REFLECTIONS

NARRATIVES of PROFESSIONAL HELPING

“To Follow” Digital Painting 707x884 Jack Pincelli 2026

Artist’s Statement: The verb *follow*, as it appears in the idiom “to follow in (someone’s) footsteps” is used in the simple sense of pursuing, but so too can it mean to understand, to abide, and to succeed. Only with the clear paths of peers and leadership ahead can helping professionals follow confidently.

General Issue

Volume 32 (2026) Number 1

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PUBLISHED BY SALEM STATE UNIVERSITY SCHOOL OF SOCIAL WORK

Publishing Partners: University of Georgia School of Social Work; Howard University School of Social Work; California State University Long Beach School of Social Work; Monmouth University School of Social Work

Executive Committee: Beth Massaro (Publisher, Salem State University), Chair; Philip Hong (University of Georgia); Sheara Jennings (Howard University); Nancy Myer-Adams (California State University Long Beach); Jeanne Koller (Monmouth University); Darlyne Bailey (Editor-in-Chief, Ex-Officio)

ISSN - 1080-0220. Published April 2026 using Open Journal Systems software. Hosted at Public Knowledge Project. Indexed in Social Work Abstracts and Social Services Abstracts. Full text available in EBSCOhost SocIndex and Proquest Research Library. The content, opinions expressed, and use of language in each article appearing in *Reflections* reflect the views of the author(s) and do not necessarily reflect the views of the Editors, Publishing Partners, or Salem State University.

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REFLECTIONS

NARRATIVES of PROFESSIONAL HELPING

General Issue Submissions (continued)

Reflections from the Editorial Team: Preparing the Next Generation of Helping Professionals

Darlyne Bailey, Monica Leisey, F. Ellen Netting, and Kelly McNally Koney

Abstract: We are excited to announce that our next publication will be the first in a series of Special Issues on Navigating Change. In this current Issue we highlight the important theme of preparing the next generation of helping professionals to be self-reflective, engage in reflexivity, learn to communicate well, and become effective supervisors and educators of the future. Eleven articles are highlighted in which authors' personal and professional experiences reinforce a deep commitment to learning from others, so that expectations, boundaries, and interventions are available to light the way in uncertain and often challenging settings. In so doing, we aim to assist helping professionals to do their best work and to support one another in the process.

Keywords**:** self-reflection, reflexivity, positionality, trauma-informed practice

We're Excited About Upcoming Special Issues

Last year *Reflections* released a call for a Special Issue entitled "Navigating Change: Reflective Insights for Helping Professionals in Shifting Political Landscapes." Guest Editors **Kenya C. Jones** (Clark Atlanta University), **Anthony T. Estreet** (National Association of Social Workers), and **James T. Freeman** (Johnson C. Smith University) have been busy ushering a very large number of submissions through the review process. We are pleased to tell you that the first of three Special Issues will be published this summer, and we want to thank Guest Editors Jones, Estreet, and Freeman for their hard work in making these Issues a reality.

As a preview, authors responding to "Navigating Change" will highlight how helping professionals have applied their competencies to adapt, advocate, and intervene in response to evolving political challenges. From racial justice and police reform to voting rights and civic engagement, our Guest Editors seek to provide a framework to focus on promoting meaningful dialogue as helping professions address contemporary political issues that affect diverse communities and to examine how both frontline responders and change agents navigate political challenges while remaining passionately committed to social justice.

As always, we are delighted to have **Cathy McElderry** as Section Editor for Teaching and Learning, **Pat Gray** and **Anh Ngo** as Co-Editors of our Practice Section, **Brie Radis** as Section Editor of Practicum Education, and **Tiffany Baffour** and **Kenya Jones** as Co-Editors of the Research Section. Our Section Editors volunteer their valuable time and expertise to the submission and review process. We are so grateful for their commitment and expertise. Thank you!!

We are delighted that Salem State University continues to be the Publisher of *Reflections* under the able leadership of **Beth Massaro**. **Jack Pincelli**, our Lead Copyeditor, continues to amaze us in his attention to detail and his creative thinking; **Kelcey Montimes**, our Salem State University Graduate Assistant, is adding to her education and providing much needed support to our Copyediting and Publishing Teams; and we cannot say enough about **Justin Snow** whose expertise in e-scholarship contributes to the overall process of publication. Behind-the-scenes are hundreds of volunteers without whom *Reflections* would simply not exist. Those volunteers are our reviewers who are invited by our Section Editors to read manuscripts and provide feedback to authors. Their value cannot be overstated, and it is a joy for us to recognize the incredible gifts they bestow upon *Reflections*.

Preparing the Next Generation

In a recent Editorial Board meeting in which we were once again "checking in," everyone began sharing the emotions evoked by personal, professional, organizational, and world-wide concerns impacting our lives. We found it a bit challenging to get to the business at hand because there were so many things happening in our respective lives and in the larger global community that required our attention. Since many of us are affiliated with universities, it reinforced how increasingly important it is "to create the space for academics to slow down the academic pace and dedicate time to turn the gaze upon [our]selves to enact academic reflexivity via dialogue with peers" (Daly & Larsen, 2026, p. 69). The opportunity to voice our concerns and reveal our vulnerabilities in places like the one we have co-created is critical to growth and understanding as educators of helping professionals.

As we prepared this editorial, we were touched by how authors in this Issue are sharing their innermost thoughts about how important it is to have instructors and supervisors skilled in preparing future practitioners and researchers for practicing and researching in sensitive and sometimes traumatic situations. There is a feeling of urgency in the articles you are about to read because the pace of our lives requires rapid response in a time when reflection and dialogue among colleagues become rare gifts. As an Editorial Team we marvel at how hard everyone works to make space for Zoom meetings across time zones and busy schedules. In short, we are not surprised that the narratives in this Issue reveal how challenging yet how essential it is to spend quality, reflective time with students, interns, colleagues, instructors, and supervisors.

So how do we prepare the next generation of helping professionals?

Just as AI is a rapidly growing tool that enhances our ability to access information and put larger amounts of data on speed dial, it is even more important to prepare the next generation of helping professionals to engage in reflexivity and critical thinking about their own positionality. Reflexivity in practice "examines the habitual ways of seeing the world and the norms of thought and behavior acquired from authoritative sources and taken for granted. It … consists of a constant process of interrogation whereby we reconstruct shared meanings with others" (Gorli et al., 2015, p. 1351).

Daley and Laren (2026) invite us to consider those assumptions we take for granted and as instructors and supervisors to encourage others "to practice what we preach" (p. 70) by becoming more reflexive in our lives. Reflexivity is both a practice method (i.e., reflective practice) and a qualitative research method (e.g., autoethnography) that requires "a conscious use of one's own self-awareness to shape meaning about others; it refers to the ways [helping professionals] are affected by their personal processes and emotions" (Herland, 2022, p. 665).

Practitioners and researchers in the helping professions are often encouraged to engage in reflexive journaling that documents their emotions and biases, to jot down notes, to keep audio diaries, and to document contextual information. The process of writing or recording helps to capture one's emotional responses and thoughts, as well as secure a trail of memories to which one can return. Narrative writing is considered a valuable tool to use in teaching students how to engage in critical reflexivity about racism (Yan et al., 2002), to focus on intergroup conflict and violence (Hagai & Bilali, 2025) and to deepen their scholarly writing beyond traditional attempts to sound objective in reporting research results (Morrow & Kettle, 2024). Helping professionals across roles and settings experience so much in their daily lives that capturing even a fragment of what they learn could fill the pages of *Reflections* over and over again.

Yet, even with the growth of qualitative research methods and the number of journals that publish qualitative research, narrative writing about "our own use of reflexivity as academic practitioners evokes a fear of 'who will publish it' given research criticisms of lack of generalizability and objectivity" (Akingbola & Blunt, 2023, p. 466). Another reason for hesitancy to share narrative writing and expressions of creativity in published work is fear in revealing one's own "experiences, vulnerabilities, and biases" (Karcher et al., 2024, p. 3). Published research articles can make it sound like each step led to another with a paragraph about limitations tacked on at the end, but there is less said about what didn't work and the missteps an author encountered in the process.

Narrative writing is not meant to be generalizable; authors do not have to apologize for being imperfect. In fact, authors reveal those very experiences, vulnerabilities, and biases that Karcher and colleagues (2024) identify because it is through reading about that learning process that the reader will learn as well.

There is never enough time to fully reflect in a world that is constantly changing and in which we are simultaneously bombarded from multiple devices with what is happening minute by minute. But that just makes it more imperative that helping professionals across roles and settings find ways to think deeply, to truly listen to others, to encourage the sharing of lived experiences, to get in touch with what it means to cultivate one's emotional wisdom.

Reflections offers a publishing platform for the reflexive helping professional in the community and in the classroom. We welcome as the narrator the author, the poet, the photographer, and the artist to critically reflect upon their personal and professional lives. We thank our authors who strive to examine their own deeply held assumptions and to use their insights to inspire others to discern and act on their values and learn from their interactions. We thank our authors for putting themselves "out there" by sharing their discomfort and vulnerabilities as well as their "aha" moments in the hope that others may learn from their stories. We look forward to hearing from readers, and we are deeply grateful to those of you who join us in valuing this Journal!!

Highlights of This Issue

In this Issue we are pleased to feature 11 articles that highlight the important theme of preparing the next generation of helping professionals to be self-reflective, engage in reflexivity, learn to communicate well, and become effective supervisors and educators of the future. Authors' personal and professional experiences reinforce a deep commitment to learning from others, so that expectations, boundaries, and interventions are available to light the way in uncertain and often challenging settings in which helping professionals strive to do their best work.

The first four articles reveal an array of experiences in which practitioners face traumatic situations. These authors reinforce how important supervisors are in creating a supportive culture. All four articles focus on very different population groups, but they are consistent in explaining how critical it is to have adequate training and supervision for helping professionals that face trauma in their work and personal lives.

Jackson-Nevels, Erickson, and Lewis take the reader into a Veterans Administration hospital in which students are assigned to patients in the Burn Unit and the Traumatic Brain Injury Unit. Given the potential for experiencing vicarious traumatization as students witness pain and suffering, the authors offer ways in which supervisors can support student resilience.

Dotson provides us with a very personal perspective about how paraprofessionals are often faced with challenging situations for which they may not be adequately prepared. This author focuses on how adequate training and supervision is absolutely critical in preparing for work with Black and Brown men who have sex with men (BMSM).

Wallace engages the reader in a narrative that reveals the conflicting views about whether it is appropriate to disclose one's traumatic experience in childhood. Suggesting educators and practicum instructors consider creating a culture of self-disclosure in professional education programs is combined with a very personal experience about when the author self-disclosed.

Jaffe provides a very different type of trauma intervention in describing being part of a Psychotrauma Unit's Animal-Assisted Crisis Response. Telling the story of a young mother's death and a police officer's emotional response, Jaffe reveals how the presence of a therapy dog became the support for the officers as they coped with a tragedy.

Although *Reflections* does not publish the results of research studies, we encourage authors to share what was learned about themselves and others in the process of conducting their research. The next four articles do a beautiful job of taking us into the reflexive process.

Myers' qualitative study focuses on communication between older Black women and their physicians, encounters too often fraught with systemic racism and lack of cultural competence. Citing the wisdom gained from narrative types of research, Myers brings forth the stories of participants who offer insight into how health care professionals need to hear the voices of their patients.

Valentich takes the reader into Canada, where she reflects on what becomes a case study of a friend's death through Medical Assistance in Dying (MAID). This in-depth analysis of the very human interpersonal realities, combined with the organizational and policy issues surrounding assisted dying, reveal the work that needs to be done in examining the many issues raised in the dying process.

Pope and Hossain's data come from in-depth interviews conducted as part of an oral history project in which auto-ethnographic writing assists in questioning dominant ways of thinking. Responding to incorporating greater reflexivity into aging studies, the authors are intentional in recognizing the differences in their own positionality as different cultures influence how they co-construct their assumptions.

Thurber reflects on an historical study of her great-grandfather, a controversial Rabbi in the 1940s. As a Jewish social worker in a time when there is a great deal of conflict in the world, Thurber takes us on a journey through the archives and how the process of doing this research influenced thinking about what it means to be Jewish and to more fully understand the contemporary world in light of one's own cultural history.

The last three articles in this Issue are written by authors whose personal experiences as students and educators reveal the need to reform social work education. Particularly in a time when diversity, equity, and inclusion are being scrubbed from curricula, these authors advocate for the importance of cultural competency in the educational process.

Gwynn writes from the perspective of a Black male in a social work doctoral program, asking that mentorship programs be available to first-generational Black men so that social isolation is addressed. Focusing on the challenges of having a double minority status requires intentional community support.

Park's article is revealing and humble in making a request from the readership for any suggestions readers can provide. Addressing a number of assumptions and expectations about students and their perspectives, Park reveals unexpected reactions and viewpoints encountered in teaching about racism.

Hamm writes about a journey into becoming an equity professional within higher education, explaining that social work as a career often leads to a number of potential experiences beyond the classroom. Committed to how the values of social work as a profession meld with the creation of diversity, equity and inclusion work, Hamm ends with a call for research in this area.

The articles in this Issue reveal the importance of self-reflection, reflexivity, and communication in the lives of students, practitioners, and service users across settings and around the world. We trust you will find this Issue as you find all of *Reflections*—full of compelling narratives that offer insights that will be useful to multiple professions, educators, practitioners, students, and others alike. Once again, we look forward to hearing from you!!

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With Gratitude...

We would like to recognize and thank the Reviewers who contributed their time and invaluable assistance to this issue of *Reflections*, Volume 32(1):

> Rosemary Barbera, Joan Marie Blakey, Shena Brown, Nathaniel L. Currie, C. Lee Anne Deegan, Mildred Lois Delozia, Nanette I. Fleischer, Priscilla A Gibson, Sarah Louise Hessanauer, E. Goldblatt Hyatt, Shakira A Kennedy, Katherine Mary Kranz, Joan Granucci Lesser, Lynn Levy, Carol Weissmann Mauck, Jane Miller, Matthias Naleppa, Nadjete Natchaba, Kanako Okuda, Jamie Peralta, Yvette Lashone Pye, Jerry Reynolds, Tawana Ford Sabbath, Johanna Slivinske, Jessica Sniatecki, Sherita L. Thompkins, Collette D. Williams, Victoria R. Winbush

We appreciate your commitment to *Reflections* and its authors!!

Supervising Medical Social Work Interns in a Veterans Medical Center Hospital

Breshell Jackson-Nevels, Kirsten Swedburg Ericksen, and Marilyn W. Lewis

Abstract: This paper presents a narrative compilation of real social work student experiences through a pair of fictitious medical interns—"Michelle" and "Dwight"—assigned to simulated practicum education placements. Exploring Michelle's work in the burn unit and Dwight's in the traumatic brain injury unit, we consider the emotional challenges interns weather in the face of extreme physical trauma and how faculty supervisors can provide support.

Keywords**:** practicum education, trauma, military rehabilitation

Introduction

Military personnel who are exposed to combat may experience cognitive as well as physical traumas. The field of medical social work has returned to the forefront after COVID-19 spotlit the value of medical care teams armed with person-in-environment theory. Training interns to tolerate traumatic injuries ("traumatic" in both the physical and emotional sense) is critical to their ability to work effectively with service members and their families. Since most post-hospitalization rehabilitation occurs at home within the context of the family, it is essential for interns to develop a holistic approach working with both the patient and the patient's loved ones to ensure sustained recovery. A component of treating patients and their families is encouraging them to partake in self-care. Thus, it should be evident it is imperative for student interns to do the same; it is crucial for student interns to incorporate regular self-care and belonging to model effective strategies for clients and address the associated stressors in their environment (Ericksen et al., 2021). This paper will address how field instructors can facilitate their students' processing of the stress they encounter during placement experiences.

Burns

A social work student intern placed on a military burn unit will need to focus on several things. Of these, two are paramount: 1) the individual patients' tolerance for pain, and 2) coordination with the family caregivers, who will be responsible for the patients' well-being after discharge. These both challenge the student to manage their feelings with exposure to the patients' trauma and to provide concrete physical support (i.e., medical care) as well as emotional support and relevant resources (i.e., social work) to patients and their families.

A burn injury is considered a *signature wound* (Zoroya, 2008), common to the point of emblemization, among the physical traumas experienced by military personnel. Burns are a common result of detonated improvised explosive devises (IEDs): homemade explosives made with a fuel source (e.g., fertilizer, gunpowder), an oxidizer to ignite the fuel (e.g., ammonium nitrate), and usually an enhancer (e.g., shrapnel, metal fragments, nails) to inflict damage from flying debris. IEDs are designed to kill, maim, and incite terror, and they may be released in the form of an expectedly dangerous pipe bomb or an innocuous-looking package—or entire delivery truck (Atkins, 2006).

It is important for the intern to learn the vocabulary of the medical unit. Social work students must be able to ask questions and understand conversations about the patient's burns. Thus, scientific, technological, engineering, mathematics (STEM) terminology and concepts, as applied to the patient's health (H), are requisite. The translation of information learned at the benchside (pharmacology and physiology) can be used at the patient's bedside. The social work intern can support the patient's feelings, fears, and confusion about their injuries, always remembering to refer the patient back to the nurse or other members of the medical team when their questions are not within a social worker's wheelhouse.

Interns who are placed on a burn unit will learn from physicians and nurses that burns are problematic in part because the skin is the largest bodily organ and covers the entire surface area of the body, as well as parts of the gustatory (nasal cavities, mouth), respiratory (throat), reproductive (genitalia), auditory (auricle, ear canal), and visual (eyelid) systems (Campbell, 2011). Both the physical and emotional trauma for the patient depend upon the extent of their injury. Subsequently, the intern's experience will depend upon the degree of the patient's damage: to be considered are breadth, depth, and location.

Breadth

One way clinicians assess the severity of burns is by applying Wallace's (1951) Rule of Nines to quantify their size. This is done by visualizing the surface area of the burn in relation to the body, known as the total body surface area (TBSA) of the burn. To do so, the body is mentally divided into smaller areas that are each approximately nine percent of the full body area: The head and neck; each upper limb; each lower limb's front (anterior) side; each lower limb's back (posterior) side; and the torso, comprising chest (anterior top), stomach (anterior bottom), upper back (posterior top), and lower back and buttocks (posterior bottom; Wallace, 1951). The last and ninth area covers one percent, represented by the genital region (Colbert et al., 2020). Generally, the size of an adult palm represents approximately one percent of the total body surface area. Jeschke and colleagues (2015) reported that among adults, a TBSA greater than 42 percent was correlated with infection and greater than 44 percent with mortality.

Depth

Skin is composed of three layers: the epidermis, dermis, and hypodermis. The outer, top layer of skin, the epidermis, is responsible for protecting the body from the environment and is the body's first layer of defense (Singh & Archana, 2008). When this layer is burned, bacteria can enter and infect the body (Singh & Archana, 2008). The middle layer, the dermis, lies below the epidermis and above the bottom layer, the hypodermis (Singh & Archana, 2008). When the burn extends to the middle (dermis) but the lowest (hypodermis) level is healthy, this interferes with support to the skin's top layer and prevention of excessive water loss (Lai-Cheong & McGrath, 2021). When the healthy bottom layer is damaged, tissues deep within the body that nourish the epidermis with nutrients and provide insulation and temperature regulation lose protection (Colbert et al., 2020). Clearly a burn to any layer of the skin can interfere with a number of vital functions that skin performs.

Medical treatment of burns involves avoiding infections (Souto et al., 2020), which can range from bacteria (e.g., E. coli, staphylococcus, MRSA) to viruses (e.g., Herpes simplex, Varicella-zoster) to fungi (e.g., Candida, Aspergillus), and repairing the integrity of the skin. Several techniques have been used for wound repair, including application of grafts to the affected areas (Shpichka et al., 2019). There are several common sources of material for grafts. Human fetal cells, as well as human cadaver or animal skin, are the primary technological techniques that are used to treat burns (Shpichka et al., 2019).

The depth of burns, and their psychological effect on the intern, can mirror the physical effect on the patient. According to Colbert and colleagues (2020), first degree burns damage the first layer of the epidermis, which becomes painful and turns red, but does not blister. The burned skin peels but does not result in scarring. Many people have experienced these burns from being in the sun without protection, thus the effect on the intern is minimal. Second degree burns damage the first as well as the second layers of epidermis and typically cause a blister, the size of which and the time it takes for the skin to recover depends upon the depth of the burn. Recovery from second degree burns that involve only the epidermis can take up to 14 days to heal, while second degree burns that extend deep into the dermis can take up to 14 weeks to heal and typically involve scarring and the potential for infection (Warby & Maani, 2019). Full thickness burns include third and fourth degree burns and extend down into the entirety of the skin, often to the bone. These burns are so deep that the pain receptors are destroyed. The skin can turn waxy and white, dark brown, or black and result in scarring. Third degree burns are susceptible to infection and can result in death. Fourth degree burns damage all layers of the skin. The skin becomes charred, and changes colors as it does with third degree burns. These burns damage the structure of the skin by killing the pain receptors, hair follicles, and sweat glands. They can extend down to the muscle, tendons and bone and are life-threatening. While victims of fourth degree burns do not feel pain, they are at high risk of infection that often results in amputations and death (Colbert et al., 2020). The patients' faces and bodies may have been distorted by fire and attempts to treat the burns with grafts. Interns may have difficulty managing their reactions to seeing the physical symptoms of the patients; many have required debriefing from their supervisor and/or field practicum professor.

A medical social work intern plays an essential role in supporting burn patients, and the intensity of this role often parallels the severity of the burns observed. With first degree burns, where injuries are mild and visually non-distressing, the intern typically provides basic psychoeducation, reassurance, and simple minimal emotional impact. For second degree burns, which involve blistering, significant pain, and potential scarring, the intern becomes more involved in helping patients manage anxiety, cope with body-image concerns, and adhere to wound care while also supporting family members; this stage may also heighten the intern's emotional response and require increased supervisory guidance. With third and fourth degree burns, where patients may experience disfigurement, risk of infection, amputations, or life-threatening complications, the intern's role expands to a trauma-informed care approach, crisis intervention, psychosocial assessment, family meetings, and long-term planning. These severe cases can evoke strong emotional reactions in interns; therefore, supervisors should provide debriefing and encourage self-care, which are crucial for managing secondary trauma.

Location

In addition to the TBSA that is affected, burn severity may also be correlated to location. In situations where the service personnel are injured by roadside bombs that ignite gasoline in their tanks or Humvees, they can be injured over extensive parts of their body. In situations where they step on a landmine, the impact of the explosion travels up from the feet to the genitals and the torso. Burns that involve joints, the face, hands, or genitals are considered more severe (Jeschke et al., 2015). Burns to the genitourinary system can have long-lasting emotional effects alongside the physical complications because these burns often severely injure the patient's ability to procreate, which can be devastating to soldiers often in their prime childbearing years.

For all burn levels, the intern contributes to patient well-being while developing professional resilience and competencies in complex medical settings. Supervisors can guide this understanding and regularly facilitate debriefing to process and assist in the development of applicable knowledge and skills.

Traumatic Brain Injury (TBI)

Traumatic Brain Injury (TBI) is another of the signature injuries seen among military personnel (Hoge et al., 2008). Because today's conflicts are fought in unconventional ways where there are no distinct battle lines, each soldier is essentially at the frontline. The preferred weapon during modern wars has become the improvised explosive device (IED), which often injures rather than kills. Detonation of an IED can result in brain injuries when the brain is shaken within the skull upon direct impact, shrapnel from flying debris, or shock waves from the blast. Immediate assessment of brain function is the best way to prevent secondary brain injury, which can occur when the brain swells in response to the explosion (Zaman et al., 2024).

Social work intern students should learn and understand the impact of TBI, including the various tests and assessments. The intern will have to be able to communicate with the neurologist and nurse to understand the depth of the patient's injuries. Additionally, it is critical for the intern to comprehend the assessment and purpose to be able to effectively communicate with family and caregivers.

Two types of imaging tests are used to assess an individual's injury (Mayo Foundation for Medical Education & Research, 2020). The first is a Computerized Tomography (CT) scan, which uses X-rays that create views of damaged bone, swollen tissue, blood clots, and hemorrhages. According to Lee and Newberg (2005), after a TBI, repeated CT scans should be done to identify the location of potential hemorrhages. The second type of imaging is the functioning Magnetic Resonance Imaging (fMRI) test, which detects brain lesions that cannot be identified with a CT scan (Lee & Newberg, 2005). Because of the level of detail in these fMRI-derived images, the physician can identify if there are individual brain lesions which are treatable (Lee & Newberg, 2005). This is important because the patient may need supplemental oxygen to allow energy that would be used to breathe to instead be used to fuel recovery. Due to the nature of TBI, anoxia or hypoxia to the brain could cause further injury.

In fact, the immediate objective after receiving a TBI is to limit swelling by increasing the level of oxygen to the tissues (Lin et al., 2008). One way to increase the amount of oxygen is by using hyperbaric oxygen treatment, which involves administering 100 percent oxygen through a facial mask while the patient is in a compression chamber (Lin et al., 2008). Reducing brain temperature is another treatment to alleviate swelling after a TBI (Sinclair & Andrews, 2010). Hypothermia can be achieved by cooling the external temperature of the body or the core bodily temperature. Andresen and colleagues (2015) reported that the target temperature should be between 89.6 to 93.2 degrees F (or 32 to 34 degrees C) for more than 48 hours.

While Haselsberger and colleagues (1988) suggest CT scans are preferable to MRIs after severe head trauma to assess bleeding outside the brain tissue, particularly if there is a possibility of postoperative complications. Additionally, CT scans are preferable when assessing TBI because there may be undetected metal shrapnel in the head (Lee & Newberg, 2005).

Because different brain areas are related to different functions, damage to different structures is related to deficits of those functions (Zaman et al., 2024). For example, because of the association of emotions in the limbic system, damage can disrupt production of hormones related to attachment (oxytocin) and interfere with their release (Colbert et al., 2020). This may have a profound effect on the patient's family members, as they are often yearning to reconnect with their loved one.

While trauma may injure only a specific location of the brain, it can also have global effects that affect the overall person (Teasdale & Jennett, 1974). Interestingly, lesions to both hemispheres (bilateral) of the prefrontal cortex can result in profound changes to one's overall personality and a loss of executive functions, such as reason and insight (Pirau & Lui, 2020). On the other hand, a lesion in only one hemisphere does not usually cause major changes to the personality (Hillis, 2014).

A social work student intern working in a TBI unit will need to be aware of the potential lack of response from patients. Especially if inexperienced with TBI, students may find themselves frustrated with symptoms that impact the sociability of patients, such as flat affect and apathy. Students facing little to no feedback, reaction, or perceived appreciation for their effort may struggle to feel confident in their work and will need support from their field supervisor to help process feelings of demoralization and insecurity. The field supervisor must ensure students are well-versed about TBI, particularly how patients' emotional responses may be dulled, to best mitigate this issue.

Relatedly, when an intern is working with a client affected by TBI, their primary client may then instead become the client's family members, who are similarly struggling as new caregivers—with the added difficulty of having prior familiarity with the patient. The student can apply professional use of self (Walters, 2008) to help the family in processing their frustration that they are no longer receiving emotional support from the patient. Kratz and colleagues (2017) conducted a study on the family members of patients who sustained moderate or severe TBI and found that they were overburdened with responsibilities; grieved the loss of the person; felt anger, guilt, anxiety, and/or sadness; and felt their lives were interrupted or lost.

Working with the family, who may be managing the patient's low responsiveness and heightened emotional outbursts, grieving the loss of the patient's pre-TBI function, and/or simply struggling to meet the patient's new need for around-the-clock support will be challenging. The social work intern may need to connect families to support groups or outside resources for additional help. Encouraging appropriate self-care for caregivers is equally important to help bolster their success and avoid caregiver burnout. Student interns can ensure caregivers receive the critical support they require to continue to provide effective aid to the patient. As discharge approaches, social work practitioners may also need to provide assistance in this decision-making.

Koehmstedt and colleagues (2018) reported TBI patients can experience increased well-being from several factors, namely being provided a more personalized medical plan, an advocate or "point person" designated to help the family, and guidance in adjusting to the chronic nature of TBI aftereffects. Social workers can ensure these are given by coordinating health and social services, providing the family with more information about the patient's specific injury, and discussing medical information in less technical language. Social workers can also coordinate community support and professional in-home help which, according to Koehmstedt and colleagues (2018), eases the strain on caregivers.

Social Work Training

How do social work schools train MSW students to provide the tools necessary to provide care to military patients with burns and TBIs and their families? In the academic setting, student interns typically receive a total of 63 credit hours of academic courses in order to graduate, which is beyond the typical 60 credit requirement due to their specialization (Norfolk State University, n.d.). During the second year of the specialization curriculum, the total number of field practicum hours providing instruction in a comprehensive military specialization is often 546 hours from MSW-trained field instructors (Council on Social Work Education [CSWE], n.d.). The level of training for the field practicum faculty includes MSW and PhDs from an accredited CSWE university. The field practicum faculty at our school, the Ethelyn R Strong School of Social Work, have well over 20 years' experience as licensed social workers or licensed clinical social workers in clinical or military sectors. Their experience has consistently provided an elevated quality of supervision. The field practicum faculty often meet with students at least two hours weekly to discuss concerns and provide support. Students are also required to attend a two-hour field seminar class each week.

According to informal data from the MSW students at their placement at a Veterans Medical Center Hospital, reports indicate students were satisfied or highly satisfied with the quality of their placement and supervision. This finding supports Cleak and colleagues' (2022) report that Master-level students' satisfaction with their placement is in large part related to the quality of supervision. Each CSWE-accredited social work school requires that every student receive a total of 900 supervised hours from a clinician for two years after earning their MSW. Satisfaction varies based on the competence and support of the instructor. A key factor in the field experience of African American students, for example, is their relationship with and perceived support from their assigned agency (Mehrotra & Gooding, 2022). These findings support the positive experiences detailed by MSW students placed at a Veterans Medical Center Hospital. Every student placed at the VA after receiving two semesters of supervision chose to apply for employment at the facility.

The students were highly satisfied their coursework prepared them to work successfully at any Veterans Medical Center Hospital as MSW social workers. Specifically, their weekly supervision and the support given in their field seminar class reinforced their learning objectives. The students' positive report of their field experience included their high level of satisfaction with the various capacities afforded to a Master-level social work clinician. Based on a CSWE curriculum, if a social work student prepares to work in the medical social work field with military patients, they can potentially receive their advanced electives in military-centered courses (e.g., social work practice with military families, effects of trauma on military personnel, medical treatment of military clients). Ideally, their field instruction will take place in military settings, thus providing them with a well-rounded intensive social work experience. If the students do not have access to a Veterans Medical Center Hospital in the community, because of the frequency of traumatic brain injuries and burns among the general population, they can still potentially work with non-military clients in general hospitals. Additionally, it has been found training in skill development assists students to alleviate burnout in hospital settings (Cohen & Gagin, 2005). It was further suggested within student feedback that understanding STEM-H terminology provides interns the ability to comprehend the condition of the patient, then translate that information to the family when meeting with them at the patient's bedside.

This article uses a compilation of experiences of Master-level students who are specializing in work with military personnel. Student Intern #1, whom we refer to as "Michelle," is working with patients in the burn unit, and Student Intern #2, whom we refer to as "Dwight," is working with patients in the TBI unit. These student simulations/replications put the spotlight on experiences student interns may encounter when working with military patients who have sustained signature injuries.

Michelle

"Michelle" is a 22-year-old student who is interested in working with military veterans who have experienced bodily trauma from IED-related injuries. Although she has not served in the military, her brother served in the Army until he was injured in Afghanistan from a roadside bomb. He was treated for burns and released to his parents' home for long-term care, where

Michelle gained personal experience caregiving. Michelle asked to be placed in the burn unit at the local VA and is now struggling with the patients' experience of pain. According to Patterson and colleagues (2004), burns that require hospitalization often cause severe pain and are the most difficult to treat compared to other sources of acute pain. Michelle wasn't prepared for the several origins of her patients' severe pain: background pain from the burn itself; pain from tissue damage; pain from procedures and treatment, including wound-cleaning, debridement (scraping off dead tissue to create a clean wound bed), harvesting and applying grafts, and changing gauze and staples; breakthrough pain that occurs when the analgesics are inadequate (Patterson et al., 2004); and pain of post-surgical procedures prescribed to repair wounds and scars (Griggs et al., 2017). Michelle needed to work with her supervisor to process her feelings about her brother's injuries upon seeing her burn patients struggle with the pain experienced from the treatments. Michelle's supervisor was able to help her differentiate her personal self and rely on her professional use of self when interacting with patients and their families.

Michelle is learning that there are several medications often prescribed for reduction of pain, including drugs in the opioid family, which can be addictive. Because pain can be long-lasting, chronic administration of opioids results in physiological tolerance. Achieving a balance between the doses needed to alleviate the patients' pain while protecting them from becoming addicted or overdosing is often difficult, and in field seminar, Michelle wrestled with her concerns that it was unethical for the doctors to cause an iatrogenic addiction in the patient. Her field instructor and classroom discussion helped Michelle come to terms with the reality that patients do sometimes become addicted as the result of their treatment, but it is the responsibility of the medical staff to help the patient withdraw safely from the opioid before they are discharged from the hospital. For example, intravenous pain medication is often required early in burn treatment, but patients prefer to be switched to oral pain medication before they are discharged home (Patterson et al., 2004).

Michelle was also not emotionally prepared for some of the patients developing anxiety and even PTSD in response to the painful medical procedures. Patients' experiences of anxiety are related to increases in their perception of pain, which results in an increased need for medication. She was grateful that the patients' anxiety was controlled by the prescribed benzodiazepines they received before the procedures (Patterson et al., 2004). According to Griggs and colleagues (2017), minor tranquilizers or anti-anxiety medication, especially benzodiazepines, are used to reduce anxiety about upcoming painful procedures and have been shown to help patients tolerate treatments. Surprisingly, they also found that antipsychotic medication has been successful in reducing procedural pain, especially in the case of anxiety (Griggs et al., 2017).

Result

Receiving field practicum instruction as a student intern placed on a burn unit at a Veterans Medical Center Hospital can be challenging because of the emotional and physical trauma the patients suffer. Michelle needs to process her feelings around her patients' experiences of pain and their family's suffering. Michelle needed much emotional support to be able to use her self in a professional manner because of the similarities between her brother's injuries and her patients'. Having learned STEM-H terminology and concepts made it possible for Michelle to learn basic tenants of pharmacology and physiology with which to understand analgesic medication. She was able to voice her concerns about patients' iatrogenic addiction from prolonged opioid use and learn how the medical team helps patients withdraw from dependency on medications needed for pain.

Dwight

Dwight is a 25-year-old, second-year, Caucasian MSW student who was working as a psychiatric technician at a free-standing psychiatric hospital for several years after he earned his BA in psychology. Working with veterans with PTSD was less interesting to him than working with veterans with brain damage. While working as a technician in the psychiatric hospital, he became familiar with young adults who had developed TBIs as the result of automobile accidents, and he decided he wanted to work with similar patients after earning his MSW. He did not personally know someone with profound TBI, but he did know several people who had suffered mild TBI (concussions).

Dwight was inexperienced in working with individuals from other cultures, and thus multicultural competency was addressed in supervision. One of the scenarios he and his supervisor discussed was the prevalence of TBI from violence in the community. His fellow field practicum student, an African American female, shared information about the danger in her community due to overpolicing. Dwight explored anecdotal evidence with her and developed cultural competency from the conversation he shared in field practicum class. He remembered Competency #1 (CSWE, 2022), which mandates he protect people's confidentiality, and did not give identifying information.

Dwight should be aware of the various challenges related to working with African American military personnel (Wong et al., 2020). Dwight needs to develop his cultural competency. His supervisor needs to have training surrounding cultural competency and the unique situations experienced by military personnel. This is an important factor, as the military has a diverse population that requires its employees to have a vast knowledge of various cultures. One particular theoretical framework that would assist when working with people of color is the Afrocentric Paradigm (Schiele, 2017), which focuses on cultural values of African patients and on eliminating oppression and spiritual alienation. This paradigm could assist Dwight in developing his professional competence as well as expanding his knowledge and skill base because its focus is the cultural values of people of African descent (Schiele, 2002).

Mendez et al. (2013) compared military patients' personalities who had experienced blast-force versus blunt-force trauma. He found those patients with blunt-force trauma were more likely to experience higher rates of aloofness, negativist involvement, and apathy (Mendez et al., 2013). When the patients in the blast-force trauma group were studied, they experienced more anger, frustration, and affective-anxiety lability. The concept of benchside to bedside care was applicable in this component of his field practicum placement. Dwight discussed this approach in team meetings to verify his understanding of the STEM information and how he would apply it to health.

One of Dwight's patients, "Kevin," exhibits injuries ranging from moderate to extreme levels of trauma. Dwight is susceptible to depression and must engage in self-care when he works with difficult cases. One aspect of self-care was for him to process his feelings with his supervisor and explore questions about his patients' success rate after treatment. One of Dwight's concerns was the inability to explain the context of the patient's injuries to family members. The patient's injuries happened as he and his fellow soldiers were in a convoy of tanks driving down the street; the tank in front of him ran over a landmine. Kevin was propelled up off the seat and hit his head against the roof of the tank. This action caused his brain to receive blunt force trauma (from striking the roof) as well as blast force trauma (from being thrown by the mine explosion). Like most of the soldiers in Iraq and Afghanistan, Kevin was young and just beginning to develop his life. Experiencing a traumatic injury can affect a young soldier's life trajectory, which includes their ability to earn a living, start a family, and maintain emotional relationships with their families and friends. Because Dwight is the same age as Kevin and many of the other soldiers who suffer TBI, he may need help separating himself from clients to use his self in a professional manner.

Result

Dwight's reaction to his internship is compounded because he is similar in age to many of the patients he will work with. Some of his patients' TBIs were received from exposure to blasts, but others were the result of automobile accidents, which is a frequent outcome that affects many individuals, including civilians. Thus, he will need to practice self-care to prevent himself from becoming overwhelmed not only by interacting with clients who have faced devastating trauma, but also the potential familiarity of how that trauma affects their lives. Learning STEM-H vocabulary is necessary for him to understand the hospital team members and not exist in a vacuum-like environment at his placement. His supervisor in his field practicum site may work with him during his assignment to help him process his reactions so he is not isolated. In addition to working with his patients, Dwight worked with families who were struggling with grief and loss of their child because their personality was profoundly altered.

Conclusion

This article introduces two fictive students who are obtaining their field experience at a Veterans Medical Center Hospital in either the burn unit or the TBI unit to consider the emotional challenges interns weather in the face of extreme physical trauma and how faculty supervisors can provide support.

In treating burns, a student may experience secondary trauma from the patient's reaction to the debridement of burned tissue or from the patient's opioid treatment for pain. The field supervision will need to be able to inform the student how to treat pain with addictive drugs. In treating TBIs, a student may struggle to process their reactions to treating young people who have become paralyzed or experienced personality changes. The supervisor may need to support the field student working with family members who have developed caregiver burnout. To best assist students, supervision guiding questions would include those that explore students' preconceived notions about addiction to hospital-administered pain medications, as well as their emotional reactions to working with individuals with TBIs to provide reinforcement and guidance.

Future qualitative research is needed to examine each student who interns on burn units and TBI units to explore their reactions to their placement and supervision.

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Sending Paraprofessionals Out as Sheep to a Pack of Wolves: A Professional Reflection

Jason M. Dotson

Abstract: Black and Brown men who have sex with men (BMSM) are often recruited as paraprofessionals to offer risk-reduction counseling services to their communities. Due to the high prevalence of HIV, mental health issues, substance use disorders, and suicidal thoughts among BMSM as compared to the general population, these service providers are often at risk themselves—yet are seldom obligated to receive continuing education or clinical supervision. This reflection shows the importance of providing organized, culturally competent support to paraprofessionals in community- and health-based institutions delivering services to an at-risk and vulnerable community. I demonstrate the implications of offering risk-reduction counseling without adequate clinical support. I also discuss what a successful supervisor of BMSM paraprofessionals might look like. Finally, I discuss what BMSM paraprofessionals need to succeed when delivering care and examine how unaddressed personal and structural factors can contribute to maladaptive coping in the face of such targeted workplace stressors.

Keywords**:** BMSM, paraprofessionals, clinical supervision, clinical training

Introduction

I am a Black man whose childhood was shaped by trauma and chronic stress. My stepfather forced my mother to allow his paramour and her children to move into our home after child protective services discovered that he was sexually abusing the paramour's eldest daughter. Because I was not biologically his, I experienced physical, mental, and emotional abuse. My elementary school days were spent assuring the school counselor that my repeated threats of suicide were exaggerated, because my stepfather's violent threats prevented me from sharing the intimate details of what was happening in our home. The message that echoed through our house was clear: "What happens in this house stays in this house!" As an adult, I do not have a healthy relationship with any of my family members, and I often describe myself as a man who has no home. These early experiences of secrecy, violence, and silencing now inform the empathy and urgency I bring to my work with young people and with Black men who have sex with men.

I am a Black man who identifies as a man who has sex with men (MSM). I have seen friends and colleagues cope with intimate partner violence, substance use issues, HIV diagnoses, excessive drinking, and sex work. As a member of the MSM community, I am part of a marginalized group that experiences multiple forms of stigma and discrimination, which contribute to negative HIV-related outcomes (Babel et al., 2021). I am also a Black man who has earned an associate degree in child development, a bachelor's degree in communication, and two master's degrees. I hold two clinical licenses, in professional counseling and in drug and alcohol counseling. I have managed and created safe spaces for LGBTQIA+ communities of color in Paterson, New Jersey; Newark, New Jersey; and Brooklyn, New York. I was one of the first men to work at a domestic violence shelter in New Jersey, hired to assist LGBTQIA+ community members experiencing intimate partner violence and domestic violence. As a former safe space liaison with New Jersey's Department of Children and Families, I provided LGBTQIA+ educational and cultural competency training to child protective services case managers at my local office and implemented LGBTQIA+-affirming practices so that our office functioned as a genuine safe environment for LGBTQIA+ youth and young adults.

My professional credentials allow me to support the BMSM community through risk-reduction services, and my own traumatic experiences remind me of how badly that support is needed. Research supports the recruitment of minority social service providers to serve minority populations, especially those who are Black and Hispanic (Hsu et al., 2014). Smith and Trimble (2016) concluded that matching a client with a provider from the same racial or ethnic background can foster increased engagement in mental health treatment. Licensed or certified providers are mandated to participate in supervision, training, and continuing education, avenues through which they may receive the support needed to confront and negotiate their own experiences. Even so, they do not always receive the necessary training to care for racially diverse populations (Fields et al., 2020). Recruiting paraprofessionals to help individuals with mental health concerns has become one response to counterbalancing a strictly medical approach to care (Morse et al., 2020).

However, those serving as paraprofessionals do not have the same professional requirements as licensed clinicians. In the United States, organizations such as the Paraprofessional Healthcare Institute and the Institute for Public Health Innovation offer community health worker and paraprofessional trainings and certificates (Xiong et al., 2019). With proper training, the use of paraprofessionals can be cost effective and lead to successful outcomes (Morse et al., 2020). Paraprofessionals from vulnerable communities, however, represent a group in need of more substantial, built-in support if they are to provide adequate services to the vulnerable communities with whom they are working and not risk their own mental health in the process. The following reflection builds on my lived experience and the existing literature on paraprofessional work to examine the costs of undertaking this work without adequate clinical supervision.

BMSM: An At-Risk Community

BMSM experience a range of medical and psychosocial challenges at a disproportionate rate. According to the Centers for Disease Control and Prevention (2024), more than one million people in the United States are living with HIV, and approximately 38,000 people are newly diagnosed each year. Men who have sex with men (MSM), who represent an estimated 2 percent of the U.S. population, account for roughly 70 percent of people living with HIV, and epidemiologic projections suggest that one out of two Black MSM and one out of three Latinx MSM will test positive for HIV in their lifetime if current trends continue (Ramchandani & Golden, 2019). Much of this research focuses on young men who have sex with men (YMSM), including young Black MSM, who face developmental as well as structural vulnerabilities (Fields et al., 2020).

BMSM also report higher rates of depression than White MSM and are more likely to experience stigma (Babel et al., 2021; Moore et al., 2019; Quinn et al., 2018). Black MSM encounter high levels of racism from White MSM and, at times, from other Black MSM through social dating applications (Wade & Harper, 2019). Because of the relative anonymity these platforms afford, users may feel more comfortable racially profiling or rejecting a person online than in physical settings. Reading profiles that state "no Blacks" or "I do not date Black people" can trigger feelings of rejection, exacerbate depressive symptoms, and further isolate Black MSM (Wade & Harper, 2019).

BMSM are also more likely to be sexually objectified or portrayed as thugs or uneducated, and they are often viewed as a homogenous group, in contrast to the heterogeneous reality of their lives. Wade and Harper (2019) describe racialized sexual discrimination as a process in which gay men of color are racially discriminated against and assigned stereotypical sexual roles, such as being presumed to have a large penis, to be dominant, and, in many cases, to be the "top" (inserting) partner. These stereotypical roles can prevent BMSM from engaging in desired romantic relationships or friendships and can contribute to social isolation and psychological distress (Wade & Harper, 2019). These patterns of racialized discrimination mirror what I have observed among Black and Brown MSM in my own work.

Additionally, internalized homonegativity is associated with elevated risk for adverse health outcomes among BMSM. Minority stress theory posits that sexual prejudice against BMSM may lead to chronic stress, including external pressure, anxiety related to the anticipation of discrimination, and internalized negative social attitudes (Moore et al., 2019). For many BMSM, these processes are associated with higher levels of depression, anxiety, substance use, and suicidal ideation, as well as increased engagement in sexual risk behaviors and reduced likelihood of accessing or remaining in HIV prevention and treatment services (Fields et al., 2020; Moore et al., 2019). Black MSM also have a higher likelihood of living in areas with multiple stressors such as crime, drug use, and poverty, which further increase the chances of engaging in behaviors that place them at heightened risk for HIV (Fields et al., 2020).

Reflections from Practice as a BMSM Counselor

In what follows, I reflect on how these broader patterns show up in my own life and work as a Black man who has sex with men working in HIV prevention. My experiences as a paraprofessional and later as a licensed clinician mirror findings from research on task-shared and peer-delivered mental health and HIV services, where non-specialist providers often carry substantial emotional burdens and are vulnerable to vicarious trauma, burnout, and compassion fatigue (Kemp et al., 2019; Kim et al., 2022; Rabie et al., 2023). These studies underscore the importance of supervision models that provide ongoing, structured support, including opportunities to process challenging client encounters, monitor emotional well-being, and strengthen practice skills, rather than relying on one-time trainings alone. Building on this literature, the following narrative illustrates how, in the absence of consistent, culturally responsive supervision, my own unresolved trauma intersected with the demands of frontline HIV prevention work.

In my own life and counseling practice as a BMSM working in the public health sector to eradicate HIV and raise mental health awareness, my unresolved childhood trauma has sometimes interfered with my ability to be fully present with clients. There have been sessions where a client's story activated my own pain so intensely that I left the room feeling overwhelmed, later engaging in risky behaviors to cope, returning to suicidal thoughts, or isolating in my office or home and crying myself to sleep. These reactions were not abstract case examples; they were my lived responses to holding other people's trauma without enough support. Thanks to employment benefits and supportive friends, therapists, and supervisors, I am now actively working through my trauma and learning to recognize early warning signs, so that my history does not prevent me from doing my job to help and reach others.

Service Provision and Professional Support

Federal, state, and local health departments often encourage community-based organizations to recruit staff from the target population to implement evidence-based interventions with their peers. For example, to modify maladaptive behaviors and educate communities, the Centers for Disease Control and Prevention (2024) have diffused several evidence-based interventions to community-based organizations in which BMSM professionals and paraprofessionals provide services to other BMSM. Two widely used group- and individual-level interventions are Many Men, Many Voices (3MV) and CLEAR (Choose Life, Empowerment, Action, and Results), which are designed for MSM, including Black MSM (Carter & Flores, 2019). In many settings, these interventions are delivered by paraprofessionals and peer workers who come from the same communities they serve and thus share many of the same risks and stressors. If these tools are to be effective, the providers using them must be appropriately trained, supported, and supervised, not only to deliver the interventions with fidelity but also to protect their own well-being.

In Jackson, Mississippi, which is ranked among the highest cities in the United States for new HIV diagnoses, several community-based initiatives have been implemented to educate BMSM about HIV prevention (Burns et al., 2020). One such initiative is Connect with Us (CWU), which employs BMSM "ambassadors" drawn from the local community (Burns et al., 2020). These CWU ambassadors play the role of outreach, educating and informing BMSM about HIV prevention and care and providing resources to effectively reduce risk behaviors. What makes this program unique is the training ambassadors receive in HIV prevention, which includes but is not limited to safer sex practices, health literacy, and pre-exposure prophylaxis (PrEP) adherence (Burns et al., 2020). Through these training sessions, ambassadors gain confidence in delivering HIV prevention education and in using their lived experience to connect with peers. At the same time, they shoulder the weight of listening to and holding the trauma, fear, and stigma that their peers disclose.

Having multiple college degrees and two clinical licenses, I understand why local and national certification and regulation boards require counselors to complete a minimum number of continuing education credits, even after completing years of clinical internship hours and supervised practice. Clients or patients can trigger or re-traumatize a counselor, professional boundaries can be crossed, and, without support, a clinician may engage in unhealthy behaviors to cope. Continuous training and monitoring offer planned opportunities to work with such experiences, acquire new competencies, and protect clients and providers. Such formal training and supervision are not typical of paraprofessionals and peer workers, despite their frequent presumption of being called upon to navigate the same trauma-filled conversations with clients.

Consequences of Insufficient Support or Training

The models used in clinical supervision of paraprofessionals and peer workers can be based on three fundamental functions: the promotion of ethical and competent practice (normative), skill development (formative), and support of the emotional well-being of the worker (restorative). Restorative and culturally responsive supervision is essential to BMSM paraprofessionals. The supervisors must be clinically trained in mental health or social work, in working with queer and trans communities of color, and with demonstrated anti-racist, trauma-informed practice (Kemp et al., 2019; Morse et al., 2020; Xiong et al., 2019). Supervision that addresses all three functions can assist paraprofessionals in navigating complicated client situations without compromising their health.

Adequate supervision of BMSM paraprofessionals in practical terms would involve having weekly or bi-weekly individual or group supervision by a licensed clinician. These sessions would allow systematic processing of vicarious trauma and of countertransference, role-playing of awkward interactions, and ethical questions. The sessions would also lay stress on the distinction between personal and professional roles, allowing the workers to discuss the experiences of racialized and homophobic individuals in the workplace and the community (Kemp et al., 2019; Kim et al., 2022; Rabie et al., 2023). Such supervision is not a luxury; it is a necessary condition for paraprofessionals to sustain themselves emotionally while they provide life-saving information and support to their peers.

I first began to recognize the problem of inadequate training and support for BMSM paraprofessionals while attending the 2008 annual National African American MSM Leadership Conference on HIV/AIDS and Other Health Disparities (NAESM). During a community forum, a colleague asked the group, “How can I help my community when I am still dealing with my shit?” At the time, I experienced his question as odd and even inappropriate, but it stayed with me. Over the years, I heard variations of that same question from different colleagues at different venues and, each year, at the NAESM conference. It began to feel as though my community was calling out into an empty void for help. That recurring question forced me to reflect on the quality of my own risk-reduction training and on the trajectories of colleagues who had either died or left the public health field.

When I started my public health journey, many of my colleagues, if not all, were not living with HIV, did not have substance use disorder diagnoses, and were in healthy relationships. As the years passed and we began providing intensive risk-reduction counseling and implementing evidence-based interventions designed to modify the target population’s behavior and increase awareness, I watched my colleagues’ well-being decline. I observed Black and Brown, same-gender-loving paraprofessionals undergoing hardship in my day-to-day work as they lacked sufficient clinical support or supervision. They were employed due to their origin, being part of the same communities and identities as the clients we served, yet they received little training and practically no long-term room to process the trauma they were observing and experiencing.

In my own life, I have tried to engage in a journey of self-care alongside my professional growth, even as I have watched my colleagues struggle. I have seen Black and Brown, same-gender-loving colleagues work tirelessly to implement group-level, evidence-based interventions for at-risk communities while silently carrying their own unresolved trauma. I have witnessed colleagues who spread HIV prevention knowledge seroconvert—test positive for HIV—without the support needed to process their experiences. I have spent hours on the phone listening to colleagues describe intimate partner violence and substance misuse in their own lives. Same-gender-loving men experience higher rates of intimate partner violence than heterosexual individuals, and these experiences can have lasting effects (Chen et al., 2020). I have sat at large conference tables with empty chairs where friends once sat with me to champion HIV policy; some of those chairs are now empty because colleagues burned out and left the field, and others because colleagues died.

As a participant at national conferences populated with Black and Brown MSM professionals, I have repeatedly observed colleagues share, in group settings, their concerns about providing clinical services or facilitating group-level conversations among MSM while carrying unresolved childhood and adult trauma. In these spaces, paraprofessionals described how certain topics in group or individual sessions triggered them, leading them to shift internally from the role of clinician to the role of client. The similarity in their stories was not in their deficiency of commitment or empathy; the difference was in their deficiency of proper training and supervision. Most paraprofessionals said they had only a few days of training before they were left to begin facilitating groups and giving counseling without either any continuity in clinical supervision or even consultation with a supervisor who was licensed. This puts group participants at risk of no life-saving information and paraprofessionals at risk of additional psychological damage.

Listening to these testimonies got me to think critically about the way I prepare. Fifteen years after I started my career in public health, I still recall that I pursued so-called “moderately intense” courses in risk-reduction counseling, specifically designed to equip me with the knowledge of how to decrease the spread of HIV in marginalized and vulnerable groups. In reality, the training lasted no more than three business days and ended with an exam that I was essentially guaranteed to pass because the instructor provided the correct answer to every question. At the time, this felt too good to be true. Looking back, I can see how my colleagues and I would have benefitted from being held accountable for our mistakes on that exam, from being required to retake the course if we scored below a reasonable threshold, and from having some form of follow-up to ensure that we were applying the information correctly and not being re-traumatized by clients’ disclosures. In many ways, it felt as if the health department had sent us, as risk-reduction counselors, out as sheep to a pack of wolves.

I am concerned that different regions of the United States continue this trend of putting a vulnerable community at further risk even as funding is allocated to address HIV. What is happening in the Southern region of the country is one example of poor planning. The Southern states account for approximately 38 percent of the U.S. population but 50 percent of new HIV diagnoses (Moore et al., 2019). Studies have shown that racial disparities in HIV treatment and prevention are driven by factors such as delayed access to care, mistrust of providers, and stigma and discrimination associated with being MSM (Sullivan et al., 2021). In my visits to many Southern community-based organizations, I have seen the same mistakes that were made on the East Coast in the 1990s: Organizations hire community members to do HIV prevention and counseling but fail to invest in meaningful training and supervision. It is not that training is unavailable—for example, Jackson, Mississippi, has programs that offer substantial HIV prevention training—but that organizations and health departments do not always acknowledge the need for comprehensive training or prioritize the resources required to provide it (Burns et al., 2020; Carter & Flores, 2019).

Addressing disparities in the HIV epidemic in the United States requires more than increased funding. While additional dollars directed toward education in Black and Brown MSM communities are helpful, it is even more important to address long-standing structural racism—systemic, institutional, and procedural—which shapes who receives care and who is supported to provide it (Bailey et al., 2017). One of the steps that should be taken towards equity is to make sure that Black and Brown MSM paraprofessionals are properly trained, clinically supervised, and emotionally supported. In order to maximize the possibility of eliminating the HIV epidemic in the United States, a multifactorial intervention is required that considers the social, cultural, economic, and environmental factors leading to the transmission of HIV (Bailey et al., 2017; Burns et al., 2020; Carter & Flores, 2019; Moore et al., 2019; Sullivan et al., 2021). Research and program design, partnerships with other community members to learn more about target populations, and holistic approaches can all be helpful in solving these social and structural factors. But, unless these discussions and findings find their way to the relevant policymakers, my community will continue to be in danger of continued inequity.

Recommendations

I intend to use this essay not only to enhance practices in HIV prevention but also to enhance how clinical services can be designed so that Black and Brown paraprofessionals who work with Black and Brown MSM will have the means and resources necessary to deliver quality services in a safe way. Paraprofessional supervision may be based on integrated clinical models of supervision that provide a balance between competency building and emotional support. In particular, supervisors may find success in reflective supervision methods, which focus on the feelings and reactions of their workers alongside the typical case analysis and support in ethical judgement seen by most. Particularly when paraprofessionals identify themselves with their clients—and especially when the work done with those clients is directly related to said identity, as it is in many cases for BMSM workers—the border between personal and professional experience may fade.

The use of BMSM paraprofessionals by organizations creates an ethical duty to incorporate supervision and support within programs. This duty is achieved by paying paraprofessionals back time in supervision, offering benefits which include mental health care access, and by fostering a culture where it is not stigmatized by staff to seek help. Agencies can provide routine debriefing rooms following hard groups or sessions, guard against the move to reschedule supervision time to meet the demand of productivity, and ensure that policies acknowledge the compound effect of vicarious trauma and structural racism on the staff.

Supervisors for BMSM paraprofessionals should meet clear qualifications. Ideally, they should hold a clinical license in counseling, social work, psychology, or a related field; have substantive experience working with BMSM and other LGBTQIA+ communities of color; demonstrate cultural humility and anti-racist practice; and be trained to recognize and respond to vicarious trauma, burnout, and compassion fatigue among staff. My own ability to seek therapy, consult with supervisors, and access benefits has helped me remain in this work, but many of my peers never had this level of support. When supervisors lack these qualifications, paraprofessionals are left to manage intense clinical situations with little guidance and no safety net.

Supervision for paraprofessionals should be regular, predictable, and focused. At a minimum, BMSM paraprofessionals should have weekly or biweekly individual or group supervision with a licensed clinician. These sessions should include time to process vicarious trauma; discuss countertransference and emotional reactions to clients; role-play difficult conversations (e.g., HIV status, intimate partner violence, sex work); and review ethical dilemmas and boundary issues. Supervision should also explicitly address the challenges of working in communities where staff and clients share racialized and homophobic experiences. Clear boundaries between personal and professional roles should be discussed and revisited, with supervisors helping staff recognize when they are slipping from the role of helper into the role of unacknowledged client.

Training cannot be a one-time event. Paraprofessionals should receive extensive initial training and ongoing continuing education in areas such as trauma-informed care, cultural humility, sexual and gender diversity, HIV prevention and treatment, and intimate partner violence. Funders can play a powerful role by requiring, in requests for proposals, that agencies seeking support demonstrate how they will provide clinical supervision and emotional support for staff, offer monthly support groups or reflective practice groups, and ensure that paraprofessionals complete a meaningful number of continuing education hours each year to maintain their competence. Funding streams should recognize that supervision time, consultation, and staff development are core program components, not optional add-ons.

Closing Reflection and Call to Action

The myth that having a high level of education or being in the position of leadership removes one’s childhood or multi-faceted trauma is dangerous. Trauma shows up differently in each of us. Many of my colleagues eventually moved into supervisory positions and managed staff and grant-funded programs, yet our own trauma remained unaddressed. After statewide retreats, we would gather and consume large amounts of alcohol, talking about everything in our lives except what had happened in the retreat rooms. We did not discuss the client who broke down after disclosing abuse, the fight we had to break up between romantic partners, or the moment someone revealed that he had exchanged sex for a warm bed. Instead, some of my friends snorted cocaine or inhaled marijuana to cope, rather than processing what these stories stirred up in them. To talk about what happened in the group would have been to risk revealing our own unresolved traumatic pasts. Yes, we are gay men. Yes, we are same-gender-loving men. But we are also men who were raised to believe that men do not show emotions or weakness, and we carried forward the rule that governed so many Black and Brown homes: What happened in our houses stayed in our houses.

Growing up, that rule kept me silent about the violence and pain in my own family. As an adult paraprofessional and clinician, I now see how that culture of secrecy can keep both clients and counselors quiet about their suffering. My hope is that organizations will refuse to send paraprofessionals out as sheep to a pack of wolves and will instead invest in supervision, training, and support that honor our communities and protect those doing the work. Only then can Black and Brown MSM paraprofessionals offer the care our communities deserve without sacrificing their own well-being in the process.

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From Student to Educator: A Social Worker’s Journey with Self-Disclosure

Bethany Wallace

Abstract: The use of self-disclosure in social work remains controversial despite the growing theoretical and empirical evidence that engaging individuals with lived experience is fundamental to providing equitable and inclusive services. Within mental health services, social workers (and other helping professionals) appear particularly reluctant to engage in the practice due to stigma and fear of professional ramifications. This is further compounded by limited research and guidance on the risks and benefits of self-disclosure. Using a personal narrative covering my journey with self-disclosure as a social worker, this paper explores gaps in social work education and supervision related to lived experience and the resulting implications for social workers and service users. Recommendations for creating a culture of self-disclosure—including the role of social work education, practicum, and supervision—are discussed.

Keywords**:** social work education, field education, practicum, lived experience, supervision

Introduction

Despite the growing evidence that engaging individuals with lived experience is fundamental for providing equitable and inclusive services (Fox, 2022; Mackay, 2023; Szczygiel, 2021), using self-disclosure in social work, particularly clinical social work, remains controversial. Literature indicates that most social workers and mental health professionals hesitate to self-disclose their personal experiences due to stigma and fear of professional consequences (e.g., Byrne et al., 2022; Campbell, 2018; Dunlop et al., 2022; Knight, 2014; Mackay, 2023; Szczygiel, 2021). This reluctance is further exacerbated by the gaps in research on the risks and benefits of self-disclosure and the need for more guidance on how to use self-disclosure and supervision effectively (Dunlop et al., 2022; Mackay, 2023; O’Neill & Del Mar Farina, 2018; Roulston et al., 2022). In this narrative, I will share my journey of self-disclosure as a social work student, practitioner, and educator. I aim to explore the gaps in social work education and supervision related to lived experience and the implications for social workers and service users. Finally, I will provide recommendations for creating a culture of self-disclosure, including the role of social work education, practicum, and supervision.

Definitions

The terms *self-disclosure* and *lived experience* will be used interchangeably throughout this narrative, though their meanings slightly differ. A review of the current literature provides various definitions for *self-disclosure* that all boil down to sharing personal information with clients, typically in a therapeutic setting (Byrne et al., 2022; Campbell, 2018; Dunlop et al., 2022; Knight, 2014). However, for this paper, *self-disclosure* is broadened to include sharing personal information in any social work setting (e.g., with clients, colleagues, professors), not just therapy. Though the term *lived experience* is not as well-defined in the literature (Mcintosh & Wright, 2019), the following definition is an accurate reflection of its meaning: “the things that someone has experienced themselves, especially when these give the person a knowledge or understanding that people who have only heard about such experiences do not have" (Cambridge, n.d., Definition 1).

Likewise, the terms *field* and *practicum* will be used interchangeably with *internship*. On its career center webpage, the University of Maryland, Baltimore County (n.d.) defines an *internship* as "a professional learning experience that offers meaningful, practical work related to a student's field of study or career interest" (para. 1). *Field education*, specific to social work education, is defined as "the signature pedagogy for social work … [teaching] future practitioners the fundamental dimensions of professional work in their discipline: to think, to perform, and to act intentionally, ethically, and with integrity" (Commission on Accreditation [COA] & Commission on Educational Policy [CEOP], 2022, p. 20). However, many schools of social work are replacing the term *field* with *practicum* as it "supports anti-racist social work practice by replacing language that could be considered anti-Black or anti-immigrant in favor of inclusive language" (Heyward, 2023, para. 3). Thus, *practicum* will be used in place of *field* throughout this paper.

My Story

Based on my personal and professional experiences, I was certain that pursuing a Master of Social Work (MSW) degree was the right path for me. I knew I wanted to work with children and youth who had experienced trauma. I wanted to be someone who understood what they were going through and believed their words. I wanted to be a person in their life who could hear their story and walk alongside them rather than recoil. I wanted to be the person I did not have growing up. While applying to social work programs, I openly shared these aspirations and was awarded a child welfare fellowship based on my disclosure. However, I was quickly discouraged from sharing this information during my master's program.

During my first internship at a children's hospital, I was faced with a case involving a severely abused toddler in critical condition. While I worked with the social work team, medical staff, and law enforcement to perform safety assessments and interviews, the child tragically passed away. As I continued to work with my practicum supervisors on the next steps, they began questioning why I was not having a more emotional response to the situation. I realized I was expected to cry or fall apart from an understandably shocking experience, especially given that I was beginning my internship. While I explained how my personal experiences of abuse and work with traumatized youth had prepared me to cope with these situations, my supervisors remained skeptical. Over the next couple of weeks, my practicum supervisors and other prominent medical team members began asking specific questions about my traumatic experiences. While I thought these interactions would strengthen my credibility and build relationships with my practicum supervisors and medical team, they ultimately led to the termination of my internship. I was informed by my school that, given my history of childhood trauma, particularly sexual abuse, the hospital determined it was inappropriate for me to intern on their unit. Additionally, they expressed concern that I was "exhibiting symptoms of post-traumatic stress disorder," such as "disassociating" and "oversharing" the details of my trauma, further indicating I should not work with vulnerable populations. However, my practicum supervisors never brought these concerns to my attention, and I was never provided an opportunity to discuss them.

Culture of Non-Disclosure

Looking back at my master's program, I don't remember being explicitly taught about self-disclosure. However, I learned through my experiences in practicum and classes that sharing my childhood trauma could impact my ability to graduate and pursue a career in social work. This message was reinforced as I progressed through my program; my classes emphasized the importance of maintaining professionalism and refraining from revealing personal aspects of myself to clients. I remained silent as professors and students debated theories on trauma and analyzed case studies of children who had experienced abuse and neglect. I frequently felt exposed as my peers scrutinized and dissected case studies that mirrored my own experiences, often describing the circumstances as "unimaginable." Discussions about how victims of abuse frequently go on to abuse others perpetuated my stigma surrounding being a wounded healer (Byrne et al., 2022; Mackay, 2023) as described below. Over time, these experiences wore me down, leading to internalized messages of being an outsider, abnormal, and broken.

Despite the overwhelming evidence that social workers are drawn to the profession based on their lived experiences, the use of self-disclosure remains divisive. Central to this controversy are inconsistent beliefs about ethics and professionalism, particularly as it relates to boundaries with clients (Campbell, 2018; Dunlop et al., 2022; Szczygiel, 2021). Traditional psychodynamic theories discourage therapists from sharing personal information because they believe maintaining neutrality is essential for clients to make therapeutic gains (Byrne et al., 2022; Knight, 2014; Mackay, 2023; O'Neill & Del Mar Farina, 2018). From this perspective, self-disclosure can be considered unprofessional, unethical, or potentially harmful to clients. However, this viewpoint often stems from the stereotype of the wounded healer, which suggests that individuals with trauma, mental health issues, or substance use problems are dangerous, incompetent, and motivated by self-healing interests (Byrne et al., 2022; Mackay, 2023).

On the other hand, interactional, relational, and attachment theories highlight the importance of transparency and authenticity in forming therapeutic connections and fostering client transformation (Knight, 2014; Mackay, 2023; O'Neill & Del Mar Farina, 2018). From this perspective, self-disclosure is seen as a therapeutic technique used to normalize and validate client experiences. However, there are varying thoughts on what information the therapist *should* disclose (Byrne et al., 2022; Dunlop et al., 2022; Knight, 2014; Mackay, 2023), leaving room for individual interpretation. Still, none of these theories consider the additional structural and sociocultural factors that impact social workers, their clients, and the therapeutic relationship (O'Neill & Del Mar Farina, 2018).

Given the limited guidance on how to utilize self-disclosure in an educational, professional, or supervisory environment (O'Neill & Del Mar Farina, 2018; Szczygiel, 2021), many professionals are hesitant to share their lived experiences due to concerns about being perceived as incompetent or a risk to clients, which could lead to professional repercussions (Byrne et al., 2022; Dunlop et al., 2022; Knight, 2014; Mackay, 2023). This creates barriers for social workers and other helping professionals to seek consultation or supervision, perpetuating a "culture of non-disclosure" (Byrne et al., 2022, p. 10). This culture, often established and reinforced at the systemic level, contributes to the stigma around mental health and trauma (Byrne et al., 2022; Dunlop et al., 2022; Knight, 2014; Mackay, 2023).

Implications for Social Work Practice

Although I obtained a new internship and graduated with my MSW, the stigma of my disclosure remained. I chose not to discuss the termination from my internship or include the experience on my resume. When I was hired as a therapist at a children's psychiatric residential facility, I was careful not to share any information that might hint at having a traumatic past. Yet, as a new clinical social worker, I faced the daunting challenge of building genuine connections with traumatized youth and felt ill-prepared. Initially, I conducted therapy sessions strictly "by the book," but I struggled to connect with clients and find my voice as a clinician. However, over time, I discovered that being genuine with my clients made connecting easier, resulting in more therapeutic progress. However, as youth courageously shared their stories of pain and suffering, I found it increasingly challenging to deflect their questions about my own experiences and to witness their uncertainty about my ability to comprehend what they were experiencing. Hence, I found myself leaning toward self-disclosure as a more authentic approach to therapy. Eventually, I perfected "disclosing without disclosing," which Byrne et al. (2022) describe as "coming to terms with one's own experience enough to draw upon it without interfering in the therapeutic work" (p. 10). Typically, this looked like comparing a client's experiences to those of "others I have worked with" while referring to my own lived experiences.

Like many social workers (Byrne et al., 2022; Campbell, 2018; Dunlop et al., 2022; Knight, 2014; Mackay, 2023; Szczygiel, 2021), due to the culture of non-disclosure, I was reluctant to consult with my supervisors and peers regarding my use of lived experience with clients. Yet, given the lack of research and guidance on preparing professionals to use self-disclosure (Byrne et al., 2022; Dunlop et al., 2022; Knight, 2014; Mackay, 2023; O'Neill & Del Mar Farina, 2018), they likely wouldn't have had the necessary knowledge to support me even if I had. Moreover, the ethical guidelines concerning self-disclosure are ambiguous and rely on the clinician's personal judgment (Dunlop et al., 2022). Therefore, more research, guidance, and training on effectively utilizing lived experience are needed to support faculty, students, supervisors, and practicing social workers.

Creating a Culture of Self-Disclosure

The standards for social work education have undeniably improved since I completed my master's program over a decade ago. However, the negative impact of sharing my trauma during my master's program has continued to influence my social work practice as a clinician, supervisor, educator, and student. The Council for Social Work Education requires that accredited social work programs recognize the crucial role of the learning environment in teaching students about the significance and meaning of cultural humility and of anti-racism, diversity, equity, and inclusion (COA & CEOP, 2022). Integrating lived experience into the social work curriculum fosters an inclusive and diverse environment by acknowledging the value and validity of experiential knowledge and allows students to challenge their unconscious biases (Campbell, 2018; Fox, 2022; Mackay, 2023; Szczygiel, 2021). Moreover, encouraging opportunities for self-disclosure and critical conversations among students helps them connect theory and coursework to those with lived experience, promoting self-awareness and reflexivity (Byrne et al., 2022; Campbell, 2018; Fox, 2022; O'Neill & Del Mar Farina, 2018; Szczygiel, 2021).

Implications for Social Work Practice

Creating a culture of disclosure in social work education does not necessitate a specialized curriculum but rather an inclusive environment for exploration and learning (Byrne et al., 2022; Szczygiel, 2021). Sharing of lived experiences by both faculty and students provides opportunities to engage in anti-oppressive practice and is in alignment with the EPAS requirement of "fostering an equitable and inclusive learning environment by facilitating important ADEI [anti-racism, diversity, equity, and inclusion] discourse" (COA & COEP, 2022, p. 16). By integrating theory, evidence-based practices, and the code of ethics into discussions of lived experience, social work educators can reduce stigma and increase student self-awareness and insight (Campbell, 2018; Knight, 2014; Szczygiel, 2021).

Self-disclosure is grounded in theoretical and evidence-based practices and aligns with social work values. According to the National Association of Social Workers (2021):

> The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. (Preamble section, para. 1)

Person-centered and humanistic theories support this mission, encouraging transparency and authenticity to build a therapeutic alliance and promote client growth (Dunlop et al., 2022; Knight, 2014). Similarly, attachment and relational theories value the therapist-client relationship as a working alliance built on mutuality and trust (Dunlop et al., 2022; Knight, 2014; O'Neill & Del Mar Farina, 2018; Szczygiel, 2021). Feminist theorists further encourage disclosure to disrupt power dynamics and empower self-determination (Dunlop et al., 2022; Knight, 2014). Lastly, psychotherapies that are rooted in these theories, such as Attachment-Based Therapy, Dialectical Behavior Therapy, and Narrative Therapy, rely on the therapist's disclosure of thoughts, feelings, and emotions to build authentic connections with clients (Dunlop et al., 2022; Knight, 2014).

As previously mentioned, conflicting opinions of ethics, professionalism, and boundaries are central to the self-disclosure debate. Therefore, addressing these concepts within an anti-oppressive framework provides opportunities to explore how systems of power and oppression influence these beliefs (COA & COEP, 2022; Mackay, 2023; Szczygiel, 2021). This framework shifts the discussion from whether social workers should engage in self-disclosure to what kinds of self-disclosure support the well-being of the social worker, their colleagues, and the clients and communities they serve (Szczygiel, 2021). Additionally, through parallel processing, students who engage in self-disclosure receive valuable feedback and validation while the rest of the group expands their understanding of others' lived experiences (Campbell, 2018; Fox, 2022; Szczygiel, 2021).

Allowing space for students to bring their whole selves into the classroom leads to deeper discussions and more comprehensive learning (Szczygiel, 2021). Through self-disclosure of my experiences, I have found that students are more likely to share their identities and experiences as well. This creates an inclusive learning environment that respects diverse perspectives, experiences, and values (Dunlop et al., 2022; Fox, 2022; Mackay, 2023; Szczygiel, 2021). I have found this to be especially true in practicum seminars, when students are in their practice placements and wrestling with how their identities, lived experiences, and values intersect with the realities of social work practice.

Practicum Education

Practicum education helps students integrate social work theory and skills into a real-world setting under the guidance of a professional social worker (COA & CEOP, 2022). Practicum placements offer students the chance to work with different groups of people, learn various roles and skills, understand different service delivery models, practice culturally responsive approaches, and engage in policy advocacy (Portland State University, n.d.). Additionally, the relationship between students and their practicum supervisors can also benefit the supervisor's professional development and contribute to the advancement of the social work profession. Therefore, practicum education plays a crucial role in changing the culture of non-disclosure.

Literature supports the notion that practicum placements are the best place for students to learn and engage in self-disclosure (e.g., Campbell, 2018; Dunlop et al., 2022; Knight, 2014; Mackay, 2023; Szczygiel, 2021); however, the same literature indicates that, given the lack of research, guidance, and stigma surrounding self-disclosure, practicum supervisors are unlikely to have the necessary knowledge, training, or tools to support students in this process. Moreover, the hierarchical and evaluative nature of the student-practicum supervisor relationship adds additional complexity to the power dynamics inherent in social work supervision (O'Neill & Del Mar Farina, 2018; Roulston et al., 2022). Research indicates that these dynamics often cause supervisees to refrain from discussing personal feelings and reactions during supervision (e.g., Byrne et al., 2022; Dunlop et al., 2022; Knight, 2014; Mackay, 2023). Therefore, emphasis must be placed on fostering inclusive and supportive practicum supervision, including targeted learning objectives and training on self-disclosure (Dunlop et al., 2022; Knight, 2014; Mackay, 2023; O'Neill & Del Mar Farina, 2018; Roulston et al., 2022).

Explicit Learning Objectives. In their study of students' attitudes toward engagement in self-disclosure, Knight (2014) identified five learning objectives for guiding conversations of self-disclosure with students that could be incorporated into seminar assignments and practicum supervision:

> (1) Articulate the major theoretical perspectives that address self-disclosure; (2) identify and discuss the impact that clients have on [your] reactions; (3) develop strategies for managing [your] reactions; (4) critically examine [your] professional use of self-disclosure; (5) identify different types of self-disclosure and indications and contraindications for their use with different clients. (p. 177)

Training. Given the need for more research and education on self-disclosure, practicum education programs should also offer ongoing training for practicum supervisors on the theoretical and evidence-based principles of integrating lived experience into practice. This training should also cover how to address structural and interpersonal power dynamics in supervision. Some potential training models to consider are the following:

Sharing Lived Experiences Framework (SLEF). SLEF was created by a collaborative group of academics, clinicians, and service users in the United Kingdom and provides a framework for deciding when and how to use self-disclosure across social work disciplines (Dunlop et al., 2022). The SLEF spans the disclosure process from pre-disclosure to disclosure to post-disclosure reflection, emphasizing the importance of supervision and self-reflection. The SLEF also provides a roadmap for six areas of consideration for disclosure, including preparedness, confidence, competence, relevance, comfort, and supervision (Dunlop et al., 2022).

Critical Conversations (CC) Model. While initially developed for social work classrooms, the CC model has been expanded and tested in practicum education and supervision (O'Neill & Del Mar Farina, 2018). The CC model offers a framework to identify and analyze the supervisory relationship's structural and interpersonal power dynamics. The framework assists participants in addressing obstacles in the supervisory relationship while fostering a deeper understanding of power, privilege, and structural inequities within the supervisory triad (supervisor, student, client). The model provides a structure to facilitate these critical conversations, enabling participants to recognize, reflect on, label, and discuss social justice issues and power dynamics that affect the supervisory relationship (O'Neill & Del Mar Farina, 2018).

Conclusion

Self-disclosure in social work, particularly clinical social work, is a divisive topic. Many social workers hesitate to share their lived experiences due to concerns about being seen as incompetent, unethical, or potentially harmful to clients. The lack of research, education, and training on the potential risks and benefits of self-disclosure, as well as its effective use in supervision, exacerbates this issue. Through my narrative and review of existing literature, I have shown that social work education plays a crucial role in changing the culture of non-disclosure. Integrating lived experiences into the social work curriculum promotes inclusivity and diversity and encourages the examination of power dynamics and discriminatory beliefs that contribute to the culture of non-disclosure.

Providing targeted training for practicum supervisors and having clear learning objectives for integrating lived experience into practicum education is essential to disrupting our profession's non-disclosure culture. This will help create an inclusive learning environment within practicum settings, where students and supervisors can openly discuss their experiences and provide opportunities to practice ethical self-disclosure. By challenging the culture of non-disclosure in social work education, social work programs can also begin to tackle the issue of insufficient research and guidance on effectively using supervision and lived experience. This can help reduce the stigma around mental health and trauma and promote equity—both within the profession and for the individuals we serve.

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Reaching Out of the Abyss: A Reflection on an Animal-Assisted Crisis Response Deployment

Batya G. Jaffe

Abstract: In the wake of crises and disasters, Animal-Assisted Crisis Response (AACR) is an innovative intervention that provides comfort and support to survivors and bystanders. This article recounts the palpable and gratifying contributions of AACR in the aftermath of a tragedy, and a crisis scene in a city in Israel demonstrates the support that can be provided through this AACR handler and her dog.

***Keywords*:** Animal-Assisted Crisis Response, animal-assisted interventions, human-animal relations, trauma

The following recollection shares how a normal day looks for an Animal-Assisted Crisis Responder while responding to abnormal circumstances, treating in an abnormal scene, with abnormal pain. Details of the event have been omitted and/or adjusted in order to protect the privacy of those involved.

It's 8:30 p.m. I just finished putting my four amazing and mischievous girls to sleep. Separated in two rooms, I had to conquer them while they were trying to conquer me. There is nothing like looking at them while they are finally sleeping calmly. I head over to my room, exhausted, and look at my phone. There is a new dispatch from the Psychotrauma Unit. I volunteer in the Psychotrauma Unit of United Hatzalah, a non-profit organization in Israel that is motivated by saving lives during crises, similar to the Red Cross. *Psychotrauma* arises as an outcome of traumatic events that may involve witnessing severe injuries to themselves or others and presents a threat to physical or psychological integrity (Vitzthum et al., 2009). The Psychotrauma Unit provides Psychological First Aid (PFA) to those at the scene of a crisis (United Hatzalah, n.d.). PFA is an initial disaster response intervention provided by mental health professionals and first responders (Jacobs & Meyer, 2006). Its goal is to promote safety and stability to disaster survivors, as well as to connect the affected individuals with help from the community and to provide them with resources in the aftermath of a disaster (Ruzek et al., 2007).

Inside of the Psychotrauma Unit, I belong to a specialized division: the Animal-Assisted Crisis Response (AACR) Unit. It is composed of trained human-animal teams that provide support and comfort to individuals affected by crises and disasters (Eaton-Stull & Flynn, 2015). In the U.S., this intervention can be seen through HOPE AACR (https://www.hopeaacr.org). HOPE is a non-profit organization dedicated to giving comfort and emotional support in crises through specially trained dogs and their handlers (HOPE AACR, n.d.). I respond to crisis calls with Lucy, my wonderful canine partner. Lucy is a Cavalier King Charles Spaniel, and she is a certified therapy dog with extensive training, experience, and certifications in crisis response across Israel and the U.S. My professional experience comes from background in animal-assisted therapy, an MSW and PhD in social work focused on AACR in Israel, and ten years of volunteering in the Psychotrauma Unit of United Hatzalah with Lucy.

I look back at my phone—the alert message I have received is describing a situation in which a young mother has passed away, and it clarifies that not all the family members have arrived yet. The Psychotrauma Unit wants an AACR response team on-scene to provide mental health support for the family and neighbors. Even though I imagined that the day was over and that I was on my way to bed to watch a Netflix movie, I gather my strength and decide to deploy. I grab my gear, my United Hatzalah vest, and Lucy's matching vest as well. Lucy sees the vest and enthusiastically jumps over to the door. She loves her work, as I do. It is our mutual passion.

I report the dispatch to the United Hatzalah Hotline, and I drive to the scene of the crisis. It's always hard to drive to a scene, but as a young mother myself, my thoughts are on the young mother that just passed away. I pass the streets that I know so well, and everything seems so calm outside, like the atmosphere of a regular evening, but I know that at the end of the road, things are not so simple and calm anymore. A crisis is unfolding, and I am on my way to it.

It is difficult to get close to the scene by car. The whole street is full of first responders, including ambulances and lots of police cars. The scene is full of blue and red lights and radio chatter. So, I park my gray Renault a block away, and we start walking. I get a cold breeze that reaches into my spine, and Lucy shakes, nervous and excited at the same time. I see tons of people in the street, the different vest colors of first responders, neighbors, and other curious folk eyeing the scene inquisitively. It is night, and uncomfortably cold out, and the many vehicles' lights render the scene even more unpleasant, along with the crowds gathered in different circles.

The whole scene is happening in the context of the COVID-19 crisis disrupting society at full force, and everyone is concerned with the possibility of infection. First responders especially fear that exposure to the virus may put their lives at risk (McAlearney et al., 2022). Nevertheless, people are outside wandering around on a cold and dark evening, supplementing the atmosphere with a feeling of confusion and unsettledness.

Protocol states that when arriving at a scene, the first thing to do is to check in with the Psychotrauma responders that are already there. As they have the information, they can debrief and explain to me where I am most needed (Vernberg, et al., 2008). This time, I don't get a chance to do that. Instead, I hear someone yelling, "Psychotrauma Unit needed here! Please!"

I approach the distressed individual with Lucy. They explain that the teenage brother of the young mother who passed is being questioned by a police officer. They say the brother was the only one with her when she passed, and he had unsuccessfully tried to resuscitate her with CPR. This is the moment when the adrenaline kicks in, all the senses are sharpened, and Lucy and I start working. I am on my way to the brother, but someone else calls to me: "We need your help here!"

I am feeling increasingly tense and overwhelmed. I feel confused— things are not clear. I am unsure who is in more urgent need of help. Making a call in the moment, I continue heading in the direction of the teenage brother. I see the brother in front of a police officer, both in the middle of the street, sitting in folding chairs. I believe I understand what is happening and where I am needed. Lucy initially agrees to go in that direction, but she senses something different and walks to the police officer questioning the brother instead. “So, tell me. How come you were alone with your sister when it all happened?” she asks as Lucy approaches.

I do not want to interfere with the police officer’s job, so I try to redirect Lucy to the brother. The brother, however, shows no interest, unlike the police officer, who reaches out to pet Lucy. Lucy goes in between the officer’s legs. The officer starts crying, hugs Lucy, and says, “I need her here with me for this.” Right now, the officer is the one in need of support. She is performing a terribly harsh task, and she is looking for the strength to do so. By briefly distracting the officer amid heavy stress that threatens her working capacity, Lucy does more than give simple comfort: She provides a break in the tension, an opportunity to express grief, and, ultimately, the power the officer needs to continue doing her job (Smith-Forbes et al., 2014).

“I was the one in charge of my sister while my parents were running some errands,” the brother says. “Her husband is a firefighter, and he was at work.” I can see that he feels guilty, but he doesn’t want to be reached out to, not yet. On the other hand, the police officer resumes the questioning while holding Lucy in her arms: “Okay, so then what happened? Did your sister call you and say she had a problem?” The questioning continues, and we stay there to provide support to the police officer.

Just as Lucy and I finish our discussion with the police officer, the chief of police approaches me. “Thank you for being here,” he says. I gain a sense of satisfaction from the knowledge that people are using my help, and it is easy to see Lucy’s interest in helping too. We have a purpose here, and we have work to do. We have seen that after years of working in the Psychotrauma Unit, slowly but surely the various first responders at crisis scenes have started to understand our role and have learned to use our services for their benefit (Chandler, 2008). We are a resource at a trauma scene, available for whoever needs us.

“I need you to please approach the husband of the young mother. I need to understand his state of mind, how he is feeling, and if we can step in for questioning to get background on the case,” the chief explains to me.

I turn to approach the husband, and again I am asked to go elsewhere and help someone else: “I need your help here, please!” I feel as though it is a multiple casualty event. In the wake of crises and disasters, a regular day can become disrupted by numerous causalities of different levels that require immediate attention. The chaos impedes logical thoughts and challenges decision-making skills. Training and preparation for these kinds of events is essential to provide an effective response (Baker, 2007). I have not even had the opportunity to reach the Psychotrauma team leader to tell him I am present at the scene, so I message him quickly before continuing with my work. Again, Lucy and I provide assistance. We decide to approach the husband first.

The husband is sitting next to his parents and his own brother in a half-circle. They are sitting also on folding chairs next to the street, on the sidewalk. Nothing seems in place. Imagine a family just sitting together in a half-circle on a sidewalk. It's the beginning of the winter, and the scene is outdoors, and it's cold, and windy, and it's late in the evening, and it's dark. But the darkness we are concerned with is to be found indoors.

His brother bursts into uncontrollable sobbing: "I just can't believe this is happening!" he cries, and the whole family starts crying again.

His mother is overwhelmed, repeating over and over again, "I can't think, I can't think!"

The husband looks at me, with red puffy eyes, and asks, "What am I supposed to do now with a four-month-old baby?" His whole world has just collapsed; he feels destroyed, beaten up by life. As is common in crises, he repeatedly makes remarks that alternate between a sense of helplessness and of guilt (Farchi et al., 2018), guilt that he wasn't there, next to her, when his wife left this world.

I zoom out for a second and try to examine the scene as if I am not part of it. I realize there is not a dry eye on the whole street. Even the police officers are crying. Everyone is crying—some loudly, some silently, and some, like me, are happy they can hide their tears behind their masks (Gispen & Wu, 2018).

Finally, I get the opportunity to approach my team. We gather outside the house, the core of the scene, and find some privacy in the garden at its side. The team leader explains that the young woman had been treated in the hospital for an inexplicable stomachache. After she took a few trips to the hospital, her doctors decided to perform surgery. However, the surgery didn't ease her pain. This evening, while her husband was at his long shift at the fire department and her parents ran some errands, she collapsed. Her teenage brother tried his best to save her, but it was too late. That four-month-old baby girl would never see her mother again.

Now, here at the crisis scene, the Psychotrauma team leader is asked to go help the grandmother, the mother of the young woman who passed. She is inside the house, but one can hear the yelling and sobbing even from the outside and into the streets. This woman is in hysterics, and the team leader does a formidable job attending to her needs. After finding her a support friend, he leaves her in good hands. It is part of our work as PFA workers to connect the survivors of the trauma to the community resources that are available to them (Shultz & Forbes, 2014).

Patients receiving negative news from physicians have been shown to have the best emotional outcomes when family is involved in the process (Monden et al., 2017). As such, our team leader must next accompany a family member to the house just at the end of the street for another impossible task: breaking this heart-wrenching news to the ailing maternal great-grandmother. The team leader grabs his gear and goes. The list of people needing emotional support seems endless. And it keeps growing and growing.

At this point, my attention returns to the younger brother who had attempted to resuscitate the young mother. He seemed too relaxed earlier, so I decide to find a different way to "reach" him. I find another Psychotrauma responder and, together with Lucy, we return to find the brother. He is now sitting in the back of the family's white SUV, inside the trunk with the door open, unable to confront what is happening. He won't stop saying he is fine. He doesn't even connect with Lucy. I feel frustrated, but fortunately my co-responder has this wonderful ability to say what someone needs to hear when there is nothing left to say. He consoles the brother himself, then uses a tenet of the PFA protocol to provide the support he most needs: By reuniting him with his waiting friends, he restores the brother's connection to his community. It seems for a moment that there is a drop of light in this dark scene.

The police officers are not only in charge of a job at the scene, but they are also eyewitnesses to the trauma involved in the scene. They, too, are apt for the Psychotrauma Unit intervention. They are visibly broken by the difficulty of the situation, yet they are able to demonstrate an immense amount of sensitivity and empathy towards the family. They do their job without compromising the family's mental health. The neighbors are outside on the street to lend the family support, bringing hot tea, providing hugs, and comforting them with blankets. Everyone is hurting.

In a moment of clarity, the husband realizes he has not checked on the baby. He cannot see her yet but needs to know that she is being cared for. We quickly learn she is with a neighbor. The husband's mother, broken-hearted, says she cannot find the strength to take the baby now. The PFA provides eight different core actions that constitute the basic objectives of immediate assistance in the aftermath of a crisis. As part of these core actions, we offer practical immediate assistance and stabilization (National Child Traumatic Stress Network & National Center for PTSD, 2006). As such, I offer to go to the neighbor's home and check on the baby for the family.

We work as a team: My co-Psychotrauma responder stays with the husband while I go to check on the baby. This doesn't fix what happened, but it comforts the husband to know his baby girl is well. Now he can mourn and not worry about the wellness of his daughter at this delicate time. I find the baby with the neighbors. She is being loved and fed, and she even had her diaper changed. What a world. Everything is so crooked. And yet, there are sparks. Sparks of goodness and love are visible along the street. Neighbors and friends are reassuring the family that they will be there along the way, for the husband, and for the baby that will grow up without her mother.

We leave the family after we connect each mourner to a friend or family member that can care for them. The brother of the husband is no longer sobbing inconsolably. The mother of the young deceased is not in hysteria anymore, but quietly sitting in their living room, yet still not wanting visits. The mother of the husband has agreed to care for the baby and put her to sleep. The husband is still heartbroken, but he has a "village" caring for him, hugging him, both physically and in spirit.

Lucy and I now approach the police officers who remained at the scene long after they had finished their duties. They are sitting in their police car, but they are not ready to go. They seem shocked. Their windows are open, they don't have seat belts on, they seem stuck, trying to process the scene. They felt part of the scene, and now they are hurting just as everyone else is.

"It's part of the job," one police officer explains to another. "I would love to tell you that you are not going to cry or experience harsh stories, but you will. I have been in this job for 25 years and only because of stories like this I need to retire. It costs too much of my well-being."

Talking to them, I realize how traumatized they are. This incident has been a turmoil of feelings and watching a family fall apart is not easy. Imagine how it might be for the police officers to interrogate the family members. I speak with each officer. One expresses her concerns to me:

"I am new in the job," she says. "This is only my first call. I can't believe this is so tough. How am I supposed to deal with this and go back home like nothing happened?"

Another police officer, the one I heard talking when I approached, expresses her feelings as well: "We have support groups, and we have [police mental health resources] to turn to, but only the ones that were at the scene really understand how hard it is. I have had enough of seeing this suffering."

The officers cry, hug, and then cry some more. They are mad, they are sad, they are hurt. I speak to them about psychoeducation (Whitworth, 2016), I explain how it is normal to feel this way in such an abnormal situation (McManus, 2005). I explain what the next few days might look like for them, and the importance of talking about it. I also provide them with some tips that can help them recover and keep going. For tonight, our work is done.

When I get back to the car, I realize how cold I am. At the scene, my own needs had not even crossed my mind. But now, my fingers are numb from the cold, my toes are as well, and I am in urgent need of a bathroom. In my old car, I find myself again—my body and my feelings. My mind and heart had been displaced somewhere else, outside, caring for the others. I had the privilege of working next to the marvelous team of the Psychotrauma Unit that was there with me. Lucy, my dearest partner, showed her immense ability to give love to those who need her, to give hugs without having hands. Together, we were able to provide support to the family, the friends, the neighbors, and the police officers.

Lucy inspires me. Lucy doesn't see external identities; she doesn't make assumptions; she is just looking for whom to help. She will not judge someone by their age, gender, or economic status. She will not check if a person wears a uniform and then assume that person is immune to trauma. Lucy feels trauma and helps treat it. Lucy only wants to help. Lucy teaches me and others not to assume but to support, without judgment, just with love.

Going back to real life after experiencing such a scene requires us finding time to recover and practice some self-care strategies (Lee & Miller, 2018). Downing et al. (2021) recognizes the increasing relevance of self-care among social workers and other frontliner responders, especially with the added stressors of COVID-19. Without self-care strategies, one can easily develop negative consequences and indirect trauma, such as compassion fatigue, which may develop itself at the cost of caring for others and their pain (Cocker & Joss, 2016), vicarious trauma, which is also an occupational challenge by the continuous exposure to victims of trauma (Jenkins & Baird, 2022), and secondary traumatization, which arises from the knowledge of traumatizing events experienced by our peers (Bride et al., 2004). Self-care not only safeguards us against compassion fatigue, vicarious trauma, and secondary traumatization but also enables us to keep going so we are healthy and strong enough for the next call. According to Burnett and Sherman (2023), it is crucial to actively participate in meaningful self-care practices for the enhancement of personal and team resilience and well-being. Important self-care strategy for crisis responders can be mental, physical, and relationship focused (Bozym, 2023). Furthermore, a key self-care approach to mitigate the adverse impacts of compassion fatigue and vicarious traumatization involves dedicating time to enhance one's resilience capacity (Burnett & Sherman, 2023).

Sitting in the car, I give Lucy a few of her favorite treats and then she dozes into a deep sleep. I need to process a bit before I drive home. I don't like bringing all these feelings into my sanctuary. I stay in the car for a while and write about the dispatch. Writing helps me put my thoughts in order, understand them better, and release the emotional pain (Bressi & Vaden, 2017). Moreover, I like sharing my writing with my partners in the Psychotrauma Unit. They are my support system; they understand what I have been through and know to direct me better for the next crisis. But this is only the first step of my mental health self-care process. Caring for ourselves provides us with the ability to care for others in the future.

While this is only a single case for some crisis responders, it is the life and the tragedy of a whole community, and its consequences are multidimensional. While crisis responders treat at the scene, they need ongoing support from their organizations and their peers in order to continue their work. More research is needed regarding what would be considered helpful support for crisis responders. According to Marcus and Stergiopoulos (2022), police, co-responders, and non-police models urgently need cross-sectional studies that inform, develop, and test effective models of crisis response support. Moreover, specific research investigating animal-assisted crisis responders and their most essential support circles is crucial. Finally, the imperative self-care for the canine partners and their welfare is a fundamental value of this wholesome approach to crisis response and not only its survival but its success and flourishment (Jaffe, 2023).

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Don’t Count Me Out: Advice from Older Black Women to Healthcare Professionals

Danette L. Myers

Abstract: Communication between healthcare professionals and older Black women can be hampered by many factors, particularly cultural gaps, sensory decline, and the fast-paced nature of healthcare settings. After witnessing my own grandmother’s struggle to be heard by her doctors, I sought to provide an avenue for others like her to share their experiences. Therefore, this qualitative case study aims to document the narratives of seven Black women ages 67+ and, in doing so, provide insight for improved communication and cultural competence.

***Keywords*:** older Black women, communication strategies, narratives, healthcare encounters, culture

The purpose of this study is to explore the participants’ stories about their communication preferences and experiences during routine doctor’s visits. Some factors that contribute to older Black women experiencing communication issues with healthcare providers include systemic racism and lack of cultural competence. These communication barriers are associated with broader disparities in health outcomes, including challenges related to chronic disease management, access to social support, and mental health outcomes among Black women (Adams & Craddock, 2023). Consequently, there is a need for specific interventions targeted to improve the older Black woman’s experience in healthcare settings.

My personal experience with my grandmother inspired this study. During numerous interactions with healthcare professionals, she often felt rushed, dismissed, and invalidated by comments such as, “You are just getting older and should expect to feel that way. Go ahead and take this prescription, and we will see you back in two weeks.” As a result, she frequently expressed frustration and discomfort when disclosing her physical ailments to her doctors. As a healthcare educator, I began to question whether my grandmother’s experiences with healthcare interactions were common among other women within her demographic group.

Navigating the communication, review, interpretation, and management of medical information can be challenging. However, these steps are essential for everyone, particularly for older adults who may need to see their healthcare providers more frequently. It’s important that everyone feels at ease when discussing their health with professionals. Finding a physician with whom patients feel comfortable talking is the first step in good communication (National Institute on Aging, 2021). The use of specialized terminology and medical jargon by physicians can be intimidating and discouraging for those experiencing the aging process. Thus, this research seeks to explore how to improve interaction between older Black women and their healthcare professionals; advice will be provided to both healthcare professionals and educators interacting with this population in hopes to increase knowledge of and comfort with communication strategies, leading to better plans of care and a higher quality of life for their patients.

Narrative research, like that applied in this study, uses various methodological approaches to analyze the stories shared by the study participants (Riessman, 2008). Individuals often make sense of their experiences through storytelling, using narratives to communicate with others and interpret the world around them. The key to narrative inquiry is the use of these stories as data: more specifically, first-person accounts of experiences told in story form, having a beginning, middle, and end (Merriam, 2009). At the heart of narrative analysis is "the ways humans experience the world" (Connelly & Clandinin, 1990, p. 1).

The method approach of positionality was utilized from my perspective as the researcher, who serves as an instrument of data collection, analysis, and a filter of the information (Denzin & Lincoln, 2003; Merriam, 2009). This implies that the data are processed through this human instrument, who makes decisions, analyzes, and reflects. To ensure credibility, the qualitative data must capture relevant aspects of the researcher's self, including biases, assumptions, expectations, and experiences, to substantiate their ability to conduct the research (Greenbank, 2003). Thus, I chose to use individual interviews to identify how others felt the same as my grandmother. During the interviews, participants simply wanted to share their stories and be heard. All study participants were happy about sharing special memories as well as challenges they face as older Black women.

To recruit participants for the study, two strategies were helpful: referrals and snowball sampling. The snowball sampling method involves the interviewee suggesting another potential candidate for interview and passing their information along. By continually asking current participants for additional contacts, the researcher is able to expand the pool of candidates like a "snowball," leading to the accumulation of more information-rich cases (Patton, 2002).

Talking about communication challenges alone could be difficult and, furthermore, embarrassing and seen as shameful when discussing personal healthcare. Pseudonyms were assigned to each participant, and specific details were omitted when documenting the stories, such as names of clinics and specific healthcare professionals.

During individual interviews, the participants were asked the following questions:

1) What are your experiences navigating interactions with healthcare professionals?
2) How did you select your healthcare professional?
3) What do you like and dislike about them?
4) What communication strategies do you prefer to be used by your healthcare professionals during your appointments?
5) How do the doctor and nurse speak to you?

After analyzing the participants' narratives on their communication preferences, a few themes surfaced: positive perceptions, frustrations encountered, and advice to healthcare professionals. The following excerpts are essential parts of data gathered from the individual interviews during this qualitative research.

Positive Perceptions

Overall, participants perceived politeness and respectful communication from healthcare professionals as indicators of positive engagement. Additionally, simple gestures such as a proper greeting, offering a handshake, eye contact, or just acknowledging their presence were viewed as encouraging signs of respectful interaction. When these verbal and nonverbal behaviors were present, participants reported more positive experiences during their interactions with healthcare professionals.

On 34 occasions, the participants used specific language to confirm the existence of their positive perceptions. Some of the cited language included the importance of a pleasant demeanor and attentive listening. Face-to-face communication, as well as the use of phone calls instead of email messages, were also documented as contributors to positive perceptions.

When asked to describe their experiences during routine doctors' visits about their communication preferences, participants did not mention medical competence and expertise; instead, they mentioned how polite and patient the doctor was. "Lilly-Mae," who previously worked as an educator, verbalized appreciation for a warm approach by the healthcare professional and the fact that she felt respected by the doctor. Below illustrates the study participants' verbatim positive feedback and communication preferences gathered in the interview.

"Kandace":

> My doctors are in San Antonio, so I sometimes must rely on phone communication. However, I always prefer face to face dialogue, especially when I have a lot of questions. Being older, I have experienced a lot over the years. I realized that I have to ask the doctors or nurses to speak louder because I do not hear them well sometimes. Some of my doctors have the tendency to mumble words and they do not realize their voice dropped and it is easy to say, "Oh, that is because she's old…" I appreciate when the healthcare professionals make eye contact with a smile and have a pleasant voice. I prefer them to take time and talk to me. Do not keep walking out the door while you are speaking because I cannot hear you well with your back toward me. I came to this appointment to meet you, so respect my time and give me your total attention.

Lilly-Mae:

> What I like about him, that he is very thorough. I feel like, "Oh everything is, you are really doing well." He is very positive. In his office there are three healthcare professionals that work together with him, so if he is not available the other two physician assistants are able to fill in the gap for him. I appreciate this because there is a good continuum of care. Oh, they also speak to me very respectfully and kind. They are concerned about my well-being.

These interviews revealed the importance of patients having positive perceptions of healthcare providers. Participants looked for various cues (e.g., eye contact, a smile, facial expressions, hand gestures, encouragement, and overall friendliness) that they reported as indications of sincerity and which fueled and shaped the participants' views of whether their general encounter was positive or not. This particular aspect of participants' interactions falls under *constructed knowledge*, during which participants placed emphasis on both subjective and objective strategies for knowing (Belenky et al., 1986). This theory posits that participants understand they can acquire knowledge by listening to their healthcare professionals but also by listening to themselves. How these study participants intuitively felt about their situation was valid because it had bearing on their inclination to schedule a follow-up appointment and how closely they would adhere to the doctor's orders. Black feminist thought supports the idea that Black women possess a unique standpoint or a unique perspective and that they share these perceptions as a group (Hill Collins, 1990). Some of these commonalities became evident through the narratives presented.

Frustrations

The collected data revealed 39 times in which study participants articulated their frustrations. Some common frustrations mentioned by the study participants included a general lack of consideration of their time and perspective. More specifically, the study participants voiced that their time was disregarded when they were forced to wait long periods of time prior to actually meeting with the doctor. Then finally, upon meeting with the healthcare professional, they were not given adequate time to address their concerns.

As individuals age, certain cognitive functions decline increasingly, such as eyesight and hearing abilities; additionally, older adults tend to process information at a slower pace and use less working memory, which may challenge their ability to process multiple bits of information at a given moment (Speros, 2009). Healthcare professionals should be attentive listeners and careful observers, recognizing both what older patients say (verbal) and what they may struggle to express (non-verbal), to better understand patients' experiences and respond to their needs.

Study participants expressed concerns about not being respected, feeling ignored, and being overlooked. In this regard, Belenky et al. (1986) explained the development of self, voice, and mind in relation to silence and the struggle to be heard, included, and respected. When ignored by healthcare professionals as mentioned by the study participants, this behavior of silence is activated. In this stage of knowing, Black women view themselves as mindless, voiceless, and without freedom to express their thoughts. For example, "Ms. Rose" said, "The doctors already know their responses without asking or consulting with me and without listening to me, so why should I say anything? They do not listen to me." Without conversing, listening to others, and drawing out their own voice, people fail to develop a sense that they can talk and think things through (Vygotsky, 1978). In addition, "Betsy" commented, "They do not give old people the attention they deserve. It is like they forgot about us." Communication is the sharing of information, the giving and receiving of messages, and the transfer of information from one or more people to one or more other people (Savery & Duffy, 1995). In coding the data, three subthemes emerged related to feelings of frustration: long wait times, not enough time per visit, and not listening. Below represents the study participants' expressed frustrations experienced during routine doctors' visits.

Betsy "The Boss Lady":

> Doctors really do not take their time because they are in such a hurry. I really do not think they take enough time with old people and give them the attention they need and deserve. Society in general seems to be in a rush. Everybody is in a rush. Everything is a rush. When the healthcare folks do not take time with me and rush me, I forget a lot of things I wanted to say and remember them when you get home. Oh well, too late now. I want them to use patience. Give us old people a chance. We do not think fast and are very slow, old, and forgetful. So, remember that we are slow, old, and forgetful. Not only in body and motion, but in our thinking facilities. Be patient with us because we are old people who are forgetful.

"Sallie":

> There are so many steps. The person who gave me the information was either a nurse or a nurse's aide, something like that, and very fast. I do not know if that was because I do not look my age. I would guess it might have something to do with that, because only older people typically will not pay attention. But she appeared to be frustrated with me. I felt like I was rushed, and I let her know. She lightened up a little bit, and we got through the appointment successfully.

Long wait times to see the doctor, not enough time with the doctor, negative feelings eroding their confidence, and feeling dismissed, ignored, and disrespected were common frustrations among the study participants. Experiencing such frustrations appeared to establish within the participants that they were being ignored and their voices silenced. In certain situations, silent women have little awareness of their intellectual capabilities and live as voiceless; therefore, when ignored it could appear as a normal act of life according to Belenky et al. (1986).

Recommendations for Healthcare Professionals and Educators

This study focuses on capturing the perspectives of several older Black women. The goal of the study was to document the stories of this population during their interaction with healthcare professionals and advocate the need for improved care for diverse populations, especially those who are elderly. Productive communication with older patients may result in increased satisfaction, improved adherence to orders, and subsequently better health outcomes. It is crucial that medical students are culturally competent and aware of how nonverbal expressions may be interpreted differently depending on the patient's background and identity.

Several times the study participants offered advice on how to increase their positive perceptions and diminish their noted frustrations. For example, being kind, polite, and visibly engaged during conversations was suggested by participants. Furthermore, they conveyed the need for healthcare professionals to thoroughly explain medical instructions. According to participants, medical information, ranging from diet to medication usage, could be communicated better. Older adults process information at a slower pace and use less working memory, which may induce challenges processing multiple bits of information at once (Speros, 2009).

Educators in healthcare should train their students in effective communication practices, as it is essential in providing quality care, particularly for vulnerable populations. Current practices should transition from a "one size fits all" model that generalizes older people into broad categories to a model that caters to diverse individuals. This study emphasizes the diversity and complexity of older Black women through their stories about frustration with their physicians. Educators should shift their curriculum towards a more encompassing model that takes into consideration these individual stories to better serve this community. Students should receive training prior to entering the field to help them connect with diverse cultures and backgrounds.

These future healthcare providers should avoid making assumptions or stereotyping individuals who may not have the same privileges as the majority population. Healthcare professionals should identify and adopt effective strategies to help them connect to their patients. Building trusting relationships allows these diverse populations, including these older Black women, to feel more comfortable communicating their healthcare concerns. When healthcare professionals understand their patients' communication preferences, they are better equipped to effectively meet their needs. Two participants provided the following advice related to this expressed a need for more detailed information.

Kandace:

> I would like them to speak to me and call me by my first name because that would be more personable. Most of the time they will just start talking and do not acknowledge me. I mean, especially if I have not seen them in a while. For example, my heart doctor, it will be six or seven months since I have seen him, so he may have forgotten the specifics about me. However, I still would hope he would at least read my chart, and say, "Okay Ms. Kandace, I see you have done this or that." Doctors should be a little more personable.

Lilly-Mae:

> Yes, I would like them to repeat what you just said. For instance, when dealing with my aging parents, the healthcare professionals need to ensure that their patients understand those instructions. The same with me: If they give me instructions about a specific medication, they should have me repeat those instructions back to them and display that I understand. Another piece of advice is to just be personable. I realize that they have personal lives too and are human beings, however, as their patients, we are priority. Healthcare professionals have a series of patients that come in and out of their offices with all sort of conditions that need to be addressed. Yes, they have families too, but they

> should be more personable. I think doctor's visits would be much better when the patient is able to talk and the healthcare professional listens. I'm not talking just to hear myself, but I need them to listen to me.

Conclusion

All study participants concluded that there are opportunities for healthcare professionals to improve their interactions with older Black women. Specifically, participants expressed a desire for healthcare professionals to be less passive and more patient during medical encounters. The interviews also revealed that participants wanted providers to make an effort to establish a personal connection by engaging in behaviors commonly viewed as courteous, such as maintaining eye contact, smiling, and speaking in a respectful tone. These behaviors were important to participants because they signaled that their personal experiences and perspectives were being acknowledged and valued.

Within the context of this study, *subjective knowledge* refers to the understanding individuals develop through their lived experiences, which shapes how they interpret interactions and evaluate whether their concerns have been (or are being) heard and respected. Each of the areas of improvement noted by participants arose from their need for healthcare professionals to be in conversation with their subjective knowledge, namely by showing attentiveness in ways that resonate with them and intentionally conveying it.

According to Wiebe (1997), unclear communication can cause an entire medical encounter to fall apart. Alongside speech, facial expressions and other forms of silent messaging are considered a particularly important aspect of the study participants' experiences. Non-verbal communication was linked to rapport, warmth, supportiveness, agreement, and interest. Unfortunately, lapses in verbal and non-verbal communication have resulted in the group of study participants feeling forgotten as individuals and as a generation. This sentiment was further verbalized in statements describing being left out, dismissed, and neglected.

In this study, the participants shared their personal experiences. Most of the participants referred to the doctor as their "own" healthcare professional, symbolizing a sense of belonging and a close connection. Eye contact, facial expressions, body language, and hand gestures were perceived as underlying messages that indicated sincerity. The study participants reported feeling more engaged and important when asked about personal details such as family events, social activities, and hobbies. The use of warm words and a friendly tone of voice was very much valued by the study participants. When participants have positive experiences to draw upon, their perceptions become more optimistic and their responses more receptive. By taking the time to demonstrate attentiveness to older Black women, healthcare professionals can improve not only their current and future healthcare experiences, but also their cognitive and physical health outcomes.

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Learning from Hanne: Reflections on Social Work Practice in Medical Assistance in Dying (MAID)

Mary Valentich

Abstract: This article details the experiences of Hanne Schafer, who is the first Canadian, outside of Quebec, to receive a court-ordered exemption on February 25, 2016, for a physician-assisted death which occurred on February 29, 2016. While helping my friend achieve her goal of a peaceful death, I reflected on the implications for social work practice with clients considering or proceeding toward what is known in Canada as MAID, Medical Assistance in Dying. I offer my ideas on how social workers can prepare themselves for engaging in this developing area of practice.

Keywords: physician-assisted death, MAID (Medical Assistance in Dying), guidelines for social workers

Canada's movement toward medically assisted dying has been captured in a timeline prepared by the Canadian organization MAiDHouse (n.d.), beginning in 1892 when the Criminal Code was introduced to Canada. That Code specified that assisting anyone to commit suicide—as well as helping anyone to die—was criminal and warranted punishment (MAiDHouse, n.d.). Since then, much change has occurred, with the culmination in 2015 when the Supreme Court of Canada struck down the prohibition on medical assistance in dying as unconstitutional (Amies, 2018; Kirkup, 2025; Martin, 2016). By June 17, 2016, the federal government passed legislation permitting medically assisted dying under certain conditions (MAiDHouse, n.d.). Although Canadians have generally supported the legislation passed on June 17, 2016 (Dying with Dignity Canada, 2021), controversies abound, primarily about the rights of mature minors, advanced directives, and the rights of persons whose sole problematic condition is mental illness that has not responded to any known treatment. Legislation on these facets of assisted dying has been proposed, studied intensively by expert committees and others, debated in various fora, argued against by some, and vigorously recommended by others (Wilson & Lemmens, 2025). Often, the federal government has responded with a "pause" intended to give Canadians more opportunity to consider the matter and health professionals more time to prepare for possible changes in practice.

In early November, 2022, Dying with Dignity, Canada's major advocacy organization for the right of persons to be able to access quality end-of-life choice and care, hosted in Toronto the 2022 World Federation of Right to Die Societies International Conference, highlighting personalities from 18 countries who have pioneered in relation to the right to decide on one's own death at the end of life (Preisig, 2022). Participants came from 23 countries, all in varying stages of the pursuit of what has been generally known as euthanasia (Preisig, 2022). One of the actions of the Congress was to agree that within the World Federation the terms "euthanasia" and "suicide" should no longer be used, as both terms have negative connotations; assisted dying would be the favoured wording within the World Federation (Preisig, 2022). The term "suicide" is still used by Alberta's United Conservative provincial government where I reside (Dawson, 2024). While some countries, such as Switzerland, The Netherlands, and Belgium, have over 20-year histories with some form of assisted dying, the Conference's presentations showed the efforts (and successes) that have gone into legalizing self-determination in uncharted territory: Australia, New Zealand, Columbia, Germany, Austria, Spain, and Italy, as well as some states in the U.S. (Preisig, 2022). Most recently, Great Britain has moved more decisively in the direction of approving medically assisted dying (Pylas, 2025), but each country has its unique story.

Canada's situation was seen as impressive, in that within six years since legalization in 2016, a network of family physicians, palliative care physicians, and nurse-practitioners has been established with varying protocols in the provinces. Further, there are clear guidelines and progress in training more medical professionals (Canadian Association of MAID Assessors and Providers [CAMAP], n.d.).

I participated in this conference with a presentation on my friend Hanne Schafer and her experience of choosing assisted death on February 29, 2016, in Vancouver, British Columbia. She had attained a court exemption to proceed prior to the actual federal legislation being passed in June 2016. She is, in my view, a pioneer, and I admired her greatly for her fortitude, clarity, and courage throughout a three-year process from diagnosis of Amyotrophic Lateral Sclerosis (ALS) to death. My role was that of a friend, but I did not turn off my social work knowledge and skills in helping her to achieve her goal. Nor did Hanne, a psychologist, cease drawing on her expertise in assisting others with mental health issues. Throughout this period of joint endeavour, I considered the implications of the process of choosing death for social workers engaging in a new area of practice that I believed would evolve significantly.

Social workers in diverse settings are often faced with questions from clients/patients regarding their options, given their current or developing serious medical condition. Guidance has not always been readily available for social workers who must act in keeping with directives—from employing agencies, their regulatory body or provincial college of social workers, the state or provincial government, and their own conscience. However, more latterly, there are social workers in Canadian health units who can offer their services to patients seeking to know about MAID (Dying with Dignity Canada, 2025). However, that was not the case in 2013, although social workers have a long history of working with clients with health issues, as detailed in journals and other literature pertaining to social workers in health settings (e.g., *Social Work in Health Care*). Relevant to the topic of MAID is social work engagement in palliative care; social workers in palliative care units offer a range of services to individuals and their families who need support and connection with resources. One might expect attention to assisted dying as an end-of-life option. However, in the qualitative research by Ho et al. (2020), the path to incorporation of MAID in palliative care has clearly been challenging for health care providers, including social workers, who may have been trained to accept death as a natural process, not an increasingly medicalized and hastened process.

My own professional experience with illness, dying, and death began in 1963 when I was a summer student in a general hospital in Hamilton, Ontario, and later in a six-month social work practicum in a home-hospital for elderly persons in Rochester, NY. Additionally, I had several months of employment as a social worker working with elderly and ill clients living in rather dire community settings in Hamilton, Ontario. Later, my life partner and I endured knowing he was terminally ill for seven years prior to his death in 2005 caused by his multiple myeloma (Valentich, 2023).

I am not alone as a social worker who has had numerous opportunities to engage with clients regarding end-of-life issues. I was aware of prominent Canadians such as Sue Rodriguez, who valiantly pursued the right to choose her own manner of death in the 1990s (Truelove, 2013), but I did not become engaged with MAID until 2013. However, when teaching Human Behavior and the Social Environment (1968–1998), I did not shy away from discussion of dying, loss, and grieving. I have long been committed to trying to break away from the denial of death so evident in much of North America (Waugh, 1948).

Hanne Schafer’s Story

Hanne’s story begins in Germany, where she qualified as a psychologist. She immigrated to Calgary, Canada, in the mid-1970s where she worked for many years for the local health authority. Initially, she lived in the same townhouse complex where my partner and I and our newborn son (born 1978) resided. Hanne and I found a commonality through our European roots and our professional backgrounds. Our love of films, concerts, and celebration of life events such as birthdays resulted in a family friendship that enriched us all. In 2013, just shortly after her retirement from practice, Hanne received a devastating diagnosis of ALS. It was a blow of major proportion. None of us, her friends nor partner Daniel Laurin, could believe that this vibrant, active, beautiful woman was now terminally ill. Like others, she sought any remedies she could, including experimental treatment. She and Daniel travelled, hiked, and continued their beloved ballroom dancing for as long as she could stay upright. However, her condition deteriorated rapidly; she became increasingly dependent on Daniel and home palliative care. Her cherished independence nearly disappeared; her condition of helplessness was becoming totally unacceptable to her.

I was not surprised one day in March 2013 to have her tell me that she had made her decision to pursue an assisted death, likely in Switzerland. She indicated that there was no help for her with seeking assisted dying from palliative care workers or organizations related to ALS. Would I help her, with Daniel and other friends, to achieve what she wanted: a peaceful exit on her terms? Though saddened by the idea of losing Hanne, I did not hesitate to say “yes.” She quickly lost her capacity to speak and began to rely on email to make regular contact. I began to print and save those emails which she typed with three fingers of her left hand. Later our correspondence formed the basis of a memoir, *Fighting for Hanne* (Valentich, 2021).

We carefully assessed the options that were available. We soon gave up on the possibility of going to Oregon, where one had to self-administer drugs, or to Quebec, where she and Daniel would have to establish residence of several months. (Quebec has had its own system of assisted dying since 2014). I recall going to a workshop in Calgary, where we all lived, offered by June Churchill, a tireless and dedicated social worker who was very active in volunteering with a chapter of Dying with Dignity. I was looking for any local physician who might be able to assist Hanne, but no one presented themselves to me, at this workshop or at another in February 2016 which was titled, rather oddly in my view, *Compassion or Convenience.* It was sponsored by a local Calgary church where my question about resources fell on deaf ears. It was a frustrating time: No one seemed able to help us. We busied ourselves with requests to physicians we knew and applications to two clinics in Switzerland, but had misgivings about the travel, assessments, and whether Hanne could manage to physically complete the administration of the drugs.

Finally, one of the European contacts resulted in Dr. Ellen Wiebe and Dr. R. Malleson, Canadian physicians practicing in Vancouver, connecting with us by video in January 2016. Dr. Wiebe had been studying assisted dying in Europe and was ready to begin her own practice in this speciality. We were greatly relieved that maybe we could make something happen in Canada. When the Supreme Court permitted a four-month extension to the federal government to pass the needed legislation, Hanne took advantage of the opportunity to seek a court-ordered exemption on February 25, 2016.

Going to court was challenging for all of us. The atmosphere was subdued, and we were unfamiliar with the protocols. However, after an agonizing wait of approximately an hour, Justice Sheilah Martin granted the exemption. We were elated. We hurried back to Hanne and Daniel's home and began dealing with the logistics of contacting Dr. Wiebe, arranging flights, a hotel, and several funeral companies who initially would not assist us, because it sounded as if we were contemplating a murder. At least we could laugh, or sometimes cry, along with the steady stream of visitors who came on Saturday and Sunday to say their final goodbyes. One of the most touching for me was the hour-long visit by my son, who'd had a special relationship with Hanne since his birth.

Hanne, Daniel, and I flew to Vancouver on February 29, on a 90-minute afternoon flight, with striking views of the mountains below. I hoped the sight of the impressive mountains might give us a sense of peace. We had only a few hours together before our last meal in the hotel's pub and then a bumpy taxi ride to Dr. Wiebe's clinic for a 7:00 p.m. appointment. Hanne died peacefully at approximately 8.30 pm on February 29, 2016.

In this compressed account of what transpired, I have not detailed the emotional ups and downs, the periods when we flailed about, not knowing which direction to take, or the moments of joy when we achieved success. Our focus remained steadfast, as did Hanne's: to enable her to achieve her goal. Grieving almost remained a secondary concern: we simply did not want her suffering to increase. We worked efficiently, with as much sensitivity as possible, but always with the realization that we might run out of time and Hanne would lose the capacity to provide consent. She did not, and bravely raised her left thumb up when Dr. Wiebe asked whether she wished to proceed with MAID.

On Tuesday morning, Daniel visited his uncle, and I some close friends. We both needed to unwind and to be with people who cared for us. We returned to Calgary on Tuesday March 1 and began the next phase—primarily advocacy, though we soon realized that such activity required another court appearance in April 2016 to remove the publication ban. Otherwise, we could not have posted her obituary which I had drafted and Hanne had approved. However, Daniel needed to get away from the local scene, where his life had so dramatically changed. I finally realized that Hanne was gone, but there was still work for me and Daniel to do in her honour: namely, to tell her story so that the journey for others seeking MAID might proceed without obstacles.

What are the implications of Hanne's journey for social work practice in situations involving assisted dying?

Guidance from Professional Organizations

When the Alberta College of Social Workers (ACSW) initially indicated that social workers should not be involved in offering services to anyone regarding assisted dying, our local Calgary Social Workers for Social Justice had vigorously protested (Valentich et al., 2020). By 2024 the Canadian Association of Social Workers (CASW) and provincial associations had issued statements to assure social workers that they will not be held liable for engaging with clients/patients who request assistance (CASW, 2024; ACSW, 2016). These clients are considering their options when experiencing a physical illness that seriously compromises their quality of life. Like my seriously ill clients in the home/hospital in Rochester, NY, people at an end stage of life often wish to review their lives and to contemplate their future. Regrettably, family members are not always on the same wavelength as their parents regarding decisions that the elderly and very sick parents may wish to make.

Currently, there are no restrictions in Canada from professional social work organizations on social workers practicing in relation to clients expressing interest in MAID; nor are there practice guidelines. However, the ACSW statement, not unlike other provincial statements, does refer to ACSW Standards of Practice (2016) that entail referral (if the social worker chooses for conscientious reasons to not provide services in relation to MAID); cultural competence (recognizing the impact of varying heritage, values, beliefs and preferences of both the social worker and the client); and dignity of client (where social workers will use "reasonable advocacy and other interventions" (p. 3) to ensure that the dignity and rights of clients are safeguarded). In the same statement, ACSW notes that ACSW does from time to time develop best practice guidelines in certain areas of practice but is not currently able to provide specific practice advice on medical assistance in dying.

My experience with Hanne as a friend prompted me to consider the implications for social work practice in situations where a client may be considering assisted dying. I readily could draw on my past personal and professional experience in living and working with seriously ill people.

Knowing One's Attitudes, Values and Beliefs Regarding Death

When I began teaching at the School of Social Welfare, University of Ottawa in 1968, there was little in the Human Behavior and Social Environment course that related to aging. This adult phase of life began to surface more prominently by 1978, when I taught a similar course at the School of Social Welfare, University of Calgary. My personal experience with my parents' deaths as well as my Croatian ethnicity had prepared me well for contact and "comfort" with death. It was not unusual for my family to go to the cemetery on a Sunday afternoon to "visit" with deceased friends and relatives. I recall going to my first funeral in a home at age three. Being curious, I peered into the casket of a family friend who had stopped by our house the week before. In elementary school in the early 1950s, I was charged with picking up flowers at the local funeral home to bring back to the Catholic church near the school. My curiosity (again) led me to tiptoe quietly into the rooms with bodies in open caskets, awaiting viewing by friends and family. These experiences prompted me to arrange field visits for my social work students to a local funeral home, where the funeral directors spoke about their work as well as cultural differences they recognized as important for their diverse clients. We were also given a tour of the facilities, including the crematorium. For those students who chose to come (and most did), it was often their first contact with death, and many thanked me years later, indicating that they had been better prepared to handle the death of a loved one.

My engagement in feminist social work practice grounded me well with respect to persons having choice, not only in reproductive matters, but most major life decisions. I fully appreciated Hanne's stance that she had no intention of dying while choking on her own phlegm. I recognized her desire to maintain her independence for as long as she could, and I honoured her right to choose how she wanted to live and to die. Sue Rodriguez' anguished cry in the early 1990s had resonated with me and many Canadians: "Whose body is this? Who owns my life?" (Truelove, 2013).

If these issues about choice and a person's right to die create personal disharmony for a social worker, it behooves the social worker to examine their own past to understand how their own experiences with illness, dying, and death have evolved. Journaling may yield surprises about the origins of one's attitudes. Opportunities to share one's grief about deceased loved ones as well as visits to cemeteries may provide insights into one's viewpoints. There are also films about people's choices of MAID and workshops offered by Dying with Dignity and other organizations that enable a person to explore their own beliefs. All of these may yield relevant information to social workers who wish to understand their own perspectives and to increase their comfort with clients who may be seeking information about MAID. Further, discussion with a trusted friend, colleague, or supervisor can greatly enhance one's self-awareness and readiness to assist a client facing a lessened quality of life.

Fortunately, Hanne, Daniel, and I were all committed to the same goal. Despite our awareness of the forthcoming loss of Hanne, we were determined to proceed as carefully and effectively as possible. We did encounter one difficult situation when a family member of Hanne's came to Canada to visit with her. The relative was not on the same wavelength as Hanne and Daniel. Ultimately, I became the point of contact with this relative, who later realized that Hanne had a right to make her own choices about her situation.

While I strongly recommend the development of awareness about one's own attitudes regarding a person's right to choose MAID, I am not suggesting that a social worker should negate their own conscientious objection to MAID, if that is their position. No one is expected to eliminate or downplay their own beliefs. What is important, in any setting, is that the client gets the attention and service that is their right. In this regard, I highlight the ACSW Standards of Practice (2016) that identify *referral* and *dignity of the client*: Appropriate referral means that "social workers who choose not to provide services around medical assistance in dying on the basis of conscientious objection must facilitate the referral of the client to another qualified provider" (p. 3), and the dignity of the client refers to a social worker using "reasonable advocacy and other intervention activities to ensure that the dignity, individuality and rights of their clients are safeguarded" (p. 3).

Listening Without Judgment

All social workers recognize the importance of hearing a client's story, even if it is repeatedly told or shared in bits and pieces. I learned this from my mother, with whom I often visited her hospitalized friends. One sat and listened, sometimes asking a question or two to clarify what was being shared. Listening is an art, and it does not mean that one does not have feelings or reactions, some of which one might choose to share. But the spotlight is on the client—what they are thinking and feeling and wishing to disclose.

Often, older persons facing an unanticipated illness or impending death want to tell their life story to someone who will listen and who cares. They desire to put their illness into a context that is meaningful to themselves and to people close to them. That is not an easy task; sometimes it is like putting the pieces of a puzzle together. The social worker can assist by prompting reflections and possibly making occasional suggestions or offering an interpretation. I always enjoyed hearing the stories that clients told me about their younger days.

One of my former students is now a social worker who wrote about her compassionate mask that she wore while listening to her clients. She never shared what her own reactions might be to anyone (Eleniak, 2010). I was regretful that this very excellent student had taken years before discovering that she did not have to carry the burden of grieving all on her own. Feminist social work practice has enabled social workers to be more open with clients or appropriate persons who could offer support (Valentich, 1986). When a social worker listens intently, they can develop with the client an assessment of the situation and, if possible, follow up with a plan. With Hanne, I either acted as a consultant or helped her with implementing her plans. She was very competent in formulating her own plans and could rely on me and her partner to carry out her wishes—for example, applying to a second clinic in Switzerland that might better suit her situation. My job with Hanne was to listen and to hear what she wanted to do. Possibly, I might have spent more time and energy in relation to her feelings of loss and grief for her life. However, I was guided by her: She wanted to put a plan in place for her peaceful death. That was her goal and that was our focus, in the emails and in-person exchanges which often entailed Hanne typing her comments on her computer. I was committed to helping her and did not want to disappoint her. I once had not followed up with a second phone call to a friend in another province who was seriously ill. I vowed that with Hanne there would be no “excuse”: We were in the same city, and I would be totally available to her and Daniel.

What do I mean by judgment? I am referring to the social worker offering an unwanted or unasked for viewpoint that negates what the client is conveying or suggests that the client is somehow off-base in their thinking. A judgmental response differs from a thoughtful perspective offered to a client who is interested in the social worker’s opinion. How the social worker responds will be determined by their previous exchanges. If the client has had a chance to thoroughly explore a topic, the social worker might give their opinion, but not as a promotion of a particular direction that the client should follow. In other words, the client takes the lead in making any decisions regarding their future behavior.

Given an unfortunate media headline about a “caseworker” promoting MAID to a veteran (Passifiume, 2022), it is important that social workers are careful to simply respond to their client’s questions and to not give the impression of suggesting a particular course of action that might be MAID. Because of the controversial nature of MAID and forthcoming proposals to extend MAID, opponents of MAID are ready to jump on any perceived undue influence by social workers on clients’ choices. Hence, documentation of the social worker’s activity with a client is important as well as reviewing one’s work with a supervisor or trusted colleague.

Listening without judgment can be emotionally tiring. In the situation with Hanne, Daniel and I could give each other support: we three could laugh and cry together. Hanne was a dear friend: I grieved her loss from the moment she told me about her diagnosis in 2013. Social workers develop varying degrees of closeness with their clients and will experience loss. It is difficult to watch someone decline physically and emotionally, and social workers need their sources of comfort and support to sustain them.

Beyond listening non-judgmentally, social workers are often key sources of information for their clients.

Knowing About MAID Resources and Processes

When Hanne was seeking information regarding assisted death in various countries around the world, she would follow any leads she found on Google. She was able to contact several clinics in European countries, all of whom responded helpfully. In Canada, from 2013 to January 2016, there were no organizations that could readily provide us with information except for Dying with Dignity. We asked questions wherever we could, usually of people we knew in the health field. The situation has changed dramatically with considerable information available through various sites on the internet. In each province, the health authority will have relevant information that social workers need to know to respond appropriately to their clients. In Alberta, one calls the Health Link number (811) regarding MAID, and information about the process of application is forthcoming. Further, many Canadian cities have local chapters of Dying with Dignity, and there are often provincial and national in-person and virtual workshops available to professionals in health fields and interested members of the public.

Another organization that has developed a curriculum for physicians and nurse practitioners who engage in practice related to MAID is the Canadian Association of MAID Assessors and Providers (CAMAP). Their website was developed for those active in this area, with clinicians able to access the curriculum without cost. For a $50 fee, the Foundations of MAID in Canada topic is available to anyone and provides pertinent information about the regulatory context for MAID in Canada as well as the "multidisciplinary roles that can support a patient who has requested MAID"; a topic of possible interest to social workers is "what resilience means for clinicians engaged in MAID" (CAMAP, n.d., para. 3). CAMAP states that while they are predominantly an association of nurse practitioners and physicians, anyone involved in the work or interested in supporting it is most welcome to join the community. They note further that "this includes social workers" and a long list of other disciplines.

A major source of information is the emerging literature on MAID in Canada. I strongly recommend Sandra Martin's (2016) *A Good Death*, which provides a background to assisted death in Canada, including an account of Hanne Schafer's journey. David R. Amies in 2018 presented an account of *Medical Aid in Dying in Canada*. My book on Hanne's journey was published in 2021, followed by two books by physicians on their experiences in providing MAID, the first by Stephanie Green (2022) and another by Jean Marmoreo and Johanna Schneller (2022). Interestingly, Jean and I were work colleagues and friends in 1965 while employed in our first professional positions at a psychiatric hospital in Toronto. I do not recall that we ever discussed dying: We were in our early 20s and looking forward to the future. We lost touch for many years, but reconnected when I learned that she was focusing on assisted dying and might be able to provide some guidance to Hanne and me. She did. There is nothing like networking with like-minded colleagues. Finally, Cynthia Clark and Carol Cram (2023) have written a book on the experiences of clients and their families with MAID.

There are also videos and television productions related to assisted dying which are very pertinent to anyone interested in working in this area. Dying with Dignity can provide information about such resources. The furor about assisted dying in Canada and beyond continues unabated (Green, 2025).

Not surprisingly, after MAID became legal in June 2016, there were calls for more data and, then, for research on various facets of MAID. With respect to social workers' involvement, there is still minimal research. However, a survey conducted in Quebec examined social workers' attitudes toward MAID for persons with dementia (Bravo et al., 2022). These researchers noted that social workers' attitudes toward end-of-life care options have received little attention, although they cite a few studies they consider outdated. Their own survey research in 2021 in Quebec revealed "a relatively high level of support for MAID" (p. 282) with one exception, namely that the respondents were roughly evenly split between agreeing and disagreeing that all suffering can be alleviated at the end of life. Their findings also indicated that social workers, somewhat more than nurses and physicians in their study, were open to greater extension of the current legislation—for example, to people who request MAID in writing prior to losing capacity.

In any area of practice, social workers engage in a range of roles—clinician, educator, researcher, policy developer, and advocate.

The Clinical Role and Beyond

Social workers in Canada function in a society where there are competing political ideologies which provide a context for practice. Social work as a profession has been characterized by a liberal philosophy that emphasizes the importance of liberty and individualism but recognizes the necessity of state intervention in situations where social goals are not being realized (Valentich & Gripton, 1985). Mullaly (1993) affirmed that social work is based on liberal values and that social workers engaged in three activities: personal reform; limited social reform; and advocacy, all pertinent to social work with MAID clients.

Thus, personal reform or clinical work entails the social worker in a facilitative role, helping the client and possibly family members to consider all the options open to them in this last phase of life. I learned early in my first-year field placement in the home/hospital for the elderly that family members were a source of both joy and distress for some residents. Generally, there was no cause for concern: Family members played supportive roles. They would visit and help their loved one with small comforts, such as trips away from the residence, or provide useful advice or assistance with respect to business matters, such as the sale of property or the loved one's will. However, occasionally, family members would take a very protective and directive stance with respect to the decisions their loved one was planning to make or had made. If a client had given their family members the legal authority to make decisions on their behalf, there was little the social worker could do except to listen to the client and attempt to convey the client's perspective to the family.

With respect to assisted dying, family members are sometimes at a loss, not wanting to lose a loved family elder but feeling left out of the process that has major consequences for their loved one (Andersson, 2023). Sometimes family members will try to override the client's wishes by persuading them to choose other options or just to delay the process. The social worker must be clear that their task is to support the client in their decision-making and, where possible, to assist family members to recognize that their relative has the right to make this decision if they fit the criteria for MAID. In a presentation by three social workers in health settings in different Canadian provinces, it was evident that considerable time was spent by social workers in dealing with family members' concerns (Dying with Dignity Canada, 2025).

Once the decision to choose MAID occurs, the social worker may assist the client and sometimes the family members with aspects of planning for the assisted death. Such planning might be longer term—such as keeping in touch with the client who may choose to delay MAID for varying lengths of time—or it may focus on more immediate arrangements—where will the death occur; who will be invited; will they participate or not, and if so, how; will there be flowers, art, music, readings? With Hanne, we moved so quickly at the end that we did not consider many of the actual details related to the hotel or the clinic. Indeed, I scampered about the hotel collecting some lovely flowers (with permission) that I could assemble in the hotel room where we waited for a few hours before going down to the restaurant for Hanne's last meal. I trust that we did address what Byock (as cited in MAiDHouse, 2022) identifies as the Five Tasks of Dying: saying I'm sorry; thank you; I forgive you; I love you; and goodbye. Because of a last-day change of venue from the hotel to Dr. Wiebe's clinic, we left at 6:00 p.m. by cab. On that ride, Daniel and I mostly cried and then just concentrated on telling Hanne we loved her. At the clinic, we were quietly ushered into a room with one bed for Hanne. She did not hesitate, giving us one last embrace. After her death, I stayed with her for about 30 minutes until I realized that Daniel had left us, somewhat distraught, for the waiting area. Dr. Malleson said she would stay with Hanne's body, whereas I could go and comfort Daniel. I was so relieved by Dr. Malleson's offer; I had not wanted, in a sense, to abandon Hanne's body by leaving it.

By 11:00 p.m. that evening, Daniel and I were sitting outside our hotel, finally relaxing and reflecting on what had transpired—he with a Cuban cigar and me with some champagne provided by kind and thoughtful hotel staff who had figured out the nature of our mission. We felt someone was taking care of us. Hanne's death had been a profound experience for us both, and we knew that we three were forever bonded. We needed now to pause.

With respect to limited social reform, the social worker can do whatever is legally possible within the setting to assure that their client has access to services such as MAID (Ho et al., 2020). This may mean helping the client find the needed information and ensuring that the unit or setting is prepared for MAID assessment and, possibly, delivery. Changes in institutional practices might enable the client to achieve their goals without being forced to move to another setting. However, there can be time limitations related to the client's deteriorating condition. Social workers need to be prepared with alternate plans that might enable the client to attain their goal. Consultation with the local health authority may be necessary and/or with one's regulatory organization.

Since Hanne's death, new issues have emerged: advanced directives, the rights of minors and people with only psychiatric concerns, and publicly funded religious institutions that transfer terminally ill patients to other settings. Hanne, Daniel, and I were united in believing people had a right to choose how and when to end their lives if their conditions were insurmountable. Hanne was an activist who regretted not being able to be interviewed by the media because she could not talk. Daniel and I had pledged to her that we would continue with advocacy after she departed.

I believe that individual social workers, many of whom work with minors or individuals with irremediable psychiatric issues, may have a range of views regarding the rights of these individuals to apply for MAID. They could provide useful information to groups studying these matters and making recommendations to the federal government that is developing legislation. However, some social workers may be constrained from making their views known by their employers. Possibly provincial associations and regulatory bodies can speak on behalf of the profession to the policymakers.

A final matter of social justice relates to equity of access to MAID. What costs are involved? When Hanne Schafer sought a court exemption, she did so as a private person who had the financial means to cover costs of approximately $13,000. Going to court after her death to lift the publication ban cost me $4,000 for the legal services. Clearly, not everyone can afford such costs. The situation is now quite different in that people usually do not have to go to court. Nonetheless, those accessing MAID tend to be among the better-educated and, hence, financially secure (Picard, 2022). It is important for researchers to track information about who has access to MAID to ensure that inequities do not exist, with some people not able to exercise their legitimate rights to MAID.

Implications for Research

While social work has a long history of practice within the health field with the elderly and seriously ill, there is a paucity of research on social work engagement in Canada or beyond in relation to what is still considered an evolving area of practice, namely, assisted dying (Rivest et al., 2023). Nonetheless, the first survey of its kind concerning Canadian social workers' attitudes towards voluntary euthanasia and assisted suicide occurred in the province of British Columbia, prior to legalization of physician assisted dying in 2016 (Ogden & Young, 1998). In that exploratory survey, the researchers found that social workers were being consulted by seriously ill patients about ways to end their lives, but in that era, there was no attention paid to assisted dying by the profession or social work education. Subsequently, Antifaeff (2019) presented a case study of her work with a dying patient who had been granted MAID and called for "social workers to document their practice experience with MAID to grow this body of literature and advance practice" (p. 191). I consider my reflections on my experience with Hanne a response to this call for documentation.

In other words, the field is open for a range of research, both qualitative and quantitative, that focuses on the role of social workers. At the time of writing, the only Canadian study which examines the attitudes of social workers in Quebec toward MAID for persons with dementia is by Bravo et al. (2022): Its authors concluded that their study gives voice to social workers' more liberal views on patients' rights to self-determination and enables them to participate in shaping future policies and practices.

Conclusions

There is no dearth of controversies related to MAID (Grant, 2019). Public debate will continue as Canada proceeds with addressing unresolved issues around which there are varying views. Of particular concern is whether there is inequity and whether Canadian society is addressing the needs of those without the means to live with dignity, due to lower income, disability, or their placement in a correctional or mental health facility. Renowned health columnist Andre Picard makes the point that we should make it easier to live with dignity than die with dignity, but that no one should be denied either (2022). However, there are opponents to MAID who believe that Canada should go back to the drawing board (Selley, 2023). Social workers can play an increasingly prominent role in promoting informed discussion, which assists both clients who want to take charge of their dying and families who recognize the rights of people choosing to apply for MAID.

Based on my experience with Hanne, I believe that knowing one's own attitudes toward death, listening without judgment, and providing needed information, as well as possible advocacy, within a health setting can facilitate a friend's or a client's final journey toward a peaceful death. These time-honoured social work interventions have not been systematically taught or studied in relation to preparing social workers for practice in assisted dying. In my view, they are essential components of effective practice with clients contemplating an application for assisted dying. Hanne would encourage us with a smile and an upraised left thumb.

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Adapting Autoethnography to Explore Cultural and Generational Differences on Aging

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Abstract: In this article we analyze a series of in-depth interviews and conversations between two women, both social workers and gerontologists, that culminate in an oral history project which created a space for dialogue across generations. The narrator (Virginia), 99, reflects on the experiences that shaped how she cared for people with dementia. The interviewer (Natalie), 42, assumes a co-interpreter role as she documented what informed Virginia's relational, person-centered approach. Additionally, reactions and responses from a graduate student (Sajjad), 42, invited by Natalie to assist with data analysis, are shared utilizing an adapted autoethnographic approach. Together, we offer two culturally and generationally divergent perspectives on aging and care for older adults. This paper highlights how autoethnography facilitates the co-construction of a nuanced understanding of aging and offers a vehicle for scholars and practitioners to examine their assumptions about aging.

Keywords**:** life history, oral history, autoethnography, gerontology, reflexivity

Introduction/Background

Currently, more than 55 million people have dementia worldwide (World Health Organization, 2023), and in 2020, about 7 million Americans were living with dementia (Centers for Disease Control and Prevention [CDC], 2023). Dementia is "an umbrella term for loss of memory and other thinking abilities severe enough to interfere with daily life" (Alzheimer's Association, 2023, para. 2). Alzheimer's disease accounts for about 60 to 80 percent of all dementia diagnoses, followed by vascular dementia (Alzheimer's Association, 2023; CDC, 2023); other types of dementia include Lewy Body dementia and frontotemporal dementia (CDC, 2023). As the size and proportion of the U.S. population 65 and older continue to grow, the number of Americans with Alzheimer's or other dementias will increase rapidly in the coming years. This oral history project with Virginia Bell (she/her) provided an opportunity to record and preserve the life and professional contribution of a social service trailblazer whose career was focused on supporting people living with dementia.

Virginia Marsh Bell (1922–2023) was a Kentucky native and graduate of the University of Kentucky College of Social Work (MSW '82) who developed an innovative model of dementia care known as the Best Friends approach (Bell & Troxel, 2012, 2016). The Best Friends model is a person-centered approach that suggests "what a person with dementia needs most of all is a friend" (Troxel & Bell, as cited in Prestige Senior Living, n.d., p. 3). This friend can be a (literal) friend, a relative, or a volunteer who shows empathy, recognizes the inherent value of the person with dementia, and knows their personal history (i.e., life story; Bell & Troxel, 2012, 2016). Virginia's story, which includes her childhood growing up in a rural community on a farm near Cynthiana, Kentucky, her parents' experience aging in a care facility, and her return to graduate school at age 60, is an important one to document. In 2020, I (Natalie), a faculty member at the University of Kentucky College of Social Work (UKY CoSW), began an oral history project to document, preserve, and disseminate Virginia's story. In highlighting the valuable work of one of the College's most important alumnae, this oral history also provided an opportunity to humanize part of the legacy of the UKY CoSW. Through my series of long interviews with Virginia, I also wanted to learn about the history of how dementia care has been approached in the U.S. and Virginia's unique contribution via the Best Friends model.

Virginia and I met three separate times for formal, qualitative interviews. Two interviews occurred in person, before the start of the COVID-19 pandemic. These conversations took place at Virginia's home in Lexington, Kentucky, in February and early March 2020. Our third interview occurred over Zoom in early 2021 (January). The data collection interviews were digitally recorded and transcribed verbatim. Outside of these three interviews, Virginia and I had connected on several occasions, including lunch at her home and during university/department events. In addition to interview transcripts, data also included detailed field notes written after each interview to record initial impressions, observations, and musings about Virginia and her life story. Interview transcripts were read in their entirety and the Comments function in Microsoft Word was used to tag data (open coding); memo writing was also used to record decision making and develop ideas for analyzing and interpreting the interviews.

During the latter part of data analysis, I brought in a graduate student, Sajjad (he/him), to help with the project. Specifically, Sajjad helped in the final coding and analysis of the interview transcripts. As an early-career gerontologist and social work educator from Bangladesh, his memos and reflective notes in response to reading Virginia's transcripts provided the impetus for this paper, which utilizes an adapted autoethnography approach.

Autoethnography

Autoethnography has been defined as an "autobiographical genre of writing and research that displays multiple layers of consciousness, connecting the personal to the cultural" (Ellis & Bochner, 2003, p. 209). This method is flexible—able to be adapted to different research questions and in various contexts. The research focus of this paper is aging, broadly, but it also addresses biological (e.g., physical illness and decline), psychological (e.g., role changes, isolation), and sociocultural (e.g., caregiving, ageism) aspects of aging. We have used data gathered from interviews with Virginia, along with Sajjad's reflective memos, to offer two culturally and generationally divergent perspectives on aging and care for older adults.

In addition to being an adaptable approach that involves an autobiographical style of writing, autoethnography is also a qualitative research method long acknowledged for its emphasis on reflexivity. Bryant (2015) argues that research is more than products and objectives, but can also "be a process *of the becoming* [emphasis added] of individuals" (p. 2). For Sajjad, reading Virginia's interviews and reflecting on them (in writing) became a kind of dialogue with himself. Through reflective writing, researchers actively construct knowledge, engaging with both the research subject (in this case, Virginia) and themselves. In this paper, we highlight how autoethnography supports the co-construction of a nuanced understanding of aging but also has implications for researchers doing this work. In the narratives that follow, we demonstrate how

Sajjad's engagement with Virginia's oral history narratives forces him to examine his assumptions about aging. Rather than his beliefs remaining unquestioned, intentional reflection via autoethnography cultivated a "becoming" (Bryant, 2015, p. 2) whereby Sajjad was able to examine his views on late life, not just for older populations broadly, but for himself specifically.

Findings

The following sections are written narratives from Sajjad. His perspective has been combined with data (including verbatim quotes) from Virginia's interviews to help contextualize his responses to her story. Specifically, the sections below highlight cultural and generational differences in how Virginia and Sajjad think about aging and longevity, caring for older adults, and multigenerational families.

Aging and Longevity

When I first arrived in the U.S. to start my PhD program, I was 42 years old. Beginning a doctoral program in my 40s felt daunting and I have often questioned whether it was an appropriate time to pursue a PhD. People in Bangladesh typically retire from work around the age of 60 (Legislative and Parliamentary Affairs Division, 2018); the current life expectancy for people in my country is about 72 years old (Finance Division, 2023). At a certain point in life, things also just get more complicated. For me, I have a family back home in Bangladesh—a wife and two young children; coming to the U.S. for my PhD program means I am away from them. My insecurities about returning to school in my 40s were reinforced by comments from my peers at the university. Soon after arriving in the States, I was attending a get-together of Bangladeshi students. As I was introducing myself to others at the party, some of them asked me questions like, "Brother, how do you dare to do PhD at this age?" It was a frightening and at the same time embarrassing question. My simple answer was, "I don't know."

I honestly felt quite depressed starting my PhD at age 42. In many ways, I feel "old" and perceive that people's capacity to work hard diminishes with age. Given my mindset about starting school so late in life, Virginia's narrative about her return to graduate school at age 60 was quite compelling to me. In 1974, Virginia and her husband moved from Nashville to Lexington for her husband to assume the role of president at Lexington Theological Seminary. While in Tennessee, she had been involved in a lot of volunteer work through the church where her husband was a pastor. In Kentucky, Virginia had trouble finding her niche in the new community and this is one reason she decided to go back to school. "There was not the same kind of volunteer work [available] at the seminary. And that led to my thinking, 'This is the time for me to go back to school.'"

To be honest, I was shocked to read about this woman who received her master's at age 62. Virginia's story gave me a different outlook on my life and my return to university studies. Even in her 80s and 90s, she has been engaged in her community and continues to do meaningful work. Not only has she helped develop a novel approach to care for people with dementia, but she's also written books and traveled around the world (all after age 60). Virginia speaks about it this way: "I brought my life experiences to the forefront … old age is like standing on a bridge. You have a lot to look forward to the generations ahead of you, but you also have a long look back." Reading her story has shifted my thinking about pursuing my doctoral degree at this stage in my life. Even more, after learning that Virginia lived to be 100 and all her siblings have had similarly long lives, the first thing that came to my mind was: "I am still super young." Rather than viewing my age as a detriment, my age brings life experience that is meaningful to what I'm doing now. I remember sharing her story with two of my Bangladeshi friends and they were similarly impressed. While at times I still worry that I am too old to start a PhD program, I feel like hearing Virginia's story has shifted my mindset. I'm trying to recognize that I potentially have a long life ahead of me and can still accomplish many things before I die.

Multigenerational Families

Like the topic of aging and longevity, another aspect of Virginia's life story that struck me as I read her transcripts was her multigenerational family. At the time of her interviews, she had five living generations in her family. While I knew that life expectancy in the U.S. was higher than in most other countries of the world, I have never really known anyone who lived into their 90s, especially their late 90s. In Bangladesh, three generations are quite common in families, but four generations are much less so. And I'm not sure I have ever known anyone in my country who had five living generations in their family. People in Bangladesh consider themselves lucky if they can see their grandchild before death, so learning that Virginia's family experienced such longevity was quite surprising. When she talked with Natalie about her older sister becoming a great-great-grandmother, she joked about becoming one herself: "I have a great-grandson who's 23, so I said to his mother [and] his grandmother, I said, 'I could be a great, great grandmother.' [His mother] said, 'Don't push it.'"

In my own family, we don't even have three complete living generations. My paternal grandfather died five years before I was born, and my mom's parents died when I was a toddler. I have no memories of them. My paternal grandmother and I were able to develop a relationship, although she died while I was in college. My kids, ages four and ten, are having a similar experience. My father died before my children were born, but they do know their paternal grandmother (my mother), and their maternal grandparents (my wife's parents). In our culture, grandfathers specifically hold immense affection for grandsons. Bangladeshi grandfathers serve as babysitters, companions, guides, and teachers to their grandsons—often spending more time with a young boy than the father does. Throughout my childhood, I yearned for the presence of older relatives, my two grandfathers especially.

Virginia's narrative revealed not only tremendous longevity among her relatives, but also closeness among the extended family, despite generational differences and being geographically dispersed. For Virginia, staying engaged with her large family that includes lots of diversity had been "a learning experience." She said this about coming to learn new things from her extended family:

> Life is just one big learning after another, and I've learned so much from our children, grandchildren and our great grandchildren. In fact, I wouldn't be doing what I'm doing now if it were not for our great grandson who set me up with my computer and helped me get started. So, life is just a whole lesson in evolving, I think.

Virginia described her family in this way: "multi-generational, multicultural, multiracial, we're different sexual orientations, we have vegans and vegetarians and Republicans and Democrats." One way that her family stays connected is through their yearly family reunions, often held at a state park to accommodate the many attendees. During COVID-19, these reunions moved to an online platform, and breakout rooms were used so the family could talk in smaller groups. About younger relatives' involvement in these family gatherings, Virginia said:

> A lot of people say that they can't get [to] the young people anymore, but last year, all 15 of my great-grandchildren were there and they came from Laramie, Wyoming and Asheville, North Carolina, Tennessee, and Kentucky. It was just a joy for me to have all of them.

The reunions originated with Virginia when her parents moved into residential care. "I've been the one that's done most of it," she explained, "but … it's never just me." In recent years, the younger generations in the family are also starting to assume planning of the yearly get-togethers. Virginia did acknowledge how much effort it takes to get such a large group together every year and said, "It's just amazing that they still [come]."

I found it amazing that such a huge family arranges reunions every year. Such family reunions are not common in Bangladesh. It is not like family members and relatives do not want to connect, but socio-economic constraints (i.e., poverty, transportation barriers) often prevent families from getting together at one time. However, on some occasions, family members and relatives get together. Usually, the deaths of older family members and weddings in the family bring family members and relatives together.

Caring for Older Adults

Although Bangladesh has been graduated from a least-developed country to a lower-middle-income country in 2014, the benefits of economic development have yet to reach all citizens (Rahman & Mujeri, 2018). Older adults in Bangladesh lack a reliable social security system, so adult children often provide full support for their aged parents (i.e., housing, financial support, and social and emotional care). This is especially true in lower-income families where adult children typically live with their aging parents. If parents become ill, children often go to great lengths to ensure they receive quality care, sometimes even selling land or their own homes.

My impression of long-term care in the U.S. is that many older adults do not receive care in their homes from friends and family. Despite this assumption, the reality is that most older Americans who have disabilities and care needs live in the community, rather than in institutional care. These older adults' long-term care needs are often provided by unpaid family and friends

(Administration for Community Living & Administration on Aging, 2020; Fabius et al., 2021). Given Virginia's eventual focus on improving care for older adults with dementia, the topic of her own parents' long-term care needs was something that came up during her interviews with Natalie. About her parents' experience aging in a rural community, Virginia said this:

> [My parents] were out in the country and … we had a hard time finding help because anybody in the community that we could find to come in and help, they were aging themselves. And nobody in Cynthiana wanted to [travel] eight miles out into the country.

Although they were eventually able to find a paid caregiver, Virginia's mother and father initially had to live in separate homes. Her mother was more open to moving to a care facility, but according to Virginia, "[A paid caregiver] stayed with my father because daddy so wanted to stay. He was a man of the land … he adored the land." She and her five sisters "lived away" and their brother, who resided close by, provided help "until he had enough" with being a caregiver while simultaneously raising his own five children. When care plans needed to be adjusted, the children talked with her father, who said, "Do what you need to do, and I'll try to make the best of it." Virginia's mother and father, who died at age 95 and 92 respectively, lived the end of their lives in residential care.

When reading Virginia's interviews, her description of navigating care needs for her parents resonated with me, both as an adult child and as someone who will (hopefully) live a long life and may one day have long-term care needs. At this time, I cannot even think of leaving my aging parents alone in their home, nor can I imagine that my children might not care for me when I grow old. In Bangladesh, filial responsibility (Afroze, 2022; Park et al., 2022) is a cultural value; most people believe that just as parents take care of their children during their (children's) childhood, children likewise are to take care of their parents in their (parents') later life. As mentioned earlier, adult children sometimes sell their only land, even their homes, to pay for their parents' treatment. In Bangladesh, leaving parents alone in later life is rare. In my own family, I am one of eight children. I used to live in the city with my wife and kids due to our (mine and my wife's) jobs. When in my home country, I would want to have my mother live with me. However, my mom prefers living in her village home to residing in an urban area. There were times when I would bring my mom into my home, and she stayed with us temporarily. Even now, while I am studying in the U.S., my mother often visits and stays with my wife and kids. All my sisters are married and have moved to their husbands' places. Of the four sons of my parents, two live in the city, and another two (including me) live abroad. None of my siblings live in the village home with my mother. My younger brother, who works in Singapore, married suddenly, allowing his wife to tend to our mother. Now, his wife lives in our village home in Bangladesh with my mother; my brother tries to visit regularly. As often as possible, my siblings and I go to our village home to spend time with our mother. Additionally, we all contribute financially to our mother's living expenses (as we are able).

I was so surprised to learn that, although Virginia has more than 100 living family members (including great-grandchildren), she lives alone. She is visited often by her children, grandchildren, and great-grandchildren, but since 2017, when her husband died, she has resided by herself. Again, I was raised in a society where this kind of situation is uncommon. While not every child can take care of their parents in later life, there is almost always *someone* who can step in and assist them (e.g., aunts, cousins). It is puzzling to me that older adults are left to live alone in later life, especially in such a wealthy and developed country like the U.S.

Conclusion

Autoethnographic writing has the power to help us question our dominant frames of thinking. Self-awareness has been connected to being a culturally responsive practitioner (Feize & Gonzalez, 2018; Yan & Wong, 2005), as well as engaging in ethical practice (Council on Social Work Education, 2008; Pieterse et al., 2013; Pompeo & Levitt, 2014) and research (Kim, 2016; Merriam & Tisdell, 2016). As professional helpers, we must acknowledge our biases and subjectivities. Everyone has "warm … and cool spots, the emergence of positive and negative feelings … experiences [we want] more of or want to avoid" (Peshkin, 1988, p. 18). Our subjectivities are consistent with us, "like a garment that cannot be removed" (Peshkin, 1988, p. 18)—present in the professional and personal aspects of our lives. Sajjad's reflective memos, written in response to reading Virginia's interviews, revealed some of the sedimented ways of thinking about what aging looked like for older adults living in the U.S. This paper responds to the appeal within gerontological and aging studies communities for more reflexivity in our scholarship (Pruchno, 2017; Ray, 2008) and illustrates how autoethnographic writing provides a way to meaningfully attend to one's subjectivity and encourage scholars to have a more humble, curious posture towards their research subjects. Whether it be in the form of memos (Birks et al., 2008), field notes (Finlay, 2002; Thompson, 2014), notes on an index card (Peshkin, 1988), voice memos, or jottings on the back of an envelope, reflective writing is crucial to intentionally recognize our positionality.

We need to acknowledge that Sajjad's narrative represents his singular perspective, informed by his family of origin, his personal experiences, his socioeconomic background, etc. His description of life in South Asia, and Bangladesh specifically, may not be the same for everyone. And yet, "experience can be a way to know and can inform how we know what we know" (hooks, 1994, p. 90). Reading on a particular subject (e.g., aging in the U.S.) is different from firsthand experience with or even vicarious learning on the subject. Experiential learning is a bridge that connects knowing *about* something to knowing *how to do* or *apply* this knowledge (Morris, 2020). Helping students integrate a conceptual understanding and practical application is a central function of education. Oral histories have been used as a pedagogical tool for experiential learning with future helpers (e.g., social workers, counselors). Educators have utilized oral history assignments to develop practice skills and competencies in undergraduate (Ames & Diepstra, 2006; Diepstra & Ames, 2006; Gammonley et al., 2014; Maschi et al., 2012; Masciadrelli, 2014) and graduate students (Bial et al., 2012). Oral histories can be a supplement in practice classes, providing an opportunity for students to apply skills and knowledge gained in the classroom. For example, Masciadrelli (2014) used an oral history assignment to teach basic interviewing and engagement skills. In addition to technical skills, educators have made use of oral histories to promote students' self-awareness (Ames & Diepstra, 2006) and teach foundational content on human behavior and the social environment (Diepstra & Ames, 2006).

Janesick (2020) speaks of interviewing as a creative act; she maintains that creativity is "about discovery" (p. 460). Qualitative interviewing is a tool we can use to gain an in-depth understanding of a person's life or an experience they've had. The process of interviewing—or close reading of interview transcripts—creates an opportunity to not only explore a person's life or aspects of the life, but "provides a vehicle for us to better understand ourselves as researchers [and people]" (Janesick, 2020, p. 460).

Autoethnography is one approach to co-construct a nuanced understanding of aging as we have done here by fusing the individual experiences of Virginia and Sajjad. Engaging with personal narratives, either by conducting oral history interviews or reading and reflecting on interview text, offers one approach to experiential learning and supporting praxis in social work classrooms. Intentional reflection using autoethnography illustrates a dialogical process whereby both the researcher/practitioner and participant/client are affected and changed.

Authors' Note

We (Natalie and Sajjad) authors would like to express our gratitude to Virginia Marsh Bell for her time, generosity, and openness in sharing her remarkable life story. Virginia's willingness to share her wisdom on life, aging, and relationships has enriched us personally. We are truly honored and grateful for having been able to know her, both personally and through her preserved narratives.

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Where Do You Stand?: Lessons I Hope My Great-Grandfather Will Teach Me

Amie Thurber

Abstract: In this piece, I reflect on my new research into my great-grandfather, an influential and controversial Rabbi who, beginning in the 1940s, lobbied against the establishment of a Jewish state. Part 1 considers the current crisis in Palestine/Israel alongside a sermon delivered by my great-grandfather 80 years ago. Part 2 reflects on the origin of this research, begun two years before the current escalation of violence, as well as the scope and potential contributions of this study to contemporary American history and to the field of social work. In Part 3, I interrogate why it has taken so long to begin this work, critically reflecting on what has held me back from engaging in anti-Zionist study and action.

Keywords**:** Palestine, anti-Zionism, social movements, reflective research

Author Note

I wrote and submitted this piece in November 2023 and received peer reviews in March 2025. Much has happened in the months in between. As this manuscript emerged from a particular moment, I have left intact my knowledge and grappling from the time of submission. While there are many variations of Zionism and anti-Zionism, in this piece "Zionism" refers to the political ethnonationalist movement that established and maintains a Jewish majority state, and which is presently reflected by the views of the governing majority in Israel, while "Anti-Zionism" refers to Jewish dissent against Jewish ethnonationalism.

Part 1: Where Do You Stand?

The days following October 7, 2023, were a blur. First: News that Hamas fighters had broken through the heavily reinforced barriers Israel erected to enclose the Gaza Strip and launched a surprise attack. Hamas had murdered over 1,000 people in their homes and communities and kidnapped some 240 others, among them infants and elders. Reports from Israel evidenced people in a state of terror, a sentiment that rippled across Jewish communities worldwide.

And then, within the day, Israel declared war on Hamas. The government cut off water, power, and the import of food and medicine, and launched a relentless bombing campaign that leveled entire blocks and included as targets journalists, ambulances and hospitals, United Nations–operated schools and universities, and places of worship. Within one week, nearly a quarter of the region's residents were homeless; the death toll in Gaza approached 2,000, of which at least 600 were children (Office of the United Nations High Commissioner for Human Rights [OHCHR], 2023).

My first morning back on campus I wandered the empty halls of the School of Social Work. I felt unmoored, desperate for connection. I paused in front of an open office; my colleague asked, "How are you?" I assumed she was asking me as a Jew and tried to put words to the choking sense of horror rising inside me: "I am terrified this is the start of a genocide." A puzzled look flashed across her face; I realized her greeting had been one of custom rather than curiosity. She did not understand, and did not really want to know.

Before the end of the second week, the numbers of Palestinians killed by Israeli forces had more than doubled (OHCHR, 2023). On October 27, the Gaza Health Ministry released a list of the names, genders, and ages of the more than 7,000 presumed dead (Democracy Now!, 2023) and shortly thereafter, most of Gaza lost phone and internet access (Al-Hlou & Abdulrahim, 2023). As the Israeli Defense Force began its ground invasion of Gaza, Palestinians inside Gaza had no way of communicating with family both inside and outside the war zone, ambulances had no way of receiving calls and responding to the wounded, and journalists had no way of letting the world know the costs of Israel's war to "wipe" Hamas "off the face of this earth" (Lubell, 2023, para. 7). Every day that passed, the death count soared, and the already unlivable conditions within Gaza deteriorated further. Within a month, I am certain: I am witnessing an attempted genocide of the 2.2 million Palestinian people in Gaza. But what can I do? What *should* I do? What are my responsibilities, as an American, as a social work educator, and especially, as a Jew?

As I grapple with this unfolding catastrophe—gut-wrenching in its inhumanity, and excruciating as it is undertaken *in our name*—I keep looking to my great-grandfather, Rabbi Irving Reichert, whose portrait hangs just above my desk. I never knew him, but I have long known of his 1943 Kol Nidre sermon, titled "Where do you stand?", delivered nearly 80 years to the day prior to October 7. On that particular eve of Yom Kippur, otherwise known as the "Day of Atonement," some 70 nations were embattled in World War II, the Nazis had conducted mass executions of Jewish people across Europe, and Hitler's plan to exterminate all Jews—along with other targets of the Nazi regime—was well known. There was an unfolding refugee crisis: Hundreds of thousands of Jewish people had fled Europe, and many more remained desperate for safety. In response, Zionist organizations worldwide deepened their efforts to establish a Jewish state in Palestine, and it was to this latter topic that Rabbi Reichert turned. It was then, as now, a highly divisive topic.

Looking out at his congregants at Congregation Emanu-El in San Francisco—one of California's oldest and among the nation's largest Jewish temples—Rabbi Reichert (1953) acknowledged that the question of a Jewish state had become "the rock upon which American Jewry has been cleft into two distinct and determined groups" (p. 136). He understood the fight as between two contrasting theories of change. On the one hand, the political Zionist movement proposed that the sole path to safety for the Jewish people was through the establishment of a Jewish nation and army. On the other hand, Reichert—along with members of the newly formed American Council for Judaism (ACJ) argued that egalitarianism and democracy were the roads to Jewish safety, and that Jewish people are safest when and where all people are safe. Reichert (1953) used this Kol Nidre sermon to make his case for the ACJ, arguing that "the basis of unity among Jews is not political nationalism, but religion" (p. 139). He referenced the violence already unfolding in Palestine—"a long series of riots, assassinations and bloody clashes between an intensified Jewish nationalism and a defensive Arab nationalism" (p. 139)—before offering the ACJ's approach to the Jewish refugee crisis:

> [The ACJ] believes that Jews and Arabs working harmoniously together in Palestine, under a democratic form of government, democratically arrived at, which shall afford equal protection and opportunity to all men regardless of race, nationality or creed, represents an equitable solution of the problem in harmony with the ideals of the Four Freedoms for which we are fighting. The Council maintains that Palestine is one of the countries to which Jews ought to be permitted to immigrate if they desire. But at the same time, it calls upon the United Nations to liberalize the opportunities for all persecuted and uprooted peoples of Europe to re-establish themselves in their former homes if that is what they want, or to find homes after the war in other lands if they wish to emigrate (pp. 139–140).

The Rabbi foresaw that the decision of whether or not to establish an ethnonationalist political state for Jewish people would have grave and lasting consequences. He ended his sermon with an appeal to his congregants:

> The postwar status of the Jews is a concern that affects deeply and intimately and permanently the lives of every one of you here tonight, and of your children and children's children. You cannot be silent and indifferent on this issue! (p. 142).

Rabbi Reichert was not silent: He spoke on national radio broadcasts, wrote editorials in national newspapers, and toured the country raising alarms about the moral, political, and human consequences of the Zionist nationalist movement. Having traveled to Nazi Germany to document worsening conditions for Jews in 1933 and again in 1937, Reichert was acutely aware of the dangers of ethnonationalist movements. In a 1936 sermon, Reichert (1953) had warned, "There is too dangerous a parallel between the insistence of Zionist spokesmen upon nationality and race and blood, and sinister pronouncements by Fascist leaders in European dictatorships … We may live to regret it" (p. 132). Concurrent with his efforts to delegitimize the *ends* of the Zionist movement—an ethnonationalist state—he warned against the movement's *means*: a proclivity of the Zionist organizers towards stacking votes, smear campaigns, and splitting the Jewish community (see Kolsky, 1990). During his 1943 Kol Nidre sermon, the Rabbi cautioned his congregants to be wary of the dogmatic approach of the Zionist leaders, quoting the president of the Zionist Organization of America, Rabbi Israel Goldstein, who had recently declared, "No Jew is a normal Jew who is not a Zionist" (as cited in Reichert, 1953, p. 137). Rabbi Reichert believed that such a conflation was erroneous and dangerous, and divided a Jewish community who could otherwise be leveraging unified pressure on the U.S. and elsewhere—including in Mandatory Palestine—to open their borders to Jewish refugees.

At the time of the Rabbi's 1943 Kol Nidre sermon, the membership of the Zionist Organization of America represented a fraction of the American Jewish population. Yet, the twin horrors of the Holocaust and the refusal of many countries to offer safe haven to refugees spurred many American Jews to shift their politics towards Jewish nationalism. The ranks of the Zionist movement swelled. Ultimately, the efforts of the ACJ were unsuccessful at materially shifting U.S. immigration policy or halting the establishment of Jewish state.

Today, the ideological dominance of Zionism is so entrenched that Goldstein's notion, "No Jew is a normal Jew who is not a Zionist," might read to many as a statement of fact. Indeed, in response to a large Jewish rally at the National Mall protesting Israel's attacks on Gaza, David Friedman, the former U.S. ambassador to Israel during Trump's first term, declared: "Any American Jew attending this rally is not a Jew!" (Tait, 2023, para. 8). For many, the trifecta of Jewish people, Zionist ideology, and the state of Israel have been so thoroughly laminated together that it is difficult to think them apart, or to imagine Jews who are not Zionist or Jews who do not universally support Israeli state actions. The more chilling effect of this lamination has been to weaponize any and all critiques of Zionism or the state of Israel as an attack against Jews as a people. In response to the National Mall rally, the Anti-Defamation League (formed to combat antisemitism), issued the following statement: "Let's be very clear—anti-Zionism is antisemitism" (Tait, 2023, para. 8). For (at least) eighty years, proponents of Zionism have been trying to silence dissenting views on the question of Jewish nationalism, and have been remarkably successful.

In my role as a social work educator, many of the Jewish students I encounter were raised with little to no exposure to anti- or non-Zionist Jews, or the role that they played in organizing against the establishment of a Jewish state. Most are unfamiliar with the once foundational Jewish belief that Zionism is fundamentally incompatible with the tenets of Judaism, as reiterated by the Union of American Hebrew Congregations in 1898: "The mission of Judaism is spiritual, not political. Its aim is not to establish a state, but to spread the truths of religion and humanity throughout the world" (p. 4002). Further, Jewish and non-Jewish students alike struggle to apply social work's bedrock commitment to social justice and human rights to the lives of Palestinians, or to consider the ramifications of a settler colonial project that provided a homeland to survivors of the Jewish Holocaust through the expulsion of the Palestinian people (Levine, 2014).

Two years ago, after wondering if my great-grandfather's story could provide a useful intervention into these knowledge gaps, I began inching my way into a research project of his life and the 13 years he spent organizing against Zionism as the national vice-president of the ACJ (Kolsky, 1990; Rosenbaum, 1980). I contacted relatives and began gathering materials. A second-cousin I have yet to meet sent me a portrait of my great-grandfather that had hung in her parent's home. I mounted it above my desk, but made little headway in the work. Now, in the midst of a genocide, I feel he is watching my every move, asking: Where do you stand?

Part 2: Why Begin This Study Now?

If there was a singular spark that turned me towards my great-grandfather as the primary focus of my scholarship, it was a viral 2021 video of New Yorker Justin Fauci squatting in the Al-Kurd family home in Sheikh Jarrah, in a Jerusalem neighborhood built in the early 1950s for Palestinians displaced by the 1948 Nakba. There was a lot happening at this time: IDF raids of worshippers at Al-Aqsa Mosque, forced evictions of Palestinians in the Sheikh Jarrah neighborhood to create space for Jewish settlers, and mobs of right-wing Israelis marching through Palestinian neighborhoods chanting “Death to Arabs” and “May your village burn” (Democracy Now!, 2021). In many ways, there was nothing novel about this moment: Israel has been expelling Palestinians from their homes since 1948. What was different was me: This time I could not look away.

The viral video shows the Long Island–raised, Brandeis-educated Justin—now calling himself Yaakov—standing in the yard of the occupied multigenerational al-Kurd family home, a home he has now moved into. Mona al-Kurd says, “Yaakov, you know this is not your house,” to which Justin responds, “Yes, but if I don’t steal it, someone else is gonna steal it” (Sabbagh-Khoury, 2022). Justin, I learned, is one of thousands of U.S. Jews recruited by U.S.- and Israeli-based settler organizations in order to manufacture a Jewish supermajority in the region, including by moving American Jews into currently occupied Palestinian homes (for more on the settlement movement, see Hirschorn, 2020).

So much about the news coverage from these weeks was jarring—the viciousness of the assaults upon people in prayer; the evictions of long-time residents, already refugees once over at the hands of the state—but the presence of Jacob and the role of U.S.-based settler organizations closed the distance between me and this “conflict” in a way that had not previously occurred. My research has focused on contested places and racialized displacement. Most of my work has been in historically Black neighborhoods in Nashville, Tennessee, and Portland, Oregon, where long-time residents are priced out and pushed out; where the places residents have generationally gathered to worship, to organize, to educate, and to celebrate have been destroyed; and where those who remain are often treated as strangers or threats in the neighborhoods where they were born and raised. If I cared about these issues *here,* how could I not care about them *there,* particularly when those displacements were led by U.S.-based organizations and American transplants?

Horrified by narratives that the safety of the Jewish people is somehow predicated on the subjugation, oppression, and annihilation of Palestinian people—and the role of U.S. Jewish organizations in crafting and recirculating that narrative—I felt compelled to act. As I considered the scholarly arena in which I may be best positioned to contribute, the spark lit by Jacob Fauci’s expression of Jewish nationalism burned a thread back to my great-grandfather’s warnings of the threats of this very ideology. It seemed then, in 2021, and more so today, necessary to document and uplift legacies of Jewish resistance to Zionism. Thus, I embarked on what I hoped would be the first comprehensive biography of Irving Reichert.

The scholarship in the area of Jewish-led anti-Zionist social movements in general, and on Rabbi Reichert in particular, is thin. While he received passing reference in texts about the ACJ (see Kolsky, 1990, and Ross, 2011), the most substantive historical accounts of the Rabbi have been offered by a single historian, Fred Rosenbaum, in chapters of two published books (Rosenbaum, 1980; Rosenbaum, 1991) and numerous speeches. In a 2017 lecture at Stanford University, Rosenbaum expressed his disdain for the anti-Zionist organizing of Rabbi Reichert and the ACJ, describing it as "the most shameful episode in all of our local history" (Rosenbaum, 2017). That Rosenbaum paid such special attention to Rabbi Reichert speaks to the Rabbi's significance as a historical figure and makes him deserving of more robust historical inquiry than has been undertaken heretofore. Particularly unexplored in existing literature is Rabbi Reichert's rationale for opposing Zionism. Through interviews with those still living who knew the Rabbi, exploration of the archival records, and review of secondary sources, I hope to gain insight into the religious, philosophical, and/or ethical foundations of Rabbi Reichert's anti-Zionist position. What were his central arguments against Zionism and how did these arguments evolve after Israel's statehood? What strategies and tactics did he and the ACJ use to oppose the Zionist movement in America? And, finally, what were the personal and professional costs of Reichert's anti-Zionist stance?

Broadly, it is my hope that this study can meaningfully contribute to the historic record of Rabbi Reichert and offer insight into Jewish-led efforts to oppose Zionism in the mid-20th century. While there are significant limitations as to what a study of a single historical figure can offer, my hope is that this study can be part of a wider reclamation of anti-Zionist pasts, and perhaps inform and inspire a future rooted in collective liberation. This study also has particular relevance to social work. As social work scholar Michael Reisch (2021) observes, "What binds many contemporary social movements most closely with the social work profession, both philosophically and practically, is their common commitment to the expansion of democracy and the promotion of human rights and social justice on a global scale" (p. 10). These commitments have led to social work engagement in various movements for economic, gender, and racial justice, and in opposition to antisemitism and xenophobia (Reisch, 2021). However, as a field, social work has been largely silent on the subject of Zionism and its impact on democracy and human rights for Palestinians, historically and at present (as exceptions, see Levine, 2014; Rees, 2016; Shalhoub-Kevorkian et al., 2022). In contributing to the published scholarship of mid-20th century anti-Zionist social movements, this study may invite social work to consider its historic and contemporary stance towards Palestinian liberation movements.

The stakes for Palestinian people have perhaps not been higher since the 1948 Nakba, when an estimated 750,000 Palestinians were displaced in the creation of the State of Israel. Concurrently, Jewish American resistance to Israeli policies of apartheid and the occupation of the West Bank and Gaza is on the rise (Fahy et al., 2023; Tait, 2023). There is no Jewish consensus: Divergent interpretations of this moment have ruptured Jewish families, congregations, and even the field of genocide studies (e.g., Klein, 2025). But there is a growing scholarship of Jewish dissent (Butler, 2012; Feld, 2024; Levin, 2023), and American and Israeli Jews are increasingly rejecting the premise that the safety of Jewish people in Israel is predicated on the absence of Palestinians (Da Silva, 2023; Sanders, 2023). Indeed, given the stakes of this moment, answering the question of "why start this study now?" is relatively easy. Much harder to explain is why I did not start it sooner.

Part 3: Why Haven't I Started This Sooner?

After deciding two years ago that I wanted to research my great-grandfather, I have been slow to get going. At first, I convinced myself it was just a matter of clearing space in my full research agenda, which was certainly true. But as openings came, and I filled them with other new projects, I realized I was buried under a landslide of doubt.

I questioned whether I was *the right kind of scholar*. I was trained as a social scientist, not a historian, and though I have robust methodological training and some experience in historical methods, this project is afield from my current research trajectory. Can I do justice to this project with the training and research experience I have? I keep assuring myself that yes, the study as I have defined it—a thorough investigation of a single historical figure—is well within my depth as a scholar. And, I reminded myself that while this work is different from my other research, it is also in line with my scholarly commitments: I have spent my adult life immersed in histories, practices, and movements to contest systemic oppression and advance justice. I have had particular interest in uplifting stories of social justice struggles that have been buried, forgotten, or silenced—stories that often help us to better know our past, understand the present, and imagine our future. Further, as a social work professor, I have a professional obligation to equip future practitioners with the skills and knowledge to create more just policies, systems, organizations, and communities (National Association of Social Workers, 2021). Thus, this work is clearly aligned with my disciplinary commitments and responsibilities.

But then, I worried that even if I had the research tools, I *lacked the subject area expertise* needed to do justice to this study. The study of my great-grandfather is entangled with the history of Jewish and Palestinian peoples. Yet, I have no expertise in Judaica, Jewish-American studies, or Middle-Eastern Studies, and I have never seriously engaged in study related to Palestine/Israel. How will I be able to do justice to the generations of Jewish people's suffering that led to the creation of the state of Israel, and the generations of suffering of Palestinians who have lost their land, liberty, and lives through Israel's creation? I reminded myself that I have long been a student of, and more recently a contributor to, scholarship that explores how relationships of inequality are emplaced and how they can be transformed. Further, background research is something I enjoy doing and do well, and this is an area I am eager to learn.

I also worried that, as a descendant, I was *too close to the subject* to be (or to be perceived as being) a reliable biographer. Yet, I have no interest in cherry-picking history, or painting an overly heroic vision of Rabbi Reichert. I already know some of his failings as a father and grandfather, and I expect to encounter more of his shortcomings—personal and professional—as the study unfolds. My goal is to conduct a holistic exploration of who he was, how he lived, what he believed, and how his views and perspectives evolved over time. There is likely as much to learn from the places in which he struggled to fully live into his values as there is to learn from his achievements. Further, my closeness to the subject has provided me access to stories and artifacts I would not otherwise encounter. Already, I have had the gift of interviewing three people in their 90s who knew my great-grandfather—two nephews and a congregant—and have received a precious bundle of letters between my great-grandfather and his brother, beginning when they were young men in rabbinical school and continuing throughout their lives.

But then again, I have also worried that I am *not close enough to the subject* to be, or be perceived as being, a reliable biographer. My great-grandfather was the last in a line of rabbis in our family tree, and my particular branch is largely secular. I was raised with a strong sense of quiet family pride in being Jewish, but unaffiliated with Jewish spiritual, cultural, and civic organizations. One consequence of this cultural isolation is that I was not introduced to/indoctrinated into Zionist thinking. However, neither was I raised in an expressly non-Zionist or anti-Zionist household. In the stories passed down about my great-grandfather, the women in my family spoke with reverence of his willingness to take unpopular and principled stands, and to risk his career in doing so. But none, including me, had been inclined to pick up the banner of his beliefs, or to investigate them more fully. Another consequence of my separation from Jewish community and religion is the sense of not being Jewish “enough.” As a child I yearned to look more Jewish and to have a more recognizably Jewish name (the irony of this is not lost on me, as internalized antisemitism and pressures of assimilation have led many Jewish children to wish the opposite). To this day I carry an unsettled mix of cultural pride and longing for a community I have never quite known how to access. But here too, I see the opportunity this research presents: a way into deeper exploration of Judaism and Jewish intellectual traditions, and deeper engagement in Jewish communities.

So, what is *really* holding me back? What is under these doubts of not being the right kind of scholar, of not knowing enough, of being too close, or not being close enough? It feels rooted in fear. But fear of what? A few days ago, a Palestinian friend recounted a recent conversation with her son, during which she shared that she was going to be interviewed by a local reporter seeking the “Palestinian perspective” on the current war. “Are you sure that’s a good idea?” her 15-year-old had asked, continuing, “Aren’t you worried people will think you are antisemitic?” She answered, “I used to be, but now I have the words to talk about it, and I’m not scared anymore.” I realized, in that moment, that I do not yet have the words. But why not?

As a young person, I mobilized around various social justice causes. In elementary school, I went door-to-door raising money to address famine in Africa. In high school, I volunteered on a campaign to oppose anti-gay ballot initiatives in my hometown, and worked overnight shifts at a domestic violence shelter. In college, I played leadership roles in various justice-oriented clubs, and started a non-profit organization to educate others about systemic oppression. Yet somehow, I never engaged in serious study related to Palestine/Israel. Sure, I have held a political position, largely parroting the position held by my great-grandfather, as best I understood it: That the State of Israel was founded on a deeply dangerous and morally flawed ideology, and that no peace is possible without equal rights for Palestinians in Israel and self-determination for those in the occupied territories. I have mostly kept that position to myself, and have done little to deepen my thinking or understanding of how the situation in Palestine/Israel unfolded over the last 75 years, how the United States is implicated in the region, what that means for the people living there now, and importantly, what this situation requires of the rest of us, particularly Jewish Americans. When I say I have done little, let me be more explicit: While I have gone to a few talks here or there, and read essays in passing, I have never taken a class on the historical or contemporary geopolitical context of Palestine/Israel, and before recently, have actually never read a complete book dedicated to the subject. How could this possibly be true? Why have I prioritized learning about so many other struggles, and not this one? Why have I waited so long to research my own family history? Why have I avoided learning, and chosen willful ignorance instead?

Part of this is most certainly a personal failing: I have not sought, in any systematic fashion, to educate myself the way I have about other comparable issues or concerns. (Indeed, thanks to a summer intensive course I took in Derry, I know more about settler-colonialism in the context of Northern Ireland, a region to which I have no connection, than I do in relation to Palestine.) Even as I've started this research project, I have stayed largely in a gathering and acquisition mode for more than a year now—seeking sources and filling my physical and digital library—and have found it difficult to actually begin reading and writing. But this also suggests a structural failing: How could engagement with Palestine/Israel, arguably the site of the most blatant form of contemporary apartheid in the developed world, be entirely absent from my education (including two master's degrees and doctoral study), the focus of which has been social justice? It is as if I have been professionally trained to look away from Palestine/Israel, to consider all other forms of injustice and suffering, but not this one. (I wish I could cite Marc Lamont Hill and Mitchell Plitnick's recent book, *Except for Palestine* here, because I have a hunch they speak to this, but it is one of the many books I have gathered and not yet read.)

The more I scratch at this, I think I have been afraid to learn, because learning would require me to act, and those actions come with risks that I have felt unprepared to take. Unprepared not as in *unwilling*, but as in *not in fighting shape*. Because it does feel that if one speaks out against Zionism—even through, as I propose, inquiry into a historical figure—one has to be prepared to enter a kind of battle. To be clear, the stakes are incomparable to those born by Palestinians who speak out against Israeli policies: There are currently 10,000 Palestinian political prisoners incarcerated in Israel (Ludwig, 2023). Consequences are also extreme for Israeli citizens who criticize the state: Jewish Knesset member Ofer Cassif was recently suspended for his statements against Israeli policies (Marsden, 2023), and Jewish Israeli students have faced arrest and expulsion for protesting the state (Da Silva, 2023). That said, from the blacklisting that my great-grandfather endured, Zionist backlash in America is not nothing.

One of the earliest stories I carry related to my great-grandfather was recounted by his son Irving Jr. as he visited his sister (my grandmother and namesake) when I was around 10 years old. I sat rapt at "Big Amie's" dining room table as these elders recounted their childhood—and the day that the head of the American Zionist Organization visited the family home to offer their father a leadership role in their movement. As Irv recalled: "They said, 'If you join us, we will give you everything West of the Mississippi. If you don't, we will destroy you.'" His father refused, and instead accelerated his efforts to thwart their campaign. In the end, the Rabbi was in many ways destroyed. On the day that the United Nations voted to create the Jewish State, Rabbi Reichert was asked to resign from his pulpit at Emanu-El. For years, he struggled to find another congregation. In 1957, he wrote to his brother, "I was turned down for two other jobs last month—it appears the Zionists still can't forgive me—and I am as before a 'controversial' figure" (Reichert, 1957, p. 1). The cost of his stance was great: In addition to losing his pulpit, he lost his political influence and sense of purpose. To this day, to resist Zionist ideology in America is rarely without risk. In these first weeks since Israel's declaration of war on Hamas, there has been a flurry of backlash against those who have criticized Israel, and even for those who have not affirmed their blanket support for Israeli retaliation quickly or boldly enough (Hartocollis, 2023; Solender, 2023).

The threat of appearing antisemitic has proved incredibly powerful in silencing critiques of Israeli policies. When these critiques emerge from Jewish people, the critics are quickly dismissed as "self-hating-Jews." When my children were in high school in a new city, they were invited to attend Rosh Hashanah services by a burgeoning friend and her family. My heart swelled to know that they were making friends and connecting with their culture, and I felt immediate appreciation for these parents I had never met, but who had welcomed my children to join them for the day. And then, when the girls returned home, I learned that the father of the household—who for all I knew had never met or even seen me—had referred to me as a Jew-hating-Jew. I was stunned: this man who knows nothing about me, and somehow, he knows *this*? By what piece of evidence did he reach this conclusion? Was I marked in some way? Did he know, somehow, about my great-grandfather's political advocacy? Highly improbable, I know, but there is a way that the Zionist threat against my great-grandfather, "and if you don't, we'll destroy you," has felt like something of a multi-generational curse, and one that I was unprepared to ward against. If they could take down my great-grandfather—renowned for his superior intellect, oratory gifts, dogged persistence, and unwavering courage—how could any of the rest of us stand up against this force?

I feel reverberations of this threat every time some public figure speaks up against Israeli policies or challenges Zionist ideology and is quickly and powerfully reprimanded. Several friends and colleagues suggested I delay starting this research until after I earn tenure. One offered, "You heard what happened to Cornel West, right?" referring to Harvard's failure to grant tenure to one of the most esteemed and prolific public intellectuals of our time, and which West believes was due to his advocacy for-Palestinian liberation (Pierre, 2021). Perhaps it is naivete or privilege, but I do not fear being personally harmed by Zionist backlash (at least, not yet). Instead, I do fear feeling unprepared, not having the words and confidence to effectively respond to such attacks. And, paradoxically, I *can't find* the words and confidence without the courage to learn.

My fear has protected me from being personally targeted with Zionist backlash, but it has also harmed me. Because I have avoided learning, I am less equipped than I should be to meet this moment, as an individual and as an educator. I am working to make up for this now, and have a lot of catching up to do. This fear has also kept me at a distance from Jewish community and Judaism. Throughout my life, I have both yearned for and been wary of Jewish organizations, in part out of fear of how I/we might handle our differences in perspectives on Zionism. And while I have learned from my great-grandfather's legacy that there have *always been* non-Zionist Jewish communities, it is not until recently that I have lived in a place where these are robustly established. Yet, I still have not made my way to them. I was raised to intrinsically reject Zionism's logic with regard to what conditions are necessary to keep Jewish people safe. It has taken until now for me to fully reject Zionism's attempts to short-circuit my learning, to silence my speech and action, and to control my relationship with Judaism and Jewish community.

Conclusion

This week, I sobbed listening to an account of Golan Abitol, whose kibbutz was attacked on October 7 (Tavernise, 2023). He grieved on air for the friends and neighbors who were murdered that day, for the destruction of the neighborhood where he and his children were born, and spoke with anguish for his community members who were kidnapped: "We want them back. We can't be a community without them. They are part of us. It's like a jigsaw puzzle. You can't take one piece and it will be OK" (Tavernise, 2023). I sobbed because I believe this about communities; this, more than anything, has been at the heart of my research for the last decade. In places where people have fought against oppression to create a sanctuary within which to survive, individuals hold multitudes, each part of a fabric that holds collective histories, present struggles, and hopes for the future. This is true in the communities formed by Jewish refugees after WWII across the world, and in Israel. It is equally true in communities created by Palestinians made refugees by the creation of the State of Israel, across the world, and in the West Bank and Gaza Strip. The fabric of collective history, struggle, and hope was torn for Israeli Jews October 7th, and it has been shredded for Palestinians in the days since.

I return to the prophecy in my great-grandfather's 1943 Kol Nidre sermon: "The postwar status of the Jews is a concern that affects *deeply* and *intimately* and *permanently* the lives of every one of you here tonight, and of your children and children's children" (Reichert, 1953, p. 142 emphasis added). Eighty years ago, Rabbi Reichert was fundamentally concerned with how Zionist ideology would ethically, morally, and spiritually corrupt Jewish people. Today, many more Jews share this concern. As one friend put it this morning: "How do we come back from this?" How do we, the people who taught the world to recognize the "signposts along the road to Auschwitz" (Roth, as cited in Perl, n.d., para. 2)—the systematic processes of dehumanization that enable genocide—who swore "never again" to ethnic cleansing, how do we live with the genocide underway in our name?

As I begin to piece together a more complex understanding of who my great-grandfather was, what he believed, and why he dedicated so much of his life to opposing Zionist ideology, I am under no illusion that this study will illuminate a path out of the horrors we now face. That path exists in our future, not in the past. Nor do I yet know how this project will shape my own Jewish identity, though I am certain it will. At present, I hope this study can help fill the well of intellectual fortitude, moral courage, and perseverance that I and perhaps other Jewish social workers so desperately need in order to meet this moment: to resist Zionist silencing; to fight against the atrocities perpetrated in the name of Jewish safety; to affirm Palestinian self-determination; to grieve for and honor all that have died; and on behalf of their children's children, to dream of a future Palestine/Israel that we have not yet seen, but still could come to be.

Acknowledgements

I extend deep gratitude to Stéphanie Wahab and Ledah Wilcox for your thoughtful comments on this piece, and to Lia Saroyan, for your editing.

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Coping as a Double Minority: Reflections of a Black Man Who Achieved His Doctorate in Social Work

Darius Gwynn

Abstract: This article discusses my personal experience as a double minority—Black and male—in a social work doctoral program, emphasizing the unique challenges posed by this intersectionality in an academic context. The narrative explores the correlation between doctoral education and the experiences of Black men, highlighting coping mechanisms and the importance of community support. By explicitly noting the double minority status within this specific academic setting, the examination of implications for social work and recommendations for future research aims to contribute to improving the experiences of the next generation of individuals navigating multiple marginalized identities.

Keywords**:** community, mental health, education

Navigating the doctoral journey presents significant challenges, both academically and emotionally. Highlighted by the concerning doctoral attrition rates ranging from 40 to 60 percent (Ames et al., 2018), these challenges can be particularly acute for Black men in doctoral programs. Data from the 2019 Survey of Earned Doctorates reveals that while 30,151 men received doctoral degrees that year, only 4.18 percent (1,263) were Black men (National Center for Science and Engineering Statistics, 2019). This disparity is even more stark when considering that Black Americans make up approximately 13 percent of the U.S. population (U.S. Census, 2023).

These statistics underscore the critical issue of educational and racial disparities faced by Black men pursuing doctoral degrees.

Beyond the general hurdles of doctoral studies, Black men often encounter unique stressors (Gwynn, 2023). These stressors require them to develop diverse coping strategies to manage the additional burdens they face in day-to-day life (Gwynn, 2023).

Traditionally, social support networks, physical activities, and self-reliance have played crucial roles in their coping strategies (Goodwill et al., 2018). However, the COVID-19 pandemic has disrupted these mechanisms through social distancing measures and limited access to Black male mentors (Molock & Parchem, 2022), particularly in social work doctoral programs. This disruption poses real challenges, potentially leading to increased feelings of isolation and stress, which can impact their academic progress.

What is Coping?

Coping is the conscious use of actions and thoughts to reduce or eliminate a stressor (Gwynn, 2023; Saeedi et al., 2023). There are three types of coping strategies—problem-focused coping, emotion-focused coping, and avoidance coping (Gwynn, 2023; Saeedi et al., 2023). Problem-focused coping strategies are direct cognitive and behavioral processes that modify or eliminate a stressor. Problem-focused coping strategies are used when a threat is perceivably controllable. A few examples of problem-focused coping strategies are studying to reduce test anxiety, practicing a speech for a conference, speaking to a therapist to decrease depressive symptoms, and budgeting to maintain healthy financial habits and reduce impulsive spending. Emotion-focused coping strategies are methods used to regulate an individual's emotional response to a stressor. Emotion-focused coping strategies are employed when a threat or stressor appears uncontrollable. Examples of emotion-focused coping strategies are emotional support, prayer, venting to a trusted person, and rumination. Lastly, avoidance coping is used to escape stressful life events, actions, people, or things by ignoring the stressor (Gwynn, 2023). Research suggests that avoidance coping is the most ineffective form of coping and is significantly associated with depression and anxiety (Gwynn, 2023).

Many scholars have asserted that Black men in higher education programs appear to use avoidance coping strategies more than other strategies (Goodwill et al., 2018; Hoggard et al., 2012). Avoidance coping strategies can exacerbate feelings of loneliness (Law et al., 2023) and position some students to be vulnerable to discontinuing their doctoral program. Considering the low number of Black male doctoral degree recipients, there may be a relationship between Black men, coping strategies, and social work doctoral program completion. To contextualize this hypothesis, the Cultural Transactional Theory of Stress and Coping (CTT; Kuo, 2011, 2013) was used to help frame a personal narrative.

Theoretical Framework

The CTT was developed to examine the association between culture, mental health, and coping (Kuo, 2011, 2013). The CTT underscores Afrocentrism, collectivism, and individualism as vital cultural and cognitive factors that impact coping (Kuo, 2011). The CTT assumes that culture is embedded into the stress-coping process, affecting the five sequentially ordered levels of the theory (Kuo, 2013). The five levels of the CTT are described as panels: Panel I involves the environmental system (e.g., social climate, stressors, and resources in family and work), Panel II personal system (e.g., cognitive abilities, personality traits, social competence), Panel III transitory conditions (e.g., life events and changes), Panel IV cognitive appraisal and coping skills (e.g., approach or avoidance coping), and Panel V health and well-being (e.g., mental and physical health; Chun et al., 2006). This paper uses relevant concepts from the CTT stress and coping model to frame the challenges encountered during my doctoral program and highlight the significance of personal experiences in shaping effective coping strategies. By examining these themes, this narrative aims to contribute valuable insights to social work discourse, particularly regarding the necessity of fostering supportive communities and culturally affirming environments for Black men in both social work practice and academic settings.

Personal Narrative

This narrative will explore my experiences coping as a double minority in a social work doctoral program. Historically, social work has been a white and women-majority field (Plummer et al., 2021). Since I identify as Black and a man, "double minority" was selected to conceptualize my position within this specific academic setting (i.e., a social work doctoral program). I want my narrative to reflect the importance of family and community.

How Did I Get Here?

Well, let's start from the beginning. I attended one of the country's best Historically Black Colleges and Universities (HBCUs) for undergrad. The lessons learned, and the experiences, truly prepared me for life. During my undergraduate studies, I majored in business administration. However, through internships and social interactions, I developed a passion for helping Black men heal. At first, I thought my passions were limited to assisting them to heal financially.

Following graduation, I accepted a job working in the financial industry. I felt stifled because I thought that I was not following my purpose. After seeing a shift in my attitude and emotions, my younger brother recommended that I pursue social work. He said, "You love helping people. You may as well try." Feeling desperate to escape the financial industry, I applied to an HBCU for their Master of Social Work program. It was at this institution that I learned the importance of mentorship. The faculty at my graduate institution were phenomenal. They were encouraging and supportive, and they unlocked a new way of thinking within me. It was also at this institution that I developed a love for research. During the first year of my master's program, I had the opportunity to visit and do research in South Africa. I enjoyed the experience and spoke so highly of it that two professors recommended that I consider a doctoral program. The recommendation was scary. I never thought myself to be an academic, and outside of my professors, I did not know anyone who achieved such a feat, and because of this, I did not believe that I could do it. However, after some convincing, I applied to one social work doctoral program and was accepted!

What Were the Challenges That I Experienced in my Doctoral Program?

I was super excited to begin my doctoral journey. The idea of being a three-time HBCU graduate of three of the most prestigious HBCUs in the country excited me. I remember my first day walking into the orientation. I could not stop smiling. I looked around the room and repeatedly thought, "How lucky am I to be among the number of people accepted into the program?" I listened to every word the speakers said and took copious notes. And later, I went home and watched YouTube videos for hours in preparation for my impending journey. I was going to be ready. I was going to make a difference.

The beginning of the first year was challenging, contributing to my feelings of being an imposter. I had to learn a new writing style, work, and financially support my family. I also had several assignments due every week. It was tough, but I promised my family that I would finish. In my family and community, I was well-known as an academic overachiever. I was a first-generation college student and the only young person in my neighborhood to pursue college. The pressure of thinking that I had to do well for my family and community caused me to develop writing anxiety.

In Panel I, the environmental system, the theory suggests that stress and coping are centered around an individual's social obligations and responsibilities towards family and community (Kuo, 2011, 2013). My family and community celebrated accomplishments, especially educational milestones, as a collective achievement. As a first-generation college student and doctoral pursuant, I knew there was a shared hope that my academic journey would break barriers and establish a precedent for future generations. The weight of this responsibility was emphasized by my family's sacrifices to wholeheartedly support me, both emotionally and financially, in pursuing all my goals and endeavors. Because I witnessed the challenges my mother and grandmother faced while growing up, their investment in my education became a source of significant pressure.

Although they never intentionally pressured me, I internalized a self-imposed sense of perfectionism. I felt compelled to become the person I believed I needed to be to support them, which, in my mind, included excelling as a writer. I viewed it as my obligation to reciprocate the support and upliftment I received from my community and family. Repayment, in my mind, manifested through achieving academic and financial success, providing for my mother's retirement, and contributing to the community through service. This was my Atlas journey, and in anticipation, I crafted a new persona that I believed would assist me in achieving my goal.

In Panel II, the personal system, the theory explores the concept of locus of control. This concept relates to how individuals perceive the forces influencing their lives (Kuo, 2013). This phase of my journey aligns with the internal locus of control concept prevalent in individualistic cultures. Individuals within individualistic environments often prioritize self-reliance and personal responsibility, striving to achieve their goals through independent effort (Kuo, 2013). The persona I adopted reflected this internalized drive. I believed that self-reliance and merit were the sole pathways to becoming an academician. This persona projected composure, strategic thinking, and social adeptness, enabling me to navigate social situations with confidence and humor. However, a continuous internal dialogue questioned my abilities beneath this confident exterior, revealing the underlying self-doubt that persisted despite the outward image.

These expectations extended beyond the individual level; they were ingrained in the fabric of my community, viewing my pursuit of higher education as a symbol of progress and opportunity. While the external validation and recognition were well- intentioned, they contributed to mounting stress and fueled the imposter syndrome during the first year of my doctoral program. The perceived pressure to excel became a constant companion, shaping my mindset and intensifying the writing anxiety I grappled with throughout the first year.

The emphasis on collective well-being resonated deeply with me as someone who values collectivism. In panel III, transitory conditions, the theorists observed that individuals who value collectivism, like me, tend to perceive disruptions to social harmony and security as more stressful than individualistic threats (Chun et al., 2006). This concept became painfully real when my social harmony was unexpectedly shattered in November of my first semester.

The first semester was challenging. While I received valuable writing feedback, it made writing feel like a chore. It worsened further after a phone call from my mother.
She informed me that my younger brother had attempted suicide. Feeling confused and frustrated, I went to the hospital, comforted my family, and headed straight to class. The drive back to my university seemed endless. I fell into a cycle of negative self-talk. I blamed myself for not being there to support him and condemned myself for thinking that I could. I fell further into feeling like an imposter. "How could I ever hope to help Black men if I could not help my brother?" The mental fog shrouded my judgment, and I missed a presentation. The missed presentation resulted in an email requesting that I remove myself from the program.

The sharply worded, straightforward email intensified the emotional turbulence I was already circumnavigating. As I opened the message, the first two sentences read "Colleagues, I have included you all, because of how everything happened tonight with him not doing his presentation. I want to ask you [me] not to respond to this email." I felt like my spirit was draining from my body and onto the floor, and a wave of anxiety washed over me. The words on the screen seemed to blur as I grappled with the potential consequences of this unexpected tum of events. The ending of the e-mail was crushing. It read, "But let me be clear, you are not going to smile your way through our PhD Program, it is more to earning a PhD than looking good and being nice." This section of the email was hurtful because I felt exposed and seen. I knew that the persona that I created was not protecting me in the ways in which I thought it would. I was vulnerable and my professor identified my Achilles heel.

The email, initially, felt like a confirmation of my innermost fears and insecurities—a stark realization that I might not be equipped to handle the challenges before me. "Maybe everyone was wrong about me." It was a moment of great vulnerability, amplifying the sense of isolation that had already taken root in my journey. The weight of the message hung heavily in the air, casting a shadow over my aspirations and reinforcing the belief that perhaps I was not cut out for the demands of a doctoral program. Although I did not respond or comply with the e-mail, I knew quitting was not an option. I had to persevere and trailblaze a new path for my family and community members.

During the struggles of my first semester, I coped with the overwhelming challenges by retreating into isolation. The weight of my brother's hospitalization and the subsequent fallout left me feeling emotionally drained and unable to reach out for support. Amid my depression, I waited for someone, perhaps a professor, to notice my struggle and offer assistance. However, that lifeline never materialized, leaving me grappling with my difficulties in silence. The perception that no one would help deepened my sense of isolation and fueled the belief that I had to navigate my troubles alone.

Isolation became a coping mechanism, albeit an unhealthy one, as I yearned for someone to question what had happened and provide the support I so desperately needed. The feelings of loneliness, avoidance, and isolation lasted throughout the coursework portion of my program.

Reflecting on my experience during that challenging first semester, I recognize how my coping mechanisms interacted with broader cultural influences. As highlighted in Panel IV, cognitive appraisal and coping skills, individuals employ various strategies to manage difficult situations (Kuo, 2011, 2013). Some approaches focus on directly addressing and changing external stressors (primary control), while others involve managing internal reactions and adapting to the situation (secondary control; Kuo, 2011, 2013). In my case, the overwhelming emotions stemming from my brother's hospitalization and the subsequent isolation I experienced seem to reflect a secondary control coping strategy. While retreating into isolation offered a temporary escape from the emotional turmoil, it ultimately stopped me from seeking the support I desperately needed, potentially hindering my ability to navigate the challenges I faced effectively.

However, the challenges embedded within my doctoral journey bore a profound connection to my identity as a first-generation college student and a Black man, linking my personal aspirations with communal expectations. The weight of familial and community hopes for my success, particularly in the context of historically Black institutions, heightened the stakes and intensified the pressure on my academic endeavors. Every step I took to pursue my PhD felt like a collective stride, breaking through barriers for future generations in my community. This sense of responsibility added an emotional weight, transforming my academic journey into a mission beyond personal achievement.

Being a double minority in academia also meant navigating uncharted territory with a sense of isolation. The perceived unwritten expectations for Black scholars to maneuver independently led me to shy away from seeking mentorship or confiding in professors about my struggles. The fear of being misunderstood or further marginalized deepened my reluctance, creating a barrier to the support that could have alleviated the emotional burden. This hesitation extended to my interactions with fellow students, fostering a sense of disconnection that echoed the broader challenges faced by individuals sharing similar identities. The emotional toll of being a double minority was palpable, shaping the hurdles I encountered and influencing the coping strategies I employed as I navigated a demanding academic landscape.

Learning and navigating through the two-year coursework portion of my doctoral program while managing the initial shock and prolonged experience of my brother's incident was an unexpected chapter in my academic career. The emotional havoc and confusion I felt left me contending to find a sense of balance. I struggled to manage my feelings of inadequacy, educational commitments, shattered sense of self, and grief, which exacerbated my anxiety.

My once well-defined vision of my PhD journey and program now seemed obscured. I lost focus and felt alone. It felt challenging to muster the motivation to develop and complete my research agenda. These feelings were only intensified by the absence of a mentor. I avoided conversations with professors about my research out of fear of judgment. Thoughts like "Will I let them down?" and "Can I write well enough to work with them?" obstructed me from receiving meaningful guidance from professors who could have understood my position and feelings. However, as time passed, I started to remember a quote I learned from an English professor in undergrad. Maya Angelou's (1975) poem "Alone" says:

> Lying, thinking
> Last night
> How to find my soul a home
> Where water is not thirsty
> And bread loaf is not stone
> I came up with one thing
> And I don't believe I'm wrong
> That nobody,
> But nobody
> Can make it out here alone.
> (stanza 1)

For weeks, I ruminated on these words and shared them with my mother, grandmother, great-aunt, and brother, who encouraged me to focus on healing and coping.

What Lessons Were Learned and How Did I Cope?

Reflecting on my tenure as a doctoral student reveals an intertwining of personal identities that shaped my experience. As a Black man, embarking on becoming the first in my family to earn a doctoral degree brought many triumphs and challenges. My family's wisdom, deeply rooted in navigating systemic obstacles, became an invaluable guiding force in the unfamiliar landscape of academia. Their insight, encouragement, and empathy provided a lifeline, reinforcing my identity and offering coping strategies in moments of stress. Laughter, a seemingly simple yet powerful tool, became a unique bond shared with my mom and brother. It was more than just a moment of levity; it became a means of connecting to my academic destiny. In the midst of challenges, their shared laughter served as a reminder of my innate resilience and determination, grounding me in the belief that I was destined for academic success, even when the path ahead seemed uncertain and unrecognized by others.

Moreover, my grandmother and great-aunt's faith and religious guidance provided a different dimension of support. My grandmother and great-aunt utilized our faith to remind me of the importance of prayer and how "prayer changes things." Their teachings accentuated the importance of spiritual grounding, emphasizing the strength found in prayer. During moments of heightened stress and uncertainty, turning to faith became a source of resilience. Their guidance reminded me of the enduring power of spiritual beliefs and provided a sense of inner strength, enabling me to navigate the challenges of academia with a fortified sense of purpose and conviction.

In the realm of personal identities, the support and lessons extended beyond the familial sphere to encompass a circle of friends who acted as firm pillars throughout my doctoral education. The support I garnered from my friends and fraternity brothers transcended the familial domain, marking an important chapter in my doctoral journey. Their unwavering presence served as a testament to the strength found in chosen family, offering me a sense of community and understanding that went beyond shared blood ties. In crafting study plans, their assistance was not just about academic guidance; it symbolized a collective commitment to my success. Their unyielding encouragement provided a constant source of motivation, acting as a lifeline during the most challenging moments of life and academic pursuit.

During times of self-doubt and imposter syndrome, my friends became my safe haven. Their collective wisdom, sarcasm, empathy, and care formed a nurturing environment that encouraged perseverance. In this shared space, I found solace and the strength to navigate the complexities of doctoral education. The camaraderie we shared became a force against life and academia's barriers, proving instrumental in my ability to endure and thrive.

The collective strength of my familial relationships and friendships became a cornerstone, guiding me through the labyrinth of academia with emotional fortitude and resilience. I learned that the road to completing and earning a doctoral degree is bumpy, and the significance of community cannot be overstated. This experience deeply connects with cultural influences shaping coping outcomes and well-being, as discussed in Panel V of the CTT (Kuo, 2011, 2013).

As a Black man navigating academia, the support from my family and chosen family served as a powerful buffer against potential feelings of isolation and self-doubt. Their collective responsibility for my success, the emphasis on spiritual grounding, and the shared laughter reflect the importance of social harmony, interdependence, and diverse coping strategies emphasized in Panel V for collectivistic cultures (Kuo, 2011, 2013). Their unwavering presence bolstered my emotional well-being and fostered a sense of belonging and purpose, reminding me that I was not alone in my journey. This experience highlights the critical role of community in fostering resilience and well-being for Black men in academia, particularly when navigating the challenges of isolation and self-doubt as a double minority.

Implications and Recommendations

After reflecting on my experience as a double minority—a Black man in the social work field—I've seen firsthand the stark lack of representation in our profession. This is not just an observation; it's a glaring issue with significant implications. Using my narrative and the CTT, I have identified several implications and recommendations for social work practice, research, and education. First, more attention in social work should be dedicated to understanding the underrepresentation of Black men in social work practice and social work education. Limited research exists regarding the specific factors contributing to this gap. To address it, comprehensive qualitative and quantitative studies are necessary. Social workers should conduct in-depth interviews, focus groups, and surveys to gain valuable insights into Black men's perception of social work, the barriers they face in entering the field, and the motivations and aspirations that could draw them towards this profession.

It is critical to acknowledge the intersecting factors of race and gender that contribute to this underrepresentation. Historical marginalization, systemic racism, and societal expectations of masculinity may discourage Black men from entering a field traditionally perceived as white and feminine. To address this deficit, the social work profession requires multifaceted interventions. Targeted outreach and mentorship programs—developed in collaboration with Black male social work organizations, Black fraternities, and community leaders—can connect with Black communities, particularly young men. These initiatives can showcase social workers' diverse roles and impact, challenging negative stereotypes and emphasizing the empowerment-aligned aspects of the profession, such as advocacy, leadership, and community improvement.

Regarding education, social work educators should consider integrating coursework and readings that amplify the voices and experiences of Black social workers throughout history, research, and contemporary practice. Some examples of Black male social work researchers that could be used in coursework are Jerome Schiele, Anthony Estreet, Laurens VanSluytman, Anthony Hill, and Sean Joe. This gives students a broader understanding of the profession and its contributions to diverse communities.

Additionally, equipping students with the knowledge and skills to effectively engage with diverse populations, including Black communities, through a culturally competent curriculum is paramount. This training should encompass implicit bias, culturally responsive practice models, and addressing systemic racism.

Additionally, social workers are uniquely positioned to collaborate and mentor Black male students. The connection and collaboration of Black male students with faculty mentors could decrease attrition rates for Black men in doctoral programs. Social work doctoral educators should explore the creation of mentorship programs that explicitly support Black men. During the first semester of their program, Black men should be paired with a mentor within their school. The mentor-mentee relationship should be guided by a mentoring contract that outlines expectations and learning objectives. In addition, social work educators should consider using the CTT theory as a framework to understand the well-being of their students. Implementing the CTT within course evaluations or end-of-semester assessments is poised to inform educators of invaluable data. The datum could notify educators of ecological elements that could impact the students' performance or retention.

One of the grand challenges of social work is to eradicate social isolation. Proctor et al. (2023) asserted that Black men in higher education are socially isolated and depressed. It is recommended that a qualitative study follow to explore the experiences of first-generation Black male social work doctoral degree graduates. This study may provide support and understanding to an unexamined population. It could also highlight opportunities for creating culturally based interventions to assist Black men in completing social work doctoral-level education. It is also recommended that a qualitative study be conducted exploring the career choices of Black male social work doctoral degree graduates and the factors that impact those career choices.

Addressing the underrepresentation of Black men in social work requires a sustained commitment to research, discourse, and collaboration. The profession can move towards a more inclusive and representative future by implementing the proposed recommendations and advocating for policy changes to support targeted programs. This will ultimately enhance the capacity of social work to serve all communities effectively and promote social justice.

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I Need Help with Teaching Racism to Students Who Appear to Internalize or Appropriate Racial Oppression

Tae Kyung Park

Abstract: This narrative delineates my engagement with race discourse within social work classrooms, with particular emphasis on the personal challenges encountered in facilitating discussions among white anti-racist students, non-white students, and students of non-white backgrounds who seem to internalize and appropriate racial oppression. While existing literature offers insights into techniques for fostering racial dialogues between white and non-white students, it provides scant guidance on pedagogical methodologies tailored for individuals grappling with internalized or appropriated racial oppression. In this paper, I humbly seek guidance in devising effective strategies to address the needs of social work students who have internalized or appropriated racial oppression.

Keywords**:** race talk, internalized racial oppression, appropriated racial oppression, teaching strategies

Personal Background

For this reflection essay, I think I need to share my personal background first for readers to better understand how I started having this inquiry. This section elucidates the influence of my educational background and lived experiences on the development of anti-racist perspectives and practices and their subsequent implications for my pedagogical approach within the field of social work.

I obtained my master's degree in social welfare in South Korea and completed my PhD in the United States. This educational trajectory places me in a unique position within the field of social work pedagogy. Despite having less than a decade of experience in teaching social work, my primary assignments have predominantly encompassed research-oriented courses, with involvement in macro practice, introductory social welfare courses, and Human Behavior in Social Environment courses. It was not until I undertook the responsibility of teaching courses such as "Social Welfare Policy" and "Trauma and Violence" at the master's level that I became cognizant of the issue that forms the central focus of this essay.

The core themes of institutional and structural racism, alongside discrimination targeting marginalized, underserved, and disadvantaged groups, serve as the primary focal points within the curricula of the Social Welfare Policy and Trauma and Violence courses. This orientation towards racism and discrimination against racial groups presented a relatively new concept to me, considering my educational background, which did not prioritize racism in social work education. At the same time, it is crucial to note the historical legacy of discriminatory practices within my country, particularly towards specific geographical populations that positioned me within a dominant group. Additionally, I was fortunate that my experiences in the United States have not entailed significant incidents of racism or discrimination. These experiences, along with my academic exposure, have influenced the development of my anti-racism perspectives and practices. However, my capacity to effectively teach and engage with this subject matter is owed largely to the abundance of scholarly literature and resources available, as well as the invaluable support of my colleagues who generously shared their insights and course materials.

I must admit that I retain certain apprehensions regarding scenarios outlined in the literature that concern facilitating discussions on microaggressions, structural and institutional racism, and white supremacy, particularly between white and non-white students (Sue, 2013). However, my teaching challenges regarding anti-racism education have primarily stemmed from unforeseen and unprepared-for aspects. I encountered fewer conflicts between non-white and white students than expected for a range of reasons. White social work students demonstrated a strong awareness of these issues and engaged in constructive discussions concerning potential solutions. Some white students may have chosen not to vocalize their thoughts or perspectives. In contrast, the conflicts primarily manifested between non-white students who appeared to internalize or appropriate racial oppression and their anti-racist counterparts, both white and non-white. As I teach these topics more frequently, I encounter an increasing number of instances of internalized and/or appropriated racial oppression.

Internalized and Appropriated Racial Oppression

Previously, I frequently employed the phrase, “If I can do it, you can do it, and anyone can do it,” as a means of offering encouragement within conversations with friends. However, I have since come to acknowledge the inadequacy inherent in this expression, recognizing its failure to consider individual circumstances and the diverse array of privileges I have enjoyed, which may not have been extended to others. This simplistic phrase reveals a profound ignorance of the intricate complexities present within our diverse society. Furthermore, I have come to realize that this expression can align with and perpetuate internalized racial oppression. Its underlying implication can be distilled as follows: As a non-white immigrant, I overcame all obstacles, therefore implying that others should be similarly capable. If individuals encounter setbacks in their pursuits, the implication often attributes it to their purported lack of diligence, rather than acknowledging the systemic barriers or lack of privilege they may face. This realization serves as a poignant illustration of how such expressions can unwittingly reinforce systems of white supremacy and undermine the concept of meritocracy, as elucidated by Crozier (2018).

Aligned with the principles of the Appropriated Racial Oppression theory (Campón & Carter, 2015; Rangel, 2014), meritocracy emerges as a potent mechanism reinforcing the subjugation and exploitation of marginalized communities. This phenomenon occurs concurrently with attributing an individual’s socioeconomic status solely to personal effort, thereby deflecting attention from the pervasive societal and entrenched structural racism that serves as the root cause of these disparities (Versey et al., 2019). Social work students have not proven immune to instances of appropriated racial oppression. A subset of non-white students, who have secured admission to Master of Social Work (MSW) programs or attained success in their endeavors, appears to endorse the ideology of meritocracy without adopting a critical perspective. The ensuing examples of appropriated racial oppression stem from my instructional experiences spanning diverse educational institutions over nearly a decade.

A noteworthy example of appropriated racial oppression surfaced in the behavior of a non-white immigrant student who displayed hesitation in acknowledging the inclusion of undocumented immigrants in the eligibility criteria for government-funded services, which are sustained through taxpayer contributions. This student clung to the misconception that undocumented immigrants make no fiscal contributions through taxation. Consequently, the proposition of extending eligibility to undocumented immigrants for state-funded welfare services encountered significant resistance from this student. It is intriguing to note that the student disclosed having relatives who were undocumented immigrants at the time of this discussion.

Yet another non-white immigrant student struggled with the concept of privilege, particularly its correlation with "unearned" advantages and benefits. Additionally, the student faced challenges in grasping how meritocracy could be employed as a mechanism of oppression against marginalized communities by proponents of white supremacy. This student adhered to the notion that meritocracy was universally recognized as a prevailing common-sense ideology globally. From the student's perspective, economic advancement is deemed a fundamental objective of human existence, and it is perceived as a universally applicable default concept.

One non-white student evinced an excessive preoccupation with pro-life ideology and the criminalization of abortion, thereby impeding their capacity for critical analysis of a specific case exemplifying the limited comprehension displayed by a young white male regarding the challenges faced by pregnant women. This case example espoused the criminalization of abortion on the premise that pregnant women merely needed to carry and nourish a fetus. Notably, this student appeared to deviate from addressing the substantive issues inherent to the case, such as the potential for pregnant women to endure abuse, when engaging with the analysis of social dilemmas. Their stance leaned towards advocacy for the case, thereby overlooking the oppressive aspects experienced by pregnant women.

In discussions concerning the heightened poverty rates among non-white demographics, a significant segment of non-white students expressed the belief that individuals in poverty had not exerted adequate effort to uplift themselves from their circumstances. Furthermore, these students contended that some individuals in poverty had exploited the welfare system. This perspective disregarded the deep-seated feelings of helplessness and despair prevalent in the lives of marginalized populations.

I wish to emphasize that my intentional decision was to refrain from explicitly specifying the racial backgrounds of individual students, with the aim of mitigating the potential reinforcement of racial biases.

From my involvement in a summer leadership program tailored for refugee youth, I garnered insights into the political inclinations of numerous immigrants. Notably, I have opted not to specify the nationality of the refugee cohort, as my aim was to prevent reader confusion and the introduction of additional bias toward any particular demographic. My observations revealed that a considerable proportion of immigrants align their political loyalties with their religious beliefs, regardless of a political party's position on immigration policies.

Upon contemplating my interactions with these students and their perspectives, I have become progressively apprehensive about the dynamics of discussions occurring within our classrooms. When such students articulate their viewpoints in classroom settings, there exists a possibility for their perspectives to inadvertently influence or distort the perceptions held by other students concerning white supremacy and racism. Given that certain students may have chosen to maintain silence deliberately, I am unable to conclusively determine the impact of these articulated viewpoints on others.

Questions

I previously harbored the assumption that individuals from non-white backgrounds inherently embraced anti-racist ideologies, a perspective I now acknowledge as overly simplistic. Consequently, as I sought out relevant literature and pedagogical resources on this subject, I began to question whether my fellow social work educators held similar assumptions or if I was singular in facing this complex quandary.

Is it sufficient to utilize identical instructional methodologies for individuals who have internalized or appropriated racial oppression as we do for students harboring explicitly racist perspectives?

Please Help Me: Suggestions

I maintain that it is crucial to continue exposing both white and non-white students to discussions on racial issues, as advocated in scholarly literature. Existing academic discourse offers insights into facilitating race-related conversations among students of varying racial backgrounds. Nevertheless, following my interactions with individuals who internalized or appropriated racial oppression, I found myself pondering the existence of social work literature that specifically addresses pedagogical strategies for instilling anti-racist principles within such individuals. Regrettably, my search for pertinent resources proved unfruitful, both within the broader academic sphere and within the domain of social work education.

In this essay, I earnestly request fellow social work educators to extend their support by sharing their own experiences and insights.

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Social Work as a Path to Diversity Work

Stephanie Hamm

Abstract: We are in an exciting time in our country as we navigate racial tensions and resolve to make our organizations better places for everyone to work and live. One way to do so is professionally as administrative leaders dedicated to this cause (often called chief diversity officers or directors of an office of diversity). Social workers are taught a skill set that is conducive to work in the areas of diversity, equity, and inclusion. This skill set includes brokering, strategic planning, evaluation, and research. Here, I focus on three essential skills that have been particularly helpful in helping to lead an organization in areas of equity and inclusion: communication, resource-gathering, and self-care. As context for the conversation, I share my journey to leadership. This article ends with implications for research and a call for willing social workers to consider entering this work at any level desirable.

Keywords**:** diversity, equity, inclusion, career, skills

Introduction

As a social work educator, I have been called on to lead in diversity, equity, and inclusion (DEI) work. Interestingly, it is a smooth transition from traditional social work to this work. We know that social work often lends itself to work beyond generalist practice and possibly into other fields. I'm curious (as some of our graduates move on to law and policymaking) what it is about social work that serves as such a robust foundation. This piece explores my journey into the work of equity and inclusion. Although I hold to my first love, I have had the privilege of doing this work in a higher education setting at a time when meeting the need for equity and inclusion continues to emerge as challenging and necessary. Here, I share my experience and the insights that have emerged.

My Path to DEI Work

As a young social worker, I had not considered being called on or even known to be one to join a public discourse on race and diversity. My whole focus was serving clients in the beautiful hills of West Virginia and then a large Texas city. Upon returning to school to prepare for a career shift to higher education, my eyes were opened to race—my own and that of others. I wanted to learn all I could. During my first years of teaching, I participated in committees, teams, and student organizations that revolved around race. I began reading, listening, and researching in areas of race. I taught (and I continue to teach) a diversity class that made me more curious. I became intrigued with American history and how color has been excluded and included inaccurately. I continue to love learning the truth about our history.

In 2016, our university president began to finalize our strategic plan. Within the plan he created five facets that were to be explored by task forces, who would develop recommendations on future implementation for the cabinet. Four of these facets included academic innovation, spiritual formation (as it is a faith-based university), experiential learning, and educational programs. The fifth facet the administration invited me to chair: the Diversity Task Force. I was honored to be asked. The team and I conducted qualitative and quantitative research, training, and readings. We spoke to various groups on campus and met with entities that served students in multiple ways. We hired a consultant. We submitted recommendations to the cabinet after two years and intermittent task force reports. Among them was an office of diversity of sorts and a chief diversity officer. The following year, the administration invited me to lead that effort. Again, I was honored but did not think I could do it justice. I was likely a logical choice. I studied race. Moreover, I was on campus already—I knew the environment and its members. I was already a critical lover of the university and wanted to see it improved in all ways possible, particularly regarding diversity and inclusion. I am a female and part of the Black and Indigenous People of Color (BIPOC) community (see Paluch & Shum, 2023, for research on the theoretical foundation of the "non-White standard").

Like many universities, ours is a predominantly white institution (PWI) growing in students of color (Espinosa et al., 2019). Amid traditions that feel like identity, we want to succeed in inclusion. We want to experience the benefits of full participation and diverse experiences and thoughts. We want every student to feel a sense of belonging and to thrive. However, some of the school's traditions do not resonate with the lived experiences of over 40 percent of the student body. As stated, we are a faith-based institution in the southwestern region of the United States. When I was a student here, roughly 20 years before returning to work for the university, I was among only a few Black students who were not athletes. Today, we are over 40 percent students of color, 20-plus percent of which are Hispanic/Latinx. It is a good school, and we are still growing.

My experience as a DEI leader[1] was not uncommon. I had interest, passion, knowledge, and (I believe) the respect of the faculty and staff. My appointment was a logical choice. However, I am a social worker, not a professional equity specialist. I could see my shortcomings clearly but understood the need for a person to pave the way for change. So, I agreed to serve for two years in a half-time role. It was a fulfilling two years and much work. We learned a great deal about our school. One of the lessons learned was that we need a full-time professional DEI leader in this role: someone who is trained to do this work, who can be strategic, who can be out in front, who can devote all their time to this vital work, and who can hold the university accountable for a collaborative sea change (Holcombe et al., 2023). I recall telling an interviewer that our school is a special place and students, faculty, and staff *deserve* a full-time equity professional.

I have come to understand that there are exciting implications to my being a social worker in this role. As a social worker, I have a skill set that lends itself to this work (Wilson & Wolfer, 2020). Many other social scientists enjoy this same skill set; however, it appears that social work also provides knowledge of areas of oppression and marginalization that we see as prevalent in this country (Council on Social Work Education, 2022). Those two areas combined make social work an excellent fit for inclusion work in many settings.

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[1] Although the term "chief diversity officer" or its initialism "CDO" may be expected, this piece will use the terms "DEI worker" or "DEI leader." Please see Pewewardy (2021) for more information on the avoidance of "chief."

Social Work Skill Set in Equity Work

Social workers practice a skill set that includes active listening, collaborating, brokering, advocating, interviewing, applying empathy, caring for the needs of others, thinking critically, and practicing self-awareness, among much else (Hepworth et al., 2023; Katz et al., 2021; Wilson & Wolfer, 2020). However, I would like to discuss a few skills that were particularly helpful to me during my time in this role.

Resource-Gathering

Resource-gathering is imperative for this work. DEI work is not accomplished in a vacuum, so we network and research (Hepworth et al., 2023; Porter et al., 2023; Wilson & Wolfer, 2020). We need everyone's insights, expertise, and resources in their settings. From networking, we gain more strategies to put in our knapsack of generalist strategies. Through networking, we locate the trainers, speakers, and reading materials for the courses we teach and the training we provide. Others help us navigate challenging circumstances and help us find innovative solutions. Networking also reminds us that we are not doing this work alone—that we do not need to carry the weight of the BIPOC population and the world on our shoulders. Networking is critical to longevity. A recent conversation with a colleague became an entrée into another relationship that will inform a future research agenda. That conversation provided insights and resources to move forward. In addition to networking, resource-gathering necessitates research. Over several years, we may learn to do many things ourselves, but evidence-based strategies change and improve as time goes by. Therefore, *research* is vital to enacting the most effective practices (Wilson & Wolfer, 2020). Whether we are engaging in our primary study or consuming the research of others, what we find is more precise answers to the challenges before us. We also discover the world's changes and what has worked and has not worked in making positive, sustainable change. Without research, we would continue to do the same things and get the same ineffective results that lead to burnout. Resource-gathering also comes in the form of attending meetings, workshops, and training. These opportunities are now easy to access because of the prevalence of online formats such as Zoom.

Communication

Secondly, I found effective *communication* to be necessary. Those doing equity and inclusion work engage others along the spectrum of acceptance of the work. We interact with those who keep their backpack ready for a march, those who do not know or care about inclusion issues, and everyone in between. These conversations might be draining or energizing, but they are always available. Communicating with diverse people while maintaining an even temper is challenging! Social workers are trained to engage in all types of communication, depending on the circumstance (Hepworth et al., 2023; Katz et al., 2021). For example, I recall in practice (and many have had this same experience) getting a phone call from an angry relative of a client that ultimately ended with that individual apologizing and acknowledging their own need for counseling. This was not done by sorcery on my part but through strategies such as listening beyond the words, responding with empathy, providing a non-anxious presence, and accepting the person where they were. We employ these types of strategies as we engage people in expressing sadness, fear, anger, discouragement, shame, joy, and peace. This work includes the same array of interactions. It is essential to be heard without judgment. I recall an email exchange with an individual who called me a fascist because of the equity work we were doing. I responded with assertiveness, empathy, and kindness. Of course, the individual softened and apologized. We often converse with those eager to act, and we must temper their excitement to make their action effective. People generally have mental clarity within themselves, and it takes the correct responses in those conversations to bring their internal awareness to the fore. Good communication involves engaged listening—even when the content is hard to hear. This type of listening is necessary to advocate, solve problems, resolve conflict, encourage, and advise (Hepworth et al., 2023). I am certainly not arguing that we communicate well every time! However, experiential practice results in doing better each time. Honest, open, brave communication creates trust and hope and is vital to the work of necessary change.

Self-Care

Finally, this work is a mental and emotional challenge (Anderson, 2020; Cutter & Weber, 2020). Therefore, *self-care* is one of the most essential values and skills (DeMarchis et al., 2022; Hepworth et al., 2023). A lack of self-care leads quickly to burnout because of the constant onslaught of negative media and news around the subject of race and difference. This includes stories about acts of hate, illustrations of negative and inaccurate stereotypes, and dismal statistics. This is common to anyone paying attention to the world around them. Still, for those of us doing inclusion work, input such as this comes in droves from social media, formal and informal personal contacts, national and world news, the research we read … you name it. It comes up in conversations because friends and acquaintances know you can explain or relate to their frustration and angst. It comes as being asked to justify or defend the work or field criticism about the changes being introduced in the organization. Moreover, because these instances are often negative, we must develop a way to keep our joy. It is hard work, so we must find ways to continue without the pain of it wearing us down. This can only be done by utilizing self-care strategies such as resting, having fun, enforcing boundaries, releasing the hurtful parts, and engaging in acts of spirituality. What works well is unique to each of us. I have found that keeping hobbies (e.g., painting, gardening, reading for fun), leaving town occasionally, and praying have helped me. I also gained healing insights from reading books or listening to podcasts that have taught me about myself. Self-awareness became self-care. It is not always appropriate to share the challenges with others (particularly with people in the same organization as your work). Therefore, these strategies must go beyond venting and verbal processing unless it is with a professional counselor or coach (highly recommended). Another helpful strategy was spending time with a “team” or “posse” (Anderson, 2020)—those who back and strengthen you with their words of affirmation. These few people remind you of who you are and where your strength comes from. I recall a particular time when I worried about failing my organization. One of my posse members stated that if this work is not practical, “it will be because [the organization] failed you” by not providing me the support and resources needed to be effective. What a gift. There is no substitute for sustainable self-care.

Pathway to Equity Professionalism

More than one social worker, eager to be involved, has asked me how to get into the field of DEI leadership. There is likely not a clear, straightforward answer; however, here are some insights:

- *Start*. Join a team of people working on these issues in your organization or sponsor a marginalized student group and work to advocate for that group. Attend a peaceful protest or join a community group. Begin networking with those who are already in the club.

- *Learn.* Consume information. Excellent books on the market teach us much about the historical and current challenges of difference in America. If I begin to recommend them, I will leave out some of the best! Attend meetings, participate in conferences, and listen to podcasts. Look up pertinent policies in your area. The key is to begin learning because the more we know, the more we understand that we cannot know all of it.

- *Act.* Look for opportunities to act more significantly on the knowledge you are gaining. Be available to participate and then lead when the time is right. This may involve vulnerability, risks, and even what feels like setbacks, but that is OK!

- *Keep learning!* Be open to continued learning (Jemal, 2020). I highly recommend seeking the formal higher education you need, understanding that some degree programs are more specialized than others. The program you choose largely depends on the setting where you are interested in working.

Conclusion

To understand my own and others' journeys from traditional social work practice to DEI work, research needs to be conducted to address it. The study will inform possible pathways for social workers pursuing this work. Research into developing DEI will help build a clearer understanding of the skills needed, the barriers to doing this work, and the skills and strategies needed to be successful. I can foresee a qualitative study seeking to understand how and why social workers become DEI leaders or one that examines the perceptions of their work for those in the DEI field. Not everyone's journey will be like mine—this is one journey. I also hope that more professionals will be engaged in justice work, as we need to be present (Jemal, 2020); our Code of Ethics calls us to it (National Association of Social Workers, 2021), and because more and more individuals, leaders, and organizations are looking for ways to grow in these areas of inclusion. Perhaps a desire to go deeper in or shift your career from traditional social work practice to full-time equity and inclusion work will lead you on a path that is challenging, fulfilling, and needed.

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