third, and most important, we must speak out against subtle or overt homophobic or heterosexist practices, both in and outside the social work arena. It may indeed be a risky endeavor, particularly for students or new professionals who fear that there will be repercussions. Yet what is the alternative? Can we be satisfied to let it go, or leave it for GLBT individuals to fight, while simultaneously embracing the ethical mandates established so clearly in our Code of Ethics? If so, I believe that we will begin to mimic the doublespeak of our current political administration who asks the nation to rally for "family values" and put on bumper stickers that say "united we stand," yet makes considerable efforts to quell any signs of dissonance and instigate fear within those who would attempt peaceful acts of civil disobedience. As a profession, we have worked to combat ongoing issues around racism, classism, sexism, abled-bodism, ageism, eurocentrism, and most recently heterosexism. We must carry that momentum forward even when it is not always comfortable or popular.

Conclusion

To conclude, I would like to offer the words of Bertha Capen Reynolds, one of the radical pioneers of social work, whose words have influenced me during difficult times. Though she wrote these words more than forty years ago as a literal reflection on the previous fifty years of social work, I believe they serve a meaningful reminder of where we have been, where we are now, and where we are headed as a profession. From her words, we draw strength and resolution to stay true to the values and ethics we have held onto for so long. She writes:

> "My beloved profession has been
> learning much about co-operation.
> We have come to see that we must

> work *with* people to 'achieve their own goals, not the goals of others for them.' Our profession has worked where it could and, in a world often hostile to its ideals, has sometimes suffered loss of its relatedness to the progressive movements of the life of its time. It has not willingly, however, accepted a role exploitive of its clients, or a police function to keep people quiet while they starve slowly." (1963, p. 323)

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BOOK REVIEW

HUMAN BEHAVIOR AND THE SOCIAL ENVIRONMENT: MODELS, METAPHORS, AND MAPS FOR APPLYING THEORETICAL PERSPECTIVES TO PRACTICE

BY JAMES A. FORTE

Reviewed by
Paul Abels, Ph.D., California State University, Long Beach

There are some books that you are supposed to read, big books like *War and Peace* and *Moby Dick.* This is a big book, and as Dr. Forte might say metaphorically, a "whale of a book." The number of pages (640 total) which first roiled my attention, I soon forgot due to the nature of the material and the contribution to knowledge that is encompassed within those pages. Hesitant at first to try the waters, I was soon into it hook, line, and sinker. His suggestion that it had value for the social work student at the Bachelor, Master, and doctoral levels was not an overstatement. In fact the experienced educator and practitioner have much to gain if they approach the book willing to examine their own models of practice in the context of his ideas.

The first hundred pages or so are related to various tools for critical thinking, particularly models, metaphors, maps, and theory building. They serve as a lengthy introduction to the major portion of the book. That section consists of four hundred pages divided into chapters in which he discusses the major theories in use by social workers and, I would add, related helping professions. The first chapter in the series is entitled "Applied Ecological Theory," the metaphor of the organism in the environment. This is followed by the chapter "Applied Systems Theory," the machine or interacting parts metaphor. The two joined together make up the much used ecosystems approach to practice. There are eight other chapters related to theoretical approaches to practice: Biology, Cognitive Science, Psychodynamic, Behaviorism, Symbolic Interaction, Social Role, Economic, and Critical Theory. Each contain the ideas basic to the theory, several leaders of each approach, ideas as to how they are applied in practice, and how each might be mapped. Each theory, one might assume, has something to offer in its time and place.

In the final portion of the book Dr. Forte gets to the heart of the matter. And I would agree that his heart and head are in the right place. He is recommending an integration of knowledge, suggesting "Theoretical Pluralism." There is no one theory, model, or paradigm that can do the job with the universe of persons our profession serves. He notes that in all of the theories there is knowledge that can be used or borrowed as if it was all in a library available for our use. Augmented by "Dialogical Conversations" with those who are familiar with or promote this knowledge, we can expand our own preferences, with a multi theory or "theoretical integration." There is at least one map for the pluralist: the "eclectic" map.

> *"The eclectic map for the theoretical integration directs the practitioner to add many techniques to his or her toolbox and to use techniques that work for the particular helping job whatever the original theoretical language of the technique"* (553).

Of course this presents a challenge to all of us. But each of us can raise the question to ourselves, quietly. Is our preferred theoretical application "all there is?"

I am still left with the nagging question I had when I first saw the book. It is big, and gets even bigger when you read all a student might need to learn in an HBSE course. With such a wide range of theoretical content, would concepts such as culture, age related development, diversity, or whatever else might be deemed vital, have sufficient space?

I gladly recommend this book to every social work educator, every practitioner and scholar. There is a great deal to be learned from it. When it comes to use in the HBSE course, the instructors, knowing their subject, and the nature of the student body, will have to make their own decisions. They have nothing to lose by examining Dr. Forte's book, and an awful lot to gain.

- Forte, James A. (2007) *Human Behavior and the Social Environment: Models, Metaphors, and Maps for Applying Theoretical Perspectives to Practice.* Thomson Brooks/Cole: Belmont, CA .

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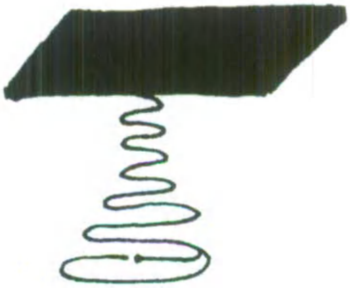

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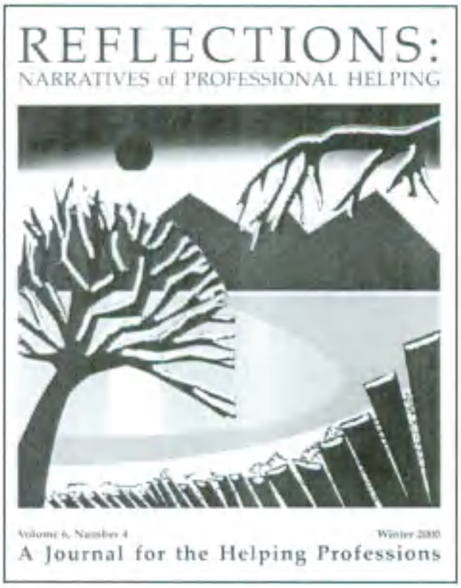

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