NEJRSP

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The New England Journal of Relational and Systemic Practice (NEJRSP) is a regional journal that disseminates pertinent relational and systemic information, giving mental health professionals the knowledge and expertise to enhance their practice.

***The New England Journal of Relational and Systemic Practice* publishes both innovations for practice and new developments, and practical information that trains current and future practitioners. We publish quarterly, and would love to present your writing.**

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***The New England Journal for Relational and Systemic Practice* is a production of the New England Association for Family and Systemic Therapy (NEAFAST).**

NEAFAST is the professional home for family and systemic therapists in Massachusetts and surrounding states. NEAFAST is a membership organization of professionals dedicated to the advancement of family and systemic therapy through advocacy, networking, and education.

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Stephen Duclos, M.Ed
Jacqueline Gagliardi, M.Ed
Jeremiah Gibson, MMFT
Frank Gomez, MA
David Haddad, EdD
Beverly Ibeh, MA (PsyD 2021)

Contact: Frank Gomez at fgomez@jri.org
Website: www.nejournalrsp.com

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The New England Journal of Relational and Systemic Practice: an Introduction

STEPHEN DUCLOS, M.ED

Editor, New England Journal of Relational and Systemic Practice

At a moment when systemic practice has evolved or devolved from a private room in a confidential space to a computer screen that faces the world in a close up portraiture, we have, quite absurdly, decided to initiate a journal, the *New England Journal of Relational and Systemic Practice* (NEJRSP). Our hope is to provide a forum, **primarily regional but also international**, that expresses the ever-changing dynamic of the client/therapist/system interchange. Meant to be the symbolic narrative of the New England Association of Family and Systemic Therapy (NEAFAST), we are hoping to capture the voices of practicing therapists, educators, and students. From the beginning, we are dedicated to diversity and inclusion, despite the masks we are forced to wear in public.

In each of our quarterly publications, we hope to present our own regional idea of what constitutes an effective therapeutic conversation. What does it mean to be a Black therapist in New England? What does it mean to be a Queer graduate student in a New England university? How does a White therapist address their own privilege in session? Where do White men fit in their own family?

At the same time that we are explicating New England perspectives, we are also looking for concomitant voices outside that ecology. How might a National Health Service effect the practice of Family Therapy? What constitutes architectural accessibility in 2021? When should aging therapists stop practicing?

The *NEJRSP* starts with racism as an invisible contributor to family health, in all communities—urban, suburban, rural—of New England. Papers that talk about systemic therapy

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therapy at the intersection of ageism, ableism, class, heteronormativity, gender inequality and racism will have a home here.

Black/African American and Hispanic families, and all aging adults, have an infection rate and morbidity far beyond everyone else. The vast majority of deaths from COVID-19 in New England occur in nursing homes. The rate of death in New England from all forms of dementia has skyrocketed in the past three months, over and above the rate of death from the coronavirus. These are the social science projects worth writing about in this spring and summer of 2020. And it is the reason we are beginning this journal.

The Impact of Telehealth on the Practice of Therapy: Survey Reflections

STEPHEN DUCLOS, M.Ed; JACQUELINE GAGLIARDI, M.Ed; JEREMIAH GIBSON, MMFT; FRANK GOMEZ, MA; DAVID HADDAD, EdD, BEVERLY IBEH, MA

Editorial Team – *New England Journal of Relational and Systemic Practice*

The field of psychotherapy has had to make significant shifts in 2020 and 2021 with the advent of widespread teletherapy usage during the COVID-19 pandemic. While the New England Journal of Relational and Systemic Practice will have traditional research articles and reflections on combining systems theory with the practice of relational therapy, the editorial team has discussed various ways to creatively present and share the perspectives and experiences of relational and systemic therapists in our region, including the interviews with the editorial team and with Porsche Lockett.

This fall, the editors asked regional therapists to participate in a survey with three questions that explore the impact of COVID-19 and shift to telehealth. These questions are:

– How are you noticing the difference between the ways that you engage and confront in the therapeutic relationship in live and virtual spaces?

– What are the differences in the therapeutic relationship between clients that you've met and clients you've only virtually met?

– How are you defining your own therapeutic presence in online therapy?

We sent out the survey in November, 2020, and received 10 responses to this survey. The small sample size speaks both to the newness of the journal project, and, more importantly, to the overwhelm and burnout that many therapists are currently experiencing.

Nonetheless, the editorial team of NEJRSP have compiled the responses to these three questions, and made reflections of their own in an attempt to articulate some of the active and potential shifts to the practice of therapy in the middle of the pandemic.

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How are you noticing the difference between the ways that you engage and confront in the therapeutic relationship in live and virtual ways? (Jackie Gagliardi)

The advent of COVID-19 catapulted many therapists to quickly transition from in person to remote. These changes presented different challenges and ways to engage.

Several respondents seeing couples stated, "There was a contrived aspect of partners sitting close together in the frame." Others talked about the "choice of seating in an office, eye contact between partners, and capturing body language, are missing."

One participant summarized: "I have noticed that not only eye contact between partners, but also eye contact between therapist and client is not always as detectable as it was pre-covid. In my practice, I have experienced my clients often not looking directly into the video or being distracted, whereas in the office they appear more focused on the session. Clients often get distracted by children, pets, other family members, texts, distractions that would not exist in an office setting." Others in the survey mentioned "the inability to read body language".

One person surveyed brought up the point that since clients no longer have to commute they often have little to no time to think about what they may want to discuss in the session, or process what happened after a session, as they immediately go back into their living environment. I am curious as to the impact a lack of transition may have on clients, and how it may affect the work that we are doing.

Although some therapists noticed "no difference", most did notice a difference in both engagement and confrontation. As I think about confrontation, I wonder if we are talking about therapeutic confrontation, or setting boundaries around the session itself. Are we talking about asking clients to not zoom while driving, wear appropriate apparel, or sit in their seats during the session, or are we talking about therapeutic confrontation?

One respondent replied, "I find sometimes I'm engaging or confronting more easily about things as we're not sitting in the same room so whatever my discomfort is in addressing things isn't as apparent. However, in other ways it's harder, for instance getting couples to end a fight can be harder when it's a screen trying to intervene vs a physical person. So it has its pros and cons." In this context it seems like the therapist is talking about therapeutic confrontation and not necessarily setting boundaries.

However, I am realizing in my own practice in seeing clients remotely, there is a casualness that is not there when seeing clients in the office. For example, clients may be sitting in their car, or appearing in their bathrobe, or getting a cup of coffee. I ask clients to exhibit the same behavior they would if they were coming to my office. This was difficult in the beginning as these were never issues that I had to deal with before. However, they were distracting enough that I chose to confront these issues.

As the pandemic comes to an end, I am wondering if some clinicians will choose to stay remote, while others may choose to see clients live. The convenience of not having to travel, not having to pay for office space, not seeing that big of a difference between remote and live, may

influence clinicians to go back to live office sessions.

What are the differences in the therapeutic relationship between clients that you've met and clients you've only virtually met? (Stephen Duclos)

The pandemic of 2020, and soon 2021, has created a fundamental paradox: Will we return to seeing families and couples in person, or will we remain doing therapy on line?
Some therapists have not seen many differences between in-person versus on-line therapy: "Not much difference at all", " …I have to speak louder on-line", "I don't find a difference in the clients", and "comfortable". Others express difficulties in their basic practices, "I have struggled to adapt to on-line", " I have been less formal and disclose more", "capturing body language (is) missing", "…shifts (are) mutated, amputated (on-line)", and "I don't feel as connected to them in an embodied way".

As with many other forms of work activity, psychotherapy will never be what it was pre-pandemic. Some therapists have long since jettisoned their offices and are committed to on-line Zoom therapy for the long term. Others will be returning to in-person therapy as soon as a vaccine can be universally distributed. And a few others have continued in-person, throughout the pandemic, masked and distant, with their clients.

It is likely that an adapted platform will be incorporated post-vaccine. Some couples and families will make an in-person appearance towards the beginning of the arc of therapy, and then continue on-line as a logistical alternative. Therapists will need to determine when it is important that a couple or family be in-person, and criteria will need to be developed. We will also have to account for differences in perspective relative to therapeutic presence and its positive or negative effects.

With the hundreds of schools of psychotherapy, there have been very few studies of the effectiveness of one therapy over another. Even when that is so, for example in the worldwide agreement that family therapy is the best treatment for anorexia, such agreement is regionally ignored. Each guild, whether psychologist, psychiatrist, social worker, mental health counselor, or family therapist, has their own ideas as to what constitutes mental health and its treatment. And now we will have disagreement as to where and how psychotherapy works best. In January of 2020, most therapists used on-line sessions sparingly. It is likely that at the end of the pandemic, in-person sessions will be correspondingly sparse.

Some of the survey respondents talk about clients only seen during the pandemic, others talk of the difference between seeing clients in-person and virtually. Several respondents commented on the "informal" and "casual" nature of on-line experiences, presumably because we are talking to each other from our respective homes. As a Couples and Sex Therapist, it is not unusual to be interviewing couples online in their bedrooms. And as a Family Therapist, it is not unusual to be talking to one or another family member in their car. Recently, couples have begun talking with me from separate computers in their shared homes. And in one instance, one part of a dyad began the session with their partner, but continued in the second half of the session on their phone while out walking, for no expressed reason. And then there are dogs, and cats, and little

children, and elderly residents, walking around in the background (and foreground), as if we had entered a public confessional, with psychotherapy now taking place in open space.

We have tried as therapists to adjust to the vagaries of a pandemic. We worry about the dramatic rise in anxiety, in substance abuse, and in suicidal ideas. And we do not know what to do with participants who are cooking dinner while talking to us, or engaging in child care processes. At what point do we regulate this new world for the efficacy of a therapeutic conversation? Where, exactly, is the best place to do therapy?

How are you defining your own therapeutic presence in online therapy? (David Haddad)

As a therapist and teacher of therapy, I have always been interested in how we define presence. With the onset of Covid19, and the online world we now inhabit, I find myself wondering if my ideas about presence might need an upgrade.

Webster defines presence as the state of existing or being present in a place or thing. When I consider this definition, my first thoughts are of an elementary teacher taking attendance and the student responding with "present". Here the student is acknowledging that they are in fact in the room, but perhaps not much more.

The recent NEJRSP survey provides a snapshot into the many ways that our community is thinking about online presence. For example, one respondent talked about the importance of "identifying and describing my physical location with the intention of being more conversational", and "to foster a more human connection." Here, it would seem that the act of calling attention to their surroundings is done to invite presence.

Another therapist respondent talked about establishing "presence" by doing their best to "look at the camera to ensure the client feels seen. I want them to feel that I am talking to them."

One way I think about these responses is to consider them as reflections of a clinician's epistemology, or what we understand as the science of how we know what we know. When I reflect on my own epistemology, I can see that my work is informed by a postmodern lens and by contemplative practices that support my goal to be more mindful and intentional in therapy. From this perspective, presence is not something that just happens but something that is both interactive and intentional.

So, what exactly is presence in online therapy? One obvious answer could be that presence is what is visible. I am a white male of a certain age. But beyond what is visible, and the techniques of therapy, there is also the feeling that the therapist wants to communicate. How does this get conveyed online? What are the qualities that might support this goal of being present online? How will these qualities show up online? What are the qualities that the clinician hopes to embody?

One student who was responding to the impact of zoom classes in a family therapy seminar talked about the initial reaction of seeing herself on the screen. "I was initially distracted by seeing my image, but eventually I started to notice how I appeared on screen and how my

appearance fit with my internal state. I notice that the experience has led to my thinking more about how my internal state does or does not represent or convey my intention. This is not something I thought about before the Covid lockdown."

Finally, one veteran clinician I spoke with defined online presence in this way: "It is always about attention, the quality of attention I bring to the moment. When I am paying attention to my own moment to moment experience, I am better equipped to pay attention to my client. When I do this, both the client and therapist feel seen."

The discussion of therapeutic presence is not a new one, but the challenges of online therapy have invited all of us to consider if our definition fits what we are actually doing. If not, we may need an upgrade.

How are you defining your own therapeutic presence in online therapy? (Beverly Ibeh)

The COVID-19 pandemic has turned our world upside down, and subsequently re-defined the culture of psychotherapy for the unforeseeable future. There was a high level of uncertainty, anxiety, and anguish that prevailed at the beginning of the stay-at-home order that has since turned into an all too familiar routine of providing mental health services to our most vulnerable populations from the make-shift privacy of our bedrooms and dining tables. This unconventional way of providing therapeutic support has pushed clinicians in the mental health field to reevaluate how they may understand their therapeutic presence with clients.

Some particiapnts shared they may "disclose that [they] are home, on Zoom, don't record, and send forms.. [and] …tend to be intentionally more conversational, and share more about personal activities (shopping, etc) when people ask if [they] go out anywhere." For many anxious clients, this has opened doors for their therapists to reconsider self-disclosure as it may be clinically relevant during these times. Perhaps sharing more of your life (e.g., whether you are also quarantined) with clients may increase their sense of connection and shared experience of loss due to the pandemic.

Some clinicians have not changed the way they engage online and "…continue to present a professional therapeutic stance", while others have attempted to integrate their virtual presence with aspects of their in-person presence. As one clinician wrote, " I'm trying to maintain the kind of frame and protected space I offer in person. I send an email orienting people to the virtual sessions, advising a bit of transition time, asking them to secure a private, uninterruptable space, to bring tissues, and for those who have known me, I occasionally remind them of my office, and the atmosphere that helped our work."

As clinicians reflect on the shift of presence from in-office to online, it is imperative to consider the immense loss of physical and emotional containment from merely sitting in a room on a weekly basis with someone you trust. How can we create this containment online, behind a screen?

Silence, which is often used as a valuable therapeutic tool for emotional regulation and distress tolerance may be called into question over zoom. Is it effective use of silence or did your

telehealth platform suddenly have a glitch that has caused it to freeze? Non-verbal cues (e.g., a wave) can be helpful for sustained engagement and making your presence known if a client is unresponsive. Particularly over zoom, I have found myself saying things like, "Are you still with me?" for quieter, more reflective clients or "Can you send a message in the chat so I know you're still there?" for treatment resistant teenagers with their videos turned off and mic on mute.

What should a therapist do when their client cries over zoom? In person, a show of concern could be a simple offering of a tissue with silence and a head nod, whereas over zoom, one may need to change posture or lean in to show concern. For some clinicians, connecting with their client through direct eye contact (e.g., looking into the computer camera) may mean sacrificing awareness of the client's non-verbal expressions as one clinician wrote, "I do my best to look at my camera so clients "feel" I'm looking at them vs looking down at the screen. I may miss non-verbal expressions when I'm talking to a client, but I want them to feel like I'm talking to them and it isn't just "another zoom call."

For clinicians seeking to answer this question of how we can define our presence over telehealth, it has been helpful to ask the counter question, "what would I do if we were in person?" and if that's not applicable, choosing the next best thing.

Conclusion (Jeremiah Gibson)

In family therapy, we note that challenges in systems are most likely to develop during transitions between stages of development. This article first identifies that we are in a significant transition stage in the practice of psychotherapy, as technological mediums for the practice of therapy become commonplace. The language that participants of the survey used to describe their experience may sound familiar to readers who practice relational therapy, but is by no means comprehensive. The editors of the New England Journal of Relational and Systemic Practice, in conjunction with the New England Association for Family and Systemic Therapy, are dedicated to highlighting and presenting the observations and experiences that therapists have pertaining to the transition to telehealth as a primary medium for psychotherapy.

Second, and more importantly, we have far more questions than we have answers at this stage of the transition, including:

- Where is the best place to do therapy?
- How do we establish boundaries and expectations around the space for therapy?
- When is it important to see a person live, and how do we establish criteria for that?
- How do qualities of presence get enacted and communicated online?
- How does a therapist attend to the emotional experiences of a client online?

Third, the transition of the practice of psychotherapy to virtual mediums parallels the shift to virtual relationships in larger cultural settings, be that texting conversations, social media forums, or online dating apps. There will be more formats to build relationships virtually as technology advances. While virtual relationship platforms have created convenience and

accessibility to communication, a lot of research suggests that these platforms decrease the quality of important relational skills, such as self-efficacy, eye contact, and differentiation.

As therapists, we have a responsibility to take note of, write about, and discuss the ways that technological mediums impact the therapeutic relationship. If we can identify the subtle (and not-so-subtle) shifts in communication between therapist and client in teletherapy, including non-verbals, cadence and pausing, and the establishment of boundaries and expectations, we can also help our clients navigate their own challenges in developing and maintaining relationships in a myriad of virtual platforms. The editorial team hopes that the *New England Journal of Relational and Systemic Practice* can effectively present those shifts and evolutions.

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Rehearsals for Growth: Conducting Action MFT Teletherapy

DANIEL WIENER, PHD

Rehearsals for Growth, LLC

Abstract: Rehearsals for Growth (RfG) is a systemically-informed action method of psychotherapy in which improvisational enactments (derived from theater Games) are offered to clients, both as assessment tools and as interventions that gently challenge habitual patterns of interaction. RfG combines verbal therapy for couples and families with distinctive action episodes offered in a playful, exploratory context.

Because embodied enactment techniques has been an integral part of RfG practice from its inception in the mid-1980s, it had been supposed that their use in virtual therapy sessions would be ineffectual. When, however, the Covid-19 pandemic necessitated teletherapy, it was found that enactments need only be *suggested* as physical for them to be effective in virtual sessions.

Following some general discussion of the pragmatics of conducting teletherapy sessions, two basic RfG enactment techniques are described: first, in their original, embodied form; then, in a modified, virtual form. These descriptions illustrate how RfG techniques have been adapted successfully to teletherapy.

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Around 1985, working in private practice as an MFT, the author developed a way of conducting relationship therapy, since named "Rehearsals for Growth" (RfG); (Wiener, 1994). In RfG, the therapist offers improvisational enactments (derived from theater Games) to clients, both as assessment tools and as interventions that gently challenge habitual patterns of interaction. RfG combines systemically-informed verbal therapy for couples and families with distinctive action episodes in a playful, exploratory context. Although of brief duration, these episodes punctuate the course of therapy, providing memorable highlights and pivotal insights.

During RfG therapy, clients, as their social selves, occasionally are directed to get up from their seats, go to another physical space (termed "the Stage), and perform, as characters different

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from their social selves, in brief scenes. For clarity, enacting clients are referred to as "players." Following these dramatic enactments, client's de-role, return to their original seats and to their roles as their familiar social selves. The therapist then leads these clients in verbally processing their just-completed on-stage experiences and on the connections between these enactments and their real-life interactions (Wiener, Osborne, Ramseur & Sand, 2020).

Since the time Covid-19 was declared a Pandemic, for nearly all clinicians, face-to-face psychotherapy has given way to teletherapy, delivered remotely/virtually over various internet platforms. This change has had even more disruptive consequences to the practices of all therapies which involve physical movement and/or dramatic enactment, such as RfG, Psychodrama and the various Creative Arts Therapies. Even more than for verbal-only psychotherapy, the virtual delivery of these Action psychotherapies has required alteration to being conducted in a far-less-embodied form, raising valid concerns both about how these changes can be effected and how such changes impact their effectiveness. The broad question thus arises, need we wait until social distancing ends before resuming action therapy practices?

Our experience over the past ten months has been that RfG teletherapy is quite feasible, even when certain established RfG techniques have had to be modified or replaced. The fundamental reason for this is that RfG enactments are *improvisational encounters in the playspace,* where "playspace" refers to an agreement among all present that on-stage actions are understood to be representations or portrayals distinct from reality (Johnson & Pitre, 2020, p. 130). Of course, the invitation to enter provisional, imaginative worlds has long been offered as part of talk-only therapy (e.g., throughout the work of George Kelly (1969) and later Social Constructivist therapists, all of whom were influenced by the philosopher Hans Vaihinger (1924).

Long before experimenting with RfG teletherapy, the author had supposed that the greater impact of RfG therapy interventions relative to talk-only ones was due to the separate contributions of and interactions among three essential factors:

(1) that the encounters in the playspace are embodied or physicalized. Bodily engagement reveals truths that verbal representation often suppresses or distorts. As Duhl noted, "…the body in action did [does] not lie" (1999, p. 88).

(2) that the practice of improvisation compels "presence in the present moment." Its "risky aliveness" takes the improviser out of the habitual reliance on pre-established stories we tell ourselves and offer to others.

(3) that the relative psychological safety of enacting fictions in character greatly reduces the performing client's fear of being seen as undesirable (unworthy, incompetent, unprepared, foolish, etc.) The word "rehearsals" in RfG points to that which is tentative and reversible, as opposed to a performance with significant, real-life consequences. Hence, exploration of novel choices is facilitated, leading to discoveries that may expand clients' repertoire.

The second and third features listed above are still available in RfG teletherapy; only the first is curtailed. Yet, somewhat surprisingly as confirmed recently through clinical experience, enactments need only be *suggested* as physical for them to be effective. Nor must the playspace be evoked in a concrete spatial location as the "Stage." Described below are, first, some modifications occasioned by the use of the teletherapy medium, followed by two examples of how elementary RfG therapy games, delivered over the Zoom platform, have been adapted.

Some Workarounds in Teletherapy

Since most clients have available only the microphone and camera that their laptops or smartphones come with, constraints to be overcome are that they: (1) will view and be viewed by others only as a head-and-shoulders image; and (2) will be seated and relatively motionless. Breaking the habits and assumptions that arise from the conventions of Zoom business meetings, we can sometimes invite clients to leave their chairs, distance from their cameras and move/be seen in full-body view, even though the audio signal will then be compromised or lost. The enactments and warmups in this mode will add variety and energy to therapy sessions' verbal directions before, and processing afterward, and will help tie things together.

The use of breakout rooms and turning off one's camera in Zoom can lessen the distractions of Gallery view, both when witnessing several others and the heightened self-consciousness arising from being viewed by everyone else; also, in family therapy, exercises may be conducted in smaller subgroups (breakout rooms) which the therapist can visit to observe passively or provide coaching.

Some Generic Changes Occasioned by Teletherapy

Since most clients have available only the microphone and camera that their laptops or smartphones come with, constraints to be overcome are that they: (1) will view and be viewed by others only as a head-and-shoulders image; and (2) will be seated and relatively motionless. Breaking the habits and assumptions that arise from the conventions of Zoom business meetings, we can sometimes invite clients to leave their chairs, distance from their cameras and move/be seen in full-body view, even though the audio signal will then be compromised or lost. The enactments and warmups in this mode will add variety and energy to therapy sessions' verbal directions before, and processing afterward, and will help tie things together.

Increasingly, clients' home space constraints affect their ability to create an "on-stage playspace," not only regarding room but also freedom from distracting "off-stage" sounds, pets, and other people in the home environment. Obtaining sufficient privacy from other persons with whom they live is a greater concern. The author finds it helpful to hold pre-session conversations with clients in which we discuss ways to prepare their home spaces and make arrangements with others living with them. Sometimes, the outcome is a decision to enlarging the treatment system into a consultation session (or even into relationship therapy) that includes others living together

with the initial client. Compared with in-person face-to-face therapy, more attention needs to be paid to warmups and transitional activities, probably because a client no longer has the built-in transition of traveling to the therapist's office, or of entering and situating self within the therapists' physical office and that interpersonal space.

Comparing RfG In-Person Enactment with Virtual RfG: Two Examples

As most readers may be unfamiliar with RfG enactments, the examples chosen below do not represent adequately the complexity of those games involving a fuller taking-on of dramatic character and where an improvised scenario is co-created by the players.

> A. Mirrors (Wiener, 1994, p. 69) is an elementary RfG exercise, sometimes used as warmup. Among its uses in conjoint therapy, Mirrors: (a) assesses and strengthens attentive cooperation in dyads; (b) provides a structured turns-taking experience; and (c) deepens intimacy between partners. In Mirrors' most basic, fully-embodied version, two clients take the Stage and stand facing one another, approximately 4 feet apart. The therapist assigns the role of Leader to one and the role of Follower to the other; the Leader is instructed to move her/his body or any body parts slowly and continuously while maintaining eye contact in silence with her/his partner. The Follower moves together with the Leader, mirroring the latter's body movements. After perhaps twenty seconds, the therapist calls "Switch!," signaling that the roles are now reversed; the former Follower becomes the Leader and now initiates the same type of movement, which is copied by the new Follower. After the therapist calls "Switch!" again, the clients reverse roles. The therapist may call for switching roles a few more times. After bringing this exercise to a close, the clients leave the Stage, returning to their seats; the therapist then leads some verbal, interactive post-enactment processing (PEP) of the Mirrors exercise.

As Mirrors is enacted in silence, it is feasible for pairs of clients who are physically located in the same space to receive the instructions close up and then perform this same fully-embodied version at sufficient distance from the camera for the remotely-located therapist to observe their interaction, so long as they can hear the "switch" direction. For pairs who are not physically together, the teletherapy/virtual version can be modified to be done with smaller gestures that are visible to one another; this can be achieved by the players moving their hands close to their heads and by focusing attention on small head movements and on facial gestures.

Important limitations of this latter, virtual version are: (1) that the sense of being in the presence of one's partner is diminished by having only a partial view of one's partner's body; (2) each player's involvement is reduced by not fully moving one's own body; (3) other cues in the visual field on-screen, such as the face of the therapist, competes with the focus on one's partner's face during the enactment. It can be helpful for the therapist to turn off his/her camera during the enactment phase, returning to view during the PEP. Once the enactment ends, clients' transitions

from their player roles to their social selves can be marked by instructing players to turn off their mics and cameras for three seconds, leave their chairs, take a few slow, deep breaths, and then turning their mics and cameras back on; this interlude "resets" their imaginations as the PEP is then begun.

B. Presents (Wiener, 1994, p. 105) is another, usually dyadic game that builds upon the culturally universal rituals of gifting. In Presents, two players stand facing one another about 3 feet apart. As in Mirrors, the players alternate in taking complementary roles. Here, the players are told that an exchange of gifts will be occurring. On each turn, one player (designated the "Giver") holds out his upraised palms toward the other (the "Receiver"). In the simplest version, the therapist instructs the Giver to make the giving gesture without any intention or foreknowledge of what he is giving. The Receiver is instructed to remain motionless at first, looking at the Giver's palms until her own imagination "informs" her of what the offered gift is by "seeing" it on the Giver's hands. Once the Receiver knows/sees what the gift is she mimes taking it from the giver's hands and indicates by her actions what the gift is. Only then does she speak, acknowledging her reactions to getting the gift from the Giver. The Giver then responds vocally and bodily to the Receiver and the turn ends. Following this enactment there is another turn with the players reversing their initial roles as Giver and Receiver.

Often this process is repeated with additional instructions from the therapist before the action commences. Many variations in initial instructions by the therapist, some of these likely to altering profoundly the feelings and dynamics of players' interactions, are possible (Author, 2012). Variations include: the gift is expected to be a desirable/ disappointing/insulting one by the Receiver; the gift is understood to be a bribe; the Receiver is getting the gift from a relative stranger/from one's father/from one's spouse; the gift, though desirable, isn't as good as the one received by the Receiver's sibling; etc. Presents may: (a) activate the imagination of the player in the Receiver role; (b) often evoke emotionally resonant past experiences with actual gifting; and (c) promote the Giver's sense of being appreciated when the Receiver expresses gratitude.

Although Presents is not enacted in silence, it is still feasible for pairs of clients who are physically located in the same space to receive the instructions close up and then perform this same fully-embodied version at sufficient distance from the camera for the remotely-located therapist to observe their interaction; here the problem may be that that the therapist cannot hear the speech of the players following the taking of the gift. For pairs who are not physically together, the teletherapy/virtual version can be modified to so that the Giver begins with an opening gesture of both hands moved outward from under the Giver's chin, while the Receiver takes the Present by moving the open outstretched hands to a more closed position under the chin.

Similar to Mirrors, important limitations of this latter, virtual version are: (1) that the sense of being in the presence of one's partner is diminished by having only a partial view of one's

partner's body and the miming of the gift; (2) each player's involvement is reduced by not fully moving one's own body; (3) other cues in the visual field on-screen, such as the face of the therapist, competes with the focus on one's partner's face during the enactment. As noted with Mirrors, it can be helpful for the therapist to turn off his/her camera during the enactment phase, returning to view during the PEP.

The Future of Virtual Action Therapy

At the present time, it appears likely that teletherapy will continue to be a significant method for delivering psychotherapy services, even after the health needs for social distancing have receded. More effective platforms will likely be developed that reduce or eliminate some of the limiting features of existing ones. The Applied Improvisation Network (AIN) is currently mobilizing with a flood of ways to improvise online, including some who are exploring Virtual Reality (VR) technology. It is expected that a fuller flowering of creativity will continue in the near future; as the composer Igor Stravinsky wrote, "The more constraints one imposes, the more one frees oneself from the chains that shackle the spirit." (1942, p. 17). the author invites readers to communicate their own suggestions and examples of improvements, joining the community of those who are innovating and exploring the new Virtual world of action psychotherapy.

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RELATIONAL SPIRITUALITY, INTERCULTURAL COMPETENCE, AND SOCIAL JUSTICE IN SYSTEMIC THERAPIES

DANIEL J. HAUGE, PhD; STEVEN J. SANDAGE, PhD; LAURA E. CAPTARI, PhD; SARAH A. CRABTREE, PhD

The Albert and Jessie Danielsen Institute, Boston University

Abstract; The Relational Spirituality Model (RSM) builds on relational, psychodynamic, and systemic approaches and serves as an orienting framework for clinical services and training. In this article, we provide an overview of the RSM, a pluralistic contextual approach to spirituality in clinical practice that (a) considers developmental dialectics of spiritual dwelling and seeking and (b) explores diverse ways that religious and spiritual dynamics can range from salutary to harmful. In light of growing attention to racism in U.S. society, we review salient research on justice-seeking spirituality and consider the roles of humility, differentiation, and hope in developing intercultural competence. Throughout, we consider implications for clinical practice and training.

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"Spirituality by its very nature not only inclines but requires one to engage the world with a sense of responsibility for the well-being of creation, and with a commitment to repair what is amiss and to act in defense of creation. Spirituality and justice seeking are thus inextricably tied; like a Möbius strip, they are not distinct realms, but flow seamlessly one to another."
(Perry & Rolland, 2009, p. 384)

This beautiful articulation of "justice-seeking spirituality" (Perry & Rolland, 2009, p. 384) has important implications for both clients and therapists. In contrast with historical segregation of spirituality and religion (SR), research now documents the impacts of SR beliefs, commitments,

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struggles, and practices on physical, relational, and mental health (Rosmarin & Koenig, 2020). For many people, SR dynamics play important roles in coping, meaning-making, relationships, and cultivating resilience. Evidence suggests that clients often desire to engage such issues in therapy if they feel they can trust their therapist to be open and accepting (Sandage, Rupert, et al., 2020), a pattern that has emerged at our clinic in Boston, despite being a region considered the "least religious" in national surveys. Numerous clinical approaches to integrating SR concerns have been developed across theoretical orientations, and a recent meta-analysis of 97 studies found spiritually integrated therapies to be at least as effective as secular treatments for psychological outcomes and superior for spiritual outcomes (Captari et al., 2018).

However, these advances do not always "trickle down" into day-to-day clinical practice for several reasons. First, a majority of therapists have little training on integrating SR dynamics, which raises understandable concerns about spiritual and religious competence (Vieten & Scammell, 2015). Second, most clinicians are concerned about sensitivity to client diversity, and some avoid asking about clients' SR lives for fear of microaggressing. For example, some therapists may tell clients they simply will not discuss "religion" or "theology," which cuts off therapeutic engagement with core values and meaning-making processes. Like many areas of diversity, engaging SR dynamics can be more complicated in relational and systemic modalities (e.g., couple or family therapy), and the vast majority of published approaches to spiritually integrated therapy focus on individual treatment. Third, while Perry and Rolland's (2009) depiction of justice-seeking spirituality could inspire some clinicians and clients, others might be skeptical and quick to note that spirituality is not always associated with social justice activism. Therapists and clients holding more socially conservative SR convictions sometimes equate social justice with a liberal political agenda that is inconsistent with their worldview. This raises complex tensions for those in clinical and training contexts who (a) value both diversity and social justice and (b) want to responsibly and effectively integrate SR dynamics into relational and systemic approaches to therapy.

In this paper, we first provide a brief overview of the Relational Spirituality Model of psychotherapy (RSM; Sandage, Rupert, et al., 2020), utilized in clinical services, training, and research at the Albert and Jessie Danielsen Institute, a community mental health training clinic at Boston University. We then apply the RSM to considerations of justice, equity, and antiracism, concerns particularly salient amidst current sociopolitical focus on racism and antiracist efforts. We explore various aspects of justice-seeking spirituality and intercultural competence, including implications for clinical practice and training.

Relational Spirituality in Systemic Contexts

Relational spirituality can be defined broadly as "ways of relating to the sacred" (Sandage, Rupert, et al., 2020, p. 24), referring to whatever is ultimately most important to a person, including a divine being and/or other spiritual entities, cherished principles and values, or ultimate concerns. This framework opens broad conceptual space to consider a variety of salutary and

harmful ways individuals relate to whatever they consider sacred or ultimate, with relational styles that include mindful dwelling, hostile mistrust, bored indifference, passionate and generous service to others, grateful surrender, fear of persecution or abandonment, ecstatic spiritual merger, active searching and study, and others. Spirituality can be practiced through religious or other social contexts, and a growing number of people in the U.S. self-define as "spiritual but not religious" (Ammerman, 2020).

We are particularly interested in the large body of research showing that individual differences in relational spirituality correlate with attachment-based experiences in interpersonal relationships with parents, caregivers, and others (Granqvist, 2020). This means relational templates in the limbic brain exert considerable influence on perceptions of spiritual experience. Furthermore, intersections between personal identity and wider systemic social structures also shape contours of relational spirituality (Powell, 2012). Perry and Rolland (2009) used the term "societal counterspiritualities" for the oppressive forces of "systemic domination" (p. 392) that can work against spiritual well-being and give rise to despair among non-dominant groups.

Additionally, some clients are part of a growing number of people in the U.S. who identify as "neither religious nor spiritual" (Lipka & Gecewicz, 2017), locating their ultimate values and sources of well-being within a secular framework. Existential themes (e.g., loss, death, fate, control, guilt, meaning, freedom, hope, etc.) are a key part of the RSM that can be relevant to all clients, and we value attending to the existential dilemmas embedded within human experience. Numerous different spiritual, religious, and existential perspectives can operate within a couple or family system, so clinicians often face the challenge in a single case of building a therapeutic alliance across diverse ways of relating to the sacred and ultimate concerns. Systemic clinical work also necessitates a relational ethic of multidirectional partiality and practicing justice through consideration of each person's perspectives within a couple or family system (Long & Kort, 2016).

Key Dimensions of Relational Spirituality

The RSM foregrounds three key developmental constructs: (a) spiritual dwelling, (b) spiritual seeking, and (c) spiritual struggles (Sandage, Rupert, et al., 2020). Spiritual dwelling refers to the numerous forms of relational spirituality that promote communal affiliation, spiritual grounding and intimacy, and practices aimed at emotional and spiritual regulation. At its best, spiritual dwelling can promote social support, well-being, and relational stability.

However, enmeshed forms of spiritual dwelling can promote closed system dynamics privileging homogeneity over diversity, and anxious spiritual dwelling can work against the flexibility and differentiation necessary to adapt to new situations and a more inclusive sense of community. Spiritual seeking is oriented toward processes of exploration, valuing reflection on existential questions, and growth in spiritual complexity. Seeking can require tolerating ambiguity, anxiety, and doubt, but can lead to new spiritual understanding, more diverse relationships, and a widening circle of social concern. However, some anxious forms of seeking can lead to perpetual searching without forming connects that facilitate well-being, and spiritual seekers do not always embrace justice concerns.

Research suggests that spiritual struggles (e.g., conflict or distress related to the Divine, meaning, morality, doubt, etc.) are a normal part of spiritual development in many traditions (Pargament & Exline, in press) but are commonly and frequently associated with mental health and well-being problems. Our research with outpatient clients has found that spiritual struggles can be related to problems in psychosocial functioning over and above the impact of mental health symptoms, which suggests this is an important area for clinical assessment (Sandage, Jankowski, et al., 2020). For some clients, spiritual struggles can prompt seeking in an effort to pursue healing and growth, while others feel stuck in painful and dysregulating spiritual struggles without a sense of agency for exploration. Clinically, it is noteworthy that some clients interpret their spiritual struggles resulting from their own internal failure (e.g., sin, lack of faith, inconsistency in spiritual practice), whereas others see external and systemic factors as sources of their spiritual struggles (e.g., homophobic religious relatives, disappointment in SR leaders, injustice in the world).

The RSM theory of change in therapy focuses on the importance of constructive relationships as holding environments for the dialectical balancing of dwelling and seeking and the integration of struggles into more coherent life narratives. For some clients, therapists offer a new and corrective experience of relating to someone sincerely interested in their core values and meaning, without trying to impose a particular worldview. Many relational and systemic therapists have used the crucible as a metaphor for the intense and anxiety-provoking processes of change that can involve destabilization prior to the construction of new developmental patterns (Sandage, Rupert, et al., 2020). This underscores the ongoing importance of the person of the therapist (Aponte & Kissil, 2016). Systemic change processes always involve clinicians' capacities to relate to clients in change crucibles with non-rescuing compassion and effective attunement to diversity and justice dynamics.

Relational Spirituality, Diversity, and Justice

Mental health treatment requires skillful capacities to engage social justice and diversity issues, and this has key implications for clinical training and ongoing therapist formation. From a systemic perspective, the efficacy of therapeutic intervention requires attention to the role of inequitable social systems on clients' presenting concerns. Honest recognition of the impact of various forms of systemic injustice on marginalized communities' well-being is vital, including the effects of minority stress, internalized racism and xenophobia. The RSM deepens this conversation by critically addressing how some SR permutations oppress and harm vulnerable clients, including those whose identities or beliefs do not align with a particular tradition's dogma, while SR values and resources can also be a powerful motivating force promoting work toward equity and change. As Constantine and colleagues (2007) have noted, awareness of these complexities necessitates that clinicians develop greater "self-awareness, knowledge, and skills in working with individuals [and families] from diverse cultural backgrounds" to more effectively address issues generated by systemic oppression, as well as to "work more broadly to effect social change" by advocating for and empowering vulnerable populations (p. 24). Our research has

explored associations between relational spirituality and individual differences in personal commitments to social justice work and intercultural competence (for a summary, see Sandage, Rupert, et al., 2020).

Dialectical tensions between spiritual seeking and dwelling provide a framework for understanding individual or systemic engagement with, or resistance to look at, social inequalities and realities of diversity. The concept of spiritual bypass has been applied to situations where spiritual defense mechanisms are used to avoid experiencing internal conflict or emotional pain (Cashwell et al., 2007). We propose that individuals can also relate to the sacred in ways that attempt to bypass awareness of systemic injustice and suffering. Pursuit of security and stability in relationship to the sacred and with others can lead to stagnation or forms of rigidity and exclusion if not accompanied by a willingness to question and consider alternate ways of thinking with an attitude of curiosity and generosity. Among graduate students in the helping professions, Sandage and Harden (2011) identified this seeking orientation as consistent with "an openness to questioning one's tradition, tolerating the ambiguity of meaning-making, and the cognitive flexibility to revise one's worldview based on new experience" (p. 823), which was positively associated with trainees' intercultural competence. Training contexts that normalize and encourage questioning one's own perspectives and learning about other cultures can facilitate these capacities to effectively relate across differences.

Our research has also found evidence that spiritual grandiosity (e.g., seeing one's spirituality as inherently superior to others) tends to hinder the development of effective capacities to relate across cultural differences even when multicultural counseling training is offered (Sandage et al., 2015). Thus, taking graduate courses or continuing education seminars may be insufficient for growth in intercultural or diversity competence. Personal exploration of implicit relational templates of self- and other-associated values and SR perspectives is a vital, yet oft-neglected, aspect of professional development

Mature Alterity, Humility, and Differentiation

Mature alterity is a related RSM construct involving a "move beyond ethnocentrism toward strong capacities to engage in relational justice characterized by mutual recognition" (Bell et al., 2017, p. 212). The ability to acknowledge others as possessing the same inherent right to define their own existence and command dignity and regard on their own terms is connected with processes of relational and spiritual growth. The RSM suggests a continuum for how people are able to embrace the possibility of multiple approaches to ultimate meaning, such that one can tolerate and even appreciate differing paths to human flourishing. Mature alterity contrasts with defensive religion or theology, which copes with existential anxiety through a sense of spiritual privilege vis-à-vis other human beings focusing on "a strong 'worldview defense' that can foster intolerance for different religious traditions" (p. 213). Bell and colleagues (2017) found that defensive theology was negatively associated with mature alterity dimensions of social justice and intercultural competence commitments among graduate students in a Christian setting, while humility was positively associated with both dimensions of mature alterity. These findings are

consistent with recent work on cultural humility, suggesting the importance of a therapeutic stance of curiosity, learning, and respectful openness to new perspectives in navigating areas of diversity (Mosher et al., 2017).

Humility and critical self-reflection about actively working to dismantle systems of power and oppression and their impact on clients' lives require capacities for healthy relational selfhood and emotion regulation practices. Differentiation of self (DoS; Kerr & Bowen, 1988) is one systemic construct that involves such relational and regulation capacities and has been positively associated with both intercultural competence and social justice commitment in training contexts (Sandage & Harden, 2011; Sandage & Jankowski, 2013). DoS is sometimes misunderstood as representing autonomy or individualism but is better conceptualized as the ability to relate effectively across differences while maintaining solid self-other awareness. This relational, intersubjective understanding of DoS is consistent with nuanced attention to differences without the need to polarize phenomena or people into good/bad binaries. Relational spiritualities grounded in DoS can facilitate empathy and tolerance for those who approach the sacred or ultimate meaning in different ways, including among differently believing family members. In contrast, low DoS and high triangulation can characterize families and SR communities where anxiety about difference tends to close off spiritual seeking (Heiden-Rootes et al., 2010). These findings speak to the importance of integrating emotion regulation and relational flexibility into clinical diversity training efforts to help clinicians become more truly systemic in their approach.

Justice-Seeking Spirituality, Hope, and Well-Being.

Perry and Rolland (2009) connect justice-seeking spirituality with the "generation of hope and well-being" among activists (p. 380). Our research with trainees has supported this theorized connection between hope and social justice commitment, which is also found in the works of social philosophers (e.g., Martin Luther King, Jr., Paulo Freire, Cornel West) (Sandage, Crabtree, & Schweer, 2014; Sandage & Morgan, 2014). However, we should not be naïve about the kind of hope that effectively sustains a long-term commitment to social justice advocacy in the face of deeply entrenched realities of racism, sexism, homophobia, transphobia, and other forms of systemic oppression. Social justice work invariably entails a wide array of stressors that challenge personal and organizational resilience. For oppressed individuals and families working for their own rights and equitable treatment, the violence, deprivations, and indignities of oppression generate distinct forms of traumatic stress (Carter, 2007). For those historically advantaged by systemic oppression, engaging in social justice work demands the ability "to manage emotional tension, tolerate ambiguity, differentiate one's sense of self from oppressive social forces, and make meaning out of the struggle" (Sandage & Morgan, 2014, p. 559). Those from privileged social locations need more than positive thinking, which is too often a thin defense against underlying guilt and fragility among Whites and other dominant group members.

West (2004) has described a "mature hope" (p. 216) that includes realism about suffering and painful systemic realities integrated with courage to keep working to change those realities.

For many social justice movements, including the Civil Rights Movement in the U.S., spiritual and religious traditions have provided resources for psychological stamina, hope, and well-being in the face of discouraging activist work. Spiritual orientations and relational processes that welcome and appreciate ambiguity and difference, and sustain a sense of meaningful and liberating relationship to the sacred in the face of dogma or exclusivity, can contribute to fierce determination that fuels hope. Those who value SR can often find narratives and practices that promote seeing oneself as collaborating with the sacred to create a more just, loving, and equitable society. To be clear, therapists and other helping professionals can value justice and diversity without SR commitments. However, in a time when spirituality and religion are frequently invoked in ways that instigate violence to diversity and justice, we want to invite awareness of research that supports the fact that commitments to social justice and intercultural competence are consistent with mature forms of relational spirituality in most traditions. We invite clinicians to continue the formative traditions of systemic therapies in cultivating relational dynamics that foster equity and justice, while uprooting structures that perpetuate oppression.

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The Impact of COVID-19 on the Future of Therapy: an Interview with the Editors of the New England Journal of Relational and Systemic Practice

STEPHEN DUCLOS, M.Ed; JACQUELINE GAGLIARDI, M.Ed; JEREMIAH GIBSON, MMFT; FRANK GOMEZ, MA; DAVID HADDAD, EdD; BEVERLY IBEH, MA

Editorial Team – *New England Journal of Relational and Systemic Practice*

In December, 2020, the editorial team of the New England Journal of Relational and Systemic Practice, sent a survey to the membership of the New England Association for Family and Systemic Therapy about the impact of COVID-19 on the practice of therapy. Upon reviewing feedback, they asked three significant questions regarding the impact of COVID-19 on the practice and future of therapy:

1) What are the positive and negative effects of therapists doing therapy online over an extended period of time?
2) How is therapy during the pandemic going to change therapy moving forward?
3) How do we prepare clinicians—as teachers, as supervisors, as colleagues—about these changes?

The following article is written in an interview format, where each of the editors discuss their perspectives on these three questions.

_ _ _ _ _

Stephen Duclos: Well the first issue is whether we even have the right to do that given we're so in the midst of it ourselves. You know, we'll do the best we can in sort of giving some responses based on the responses of other therapists but we're not necessarily the experts on any of this; these are just the responses we've been talking about for some months.

Beverly Ibeh: Yeah, and I think just to echo that, Stephen, I was recently preparing an agenda

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for a parent support group and one of the topics that we talked about was how do you balance parenting and working from home and just this new method that we're engaging in together in terms of the stay-at-home order, and I found that myself and the co-lead were almost resistant to creating this parent support group agenda because we were finding that the very things we were coming up with for this agenda we were struggling with ourselves. How do you create a workspace that doesn't interfere with the boundary you've set between home and work life? And so, thinking about if you're doing therapy in your room consistently, how are you creating boundaries around that in your personal space so it's not affecting your own self-care and the way in which you're able to separate from the work? Because now we're all engaged in it in one place, in one environment. So I just wanted to add that little piece that was coming up for me: that we're all struggling with this; as we're trying to help parents and children and adolescents think about creating boundaries in our home space we're also having issues with this ourselves.

Jackie Gagliardi: I agree with that, Bev, because I think—and other people have said as well—that they tend to be working more because that space is there, and it's not that they're going to their office and then there's a separation called an office. And so they're spending much more time in their office and doing much more work than they ordinarily would've done before COVID.

Beverly Ibeh: I would certainly say these are some of the negative effects that we're seeing. It's harder to have that separation.

Frank Gomez: Working from home has its own challenges too. As a supervisor I get to work with a team, and one of the things that has come up more recently is this feeling of disconnection. I think it has something to do with the time that we've been working from home. But there was something about being able to go to your teammate or the therapists next door or something and taking out some questions that you might have about how to approach a service or a presentation. That was something that was really valuable for clinicians that were working and working alongside other clinicians that were starting out. But now there's more of that reaching out to the direct supervisors or this managerial staff and less of that peer support. And that is something that has been challenging for a lot of people. A lot of...they don't want to create this dynamic where they're always asking questions to their supervisor and that has been something definitely that has been part of the conversation. I love these questions, but sometimes I feel some people might feel comfortable just going towards the supervisor rather than using their peers.

David Haddad: This kind of strikes me, the question: "How do we prepare clinicians going forward?" It strikes me as a kind of philosophical question; that COVID has kind of forced people to speed up, but the question is always the same; it's "How am I thinking about this?" And these conversations that we're having are exactly like what relational therapy is about: the answer isn't in my head, it's between us. So unless we're remembering that, then it seems like we're always trying to fix the problem, as opposed to: "No, we're developing a way to talk about it that moves us forward." At least I think, in the kind of postmodern world that many of us inhabit, the problem

isn't inside the client, the problem is in the system. It's between us, how we talk about it...and then what comes next. These seem like all really such important and heady questions. But that's what I appreciate about the survey is we get a chance to talk about it, and our community gets a chance to talk about it.

Jackie Gagliardi: I was struck by one of the participants who said something I hadn't really thought about. His concern was that clients do not have the time to process before or after a session the way they would if they were driving there and driving home. It's something I really hadn't thought about but it made sense.

David Haddad: How so? I find that interesting. How does that make sense? Because they have the same amount of time they've always had…

Jackie Gagliardi: Well, but they don't. Because, say, they're taking care of their kids, and they run in to do a session, and they run out, and they're back in the same environment. They don't have that space to say, "This is what I want to talk about," while they're driving to session. They're helping their kids with their homework, actually doing online teaching...so they don't have that space for themselves. And I'm just wondering for some people—I'm sure that's not true for everyone—what impact that has on the work that we're doing.

Jeremiah Gibson: And I think that there's an assumption that every client is a good candidate for teletherapy. Not every client is a good candidate for teletherapy. I have a couple that I'm working with that I'm in the process of having this conversation with—that the process of teletherapy kind of shines a light on how disorganized the relationship is, and how they're really just hanging on for dear life. And they need that separate space. Without that separate space, the camera itself is never settled, the point of impact is very seldom on the relationship; it's usually just on whomever is doing the speaking. And I think that one of the things that we're going to have to figure out—because teletherapy is not going away—is having conversations about when is it appropriate to do teletherapy, and also when is it not appropriate to do teletherapy? When is teletherapy not effective for folks? And do that not in a shaming way, but thinking about it more in terms of the number of variables that are going on in a person's life.

Jackie Gagliardi: I almost think that you can check that out with the client as well in terms of the relationship, like, "Is this working for you? Do you need a quiet space and is this not a space that's working as well as being in the office?"

Stephen Duclos: Getting back to David's question about between us...one of the things that's between us is the computer. This computer, we take it for granted that we can all talk together, but this computer is between us and them. And it's a problem for us and it's a problem for the people we work with. And the computer becomes problematic in thousands of different ways. One session goes well, the next session you have technical glitches, you have someone walking around the room

and you only see parts of them, a cat jumps up on the keyboard and you're gone for 5 minutes. There's all kinds of stuff that happens that prevents us from doing the work. And then that turns into the work in a way, like Jeremiah was saying. Maybe, "We're going to have to figure something else out or have a better connection the next time we talk because we lost 20min today because we couldn't connect at the beginning, we couldn't connect in the middle. You know, it might be good if we kept the cat somewhere else, because—I know you love the cat–but if he jumps on the keyboard, we all go away." So the between us thing is the big deal. How do we do the between us thing?

David Haddad: One of the things I'm reminded of as you say that, Stephen, is the power of the observing team, at least in the beginning—having the watcher. So we have capacity with online, particularly with Zoom, to witness; for people to see themselves. So video recording as we're doing here, that people have the opportunity to kind of see themselves, and do they show up in that encounter...what does that say about how they're seeing themselves? Are they embodying? Are they being the way that they think they are? Is that consistent with their intention?

Frank Gomez: I was going to say to your point as well, I feel like it sometimes amplifies what's being shared, because, in my experience, youth and their caregivers, they might say something very quiet on the side. But you can't really be quiet and the same volume through Zoom. I've experienced that some statements are amplified and I think it's more significant when they're this close in therapy. Now that everybody's having the headphones and being really attentive to what the other person is saying.

Jeremiah Gibson: And also, David, thinking about your question about the space between us, I'm also thinking about myself as a therapist and how is the therapist that's on the computer screen engaging in a different way then they would be if they were sitting with that couple in a room. For instance, I notice that I engage with conflict a little bit differently when I'm able to see it on a screen, that I can remove myself from it in a bit of a different way—and actually name the process a little bit quicker—than I would be if I am engaging with that same conflict live in the same space. I'm not saying that's good or bad, just noticing that that's different. That anytime we're engaging in some kind of an avatar, some kind of a technological representation of ourselves, that's going to have a different outcome than it would if we're engaging with someone in a live space...and how does that impact the therapeutic process?

Jackie Gagliardi: I agree with that on two fronts. For me, it's a distraction because I'm seeing myself as well, but on the other hand, I'm looking at my own facial expression and then realizing, "Gee, I look too serious." I think that there's another component to that. There are multiple things going on at once; both you and the clients are having your own thoughts, you're having this conversation together. Now I'm having two conversations: one about the client but also one about myself...and how I'm responding. Whereas, in the therapy room, I can't see myself. I don't know if that's a good thing or a bad thing, but it's definitely a distraction, an added component to therapy.

Beverly Ibeh: I would absolutely agree with that, and I'm thinking about, too, resistance and resistance may show up right now over telehealth. And I think about how I might've managed that in the room, especially working with adolescents or treatment-resistant clients that might need therapy but not necessarily want it. And now I'm re-thinking about what progress looks like in therapy: "If I'm seeing the top of your head, then I know you're still with me, at least, and that you haven't left the room, the therapy room, and that's going to have to be enough," as opposed to What I've engaged in in the past, at the beginning of teletherapy: "Can you put your mic down and could you bring the camera so I can see your face." That's essentially the same as if a teenager was on your couch and turned their back on you and said, "I don't want to talk to you." They've now flipped their camera to the ceiling and that's their resistance and that's going to have to be enough. So it's really a thinking about how we manage that now and how different that looks, and having to sit with that and tolerate that ourselves: that it's going to look very different over Zoom.

Jackie Gagliardi: That also brings up the issue around body language. Someone else was talking about how you can't see what's going on, if the foot is going up and down, if the hands are twisting. So it seems like there's less information than you would get if you were in person.

Beverly Ibeh: Absolutely.

Frank Gomez: Along the same lines, I'm thinking a lot about your presence as a therapist in the virtual room and how, especially with youth or clients that have experienced trauma, often you as a therapists are invited to that state of alertness, and in the room, it's very evident when you're there; but when you're virtual, during these virtual times, it might be a little difficult to meet people where they're at, and see all of these signs that might come up while you're in the room.

David Haddad: And also like what's the experience of: "Do they see the therapist full screen? Is their voice too loud? All of those cues that might sort of trigger that. That's interesting, Frank.

Frank Gomez: Right. And if they're inviting you to be there, are you meeting the needs of this sort of therapeutic relationship in the moment? I'm thinking a lot about that. And if I am going there virtually, what's my ability to support this person during this session?

Jeremiah Gibson: And, Frank, to add to that, what does it mean to virtually be a part of the system, as opposed to being in real life part of the system? I think it's much more than just body language and non-verbal cues that we end up missing.

David Haddad: It may point back to that question you were posing earlier which is: Not everybody is a candidate for online. That this therapy requires some kind of active participation, an ability to participate given the medium. So you're screening: "Do you know what you're signing up for? That it requires you to be more active? To be more intentional?" Just like the therapist has to be more intentional.

Stephen Duclos: Yeah, I was thinking of Beverly's little family and the problem of teenagers and putting their hood over their face and moving like this so you can't see them or moving right out of the screen, and the first time that happened I was thinking about many years ago when younger people, teenagers and younger children were coming in with their phones. At first I was opposed to them looking at their phones, and then I realized that, when I asked them not to use their phones, I realized I didn't understand how they used their phones. Or the parents would say, "I don't want you using your phone." And after a while I would say, "No, it's perfectly fine if they use their phone, as long as we all feel like we're listening to what's going on." Now, of course, a twelve year old boy or girl using their phone is a lot different than my conceptualization of what using a phone is like. I don't like to use my phone, I'd prefer not to use the phone, I don't like phones. But this is not my experience. So we have to do another kind of translation now about a teenager in the room who moves the screen up. You know, we have to say, "That's fine, you can do that, just as long as we know that you're still listening." And we have to sort of translate our visual experience in a room to the medium we have available to us. So, "Can you somehow indicate to me that you're still listening? And I don't have to see you." And we have to keep doing these translations from what we used to know to what's actually happening now, and that's difficult and we don't have training for that.

Jeremiah Gibson: And I think it's especially difficult if you didn't grow up in the middle of the virtual technology revolution. Like I grew up, more or less, with instant message, those sorts of things...that was my adolescence. So, I figured out how to engage and make sure that my online presence is as close as possible to my real presence even though there's nuanced differences. And I'm curious, Bev and Frank, about your experience with this too, and I'm curious if younger therapists and therapists who didn't have their childhood and adolescence in the technological revolutions of instant messaging and Facebook and all that, if there's not a difference of your experience as virtual therapists. So, Frank and Bev, I'm curious how the two of you are noticing the adjustments that you're making in being a virtual therapist and how that might be different for you, Stephen, David, and Jackie.

Frank Gomez: It's an interesting question.

Beverly Ibeh: I'm thinking about my work with younger children because that is their entire world. You know, as young as three, you have your own iPad, you know how to work it with the passcode. So I'm thinking about them and having to adjust and just like, for example, engaging with a five or six year old on Roblox—the app or online website, this virtual world, where they play games—and I remember for four or five weeks that's what we did for therapy; we would meet in this virtual world and my client would show me this world that they're in. And having to say to my supervisor, "This is therapy…? Is this ok that we're engaged in this app? And this is essentially how we communicate and engage with each other." And then having to think about, as Stephen was saying, making this translation. What is this child really doing in this app? What are themes coming up? Essentially, that would be the same as the child playing with my toys in the room.

We're in a virtual world, just online. And they're playing with me. But it looks different, it feels different; I'm observing it like an outsider behind the screen. But it's play. So really re-envisioning what it looks like for clients to engage on this online platform has been really interesting. And having to have validation from the treatment team, like, "Yes, you're engaging in these treatment goals within this virtual world and this is the option we have right now and it's better than nothing, so this is how we're going to engage—because this is what we have. You can't go into their home, they can't come into your office, and so this is how you can play, essentially, online. So that's been really interesting for me.

Stephen Duclos: We have about 5min left before we have to stop. Frank?

Frank Gomez: I was going to say that, I guess briefly, that as a young therapist, I didn't have very much of a challenge getting used to Zoom or Doxy.me or all these different ones that different agencies use...what is it, Microsoft Teams? That has been ok. The challenging part is the restrictions that come with doing services through telehealth, especially, I like to introduce more expressive ways of interventions. I think it provides a little bit of energy to what families are working on. But I'm lacking that part, for the most part. I think that that, for sure, is something that I've had to think creatively about, which speaks to some of the things that Bev was talking about. So not too many issues with technology.

Beverly Ibeh: I would say not too many issues, but even for me as a younger clinician, when I think about technology, it's part of my leisure world. Prior to COVID, I went into social media for leisure and all these other apps, and now it feels like it's a vital part of the work, so I've had to just integrate. So that's been I think the biggest change is integrating those two worlds, like this is now part of my work, whereas before, I'm really looking for that person-to-person...the relational piece that David was talking about: what's between us, what's occurring in the room; and now it's: what's occurring in this virtual world that I can kind of pick apart in terms of how the client is presenting.

Stephen Duclos: We haven't really talked either about the idea that there are physical changes in terms of presence. There's the problem that therapists are having with eye strain and visual migraines and things that we've never had to worry about because we weren't looking into a screen for 8hrs a day. And these things need to be addressed and other therapists need to realize that they're not alone when these things happen. When we get really exhausted at the end of the day because we're not getting a whole lot of feedback, somatic feedback, from the families we're working with, that's a different kind of tired than we had before when we were seeing people live. I don't think that the computer helps us to assess our own feelings between sessions. We move straight from one session to another without a whole lot of processing in between. When we're in our office at least we get up and walk people out and we meet another person in the waiting room, or we travel to a person's house and we see them, then we drive to another person's house, and we get to process stuff. But we don't have that now. It's just maybe grab a cup of coffee and then run back to your screen. Which is exactly what the participants we're working with are doing. They're

not thinking about where their cat should go, or they're not thinking about: "We need a private space and I need 10min before and 10min after so we can talk about what just happened." You know, they're already thinking before the session's even started, "This ends at 11 and at 11:05 I have a meeting for my work."

David Haddad: It's sort of like it's a new era of social-emotional learning for everybody.

Stephen Duclos: Yeah, and we haven't really adjusted to some of these things. We're just doing them; we're not sort of adjusting or examining them or thinking about other ways of doing it or rules...what are the protocols? Should you have two sessions back-to-back? And how many sessions should you have in a day? How much time off do we now need because we're doing all this stuff? What should our case loads be like? How much can we actually bear?

David Haddad: Or even policy. Should therapy be like peace work where you have to see 80% of productivity or whatever it might be...it's almost like peace worker or in a factory; kind of crank 'em out.

Stephen Duclos: That's not going to work.

Jackie Gagliardi: Yeah, I'd like to attend to Jeremiah's question about seasoned therapists as opposed to newer therapists in terms of technology. I think that's really an important piece to talk about. For example, for me, who did not grow up with a computer and who maybe 20 years ago got involved with computers, there's been lots of work in terms of learning and adapting. I mean, I can do it and I'm doing it. But it's like twice as much work to do so. And I think maybe the difference is too that I'm teaching and doing teletherapy and the teaching piece has been more of a challenge given that it's totally online. But I'm adapting. I feel bad for the older therapists who just used email or maybe Facebook, and now all of a sudden they have to use Zoom and get more involved with technology. I think there's all kinds of levels of experience in terms of the use of technology.

Stephen Duclos: We have to end but I'd like to sort of hear from Frank or Beverly about being a new therapist in pandemic land and what's that like.

Beverly Ibeh: My goodness, it's been very challenging in many ways. I'm thinking about what's been brought up several times during this meeting in terms of having that community of the treatment team as an early-career psychologist. Being able to run into my supervisor's office and say, "I have a quick consult about a case before I run in," and not having that has been very challenging. I think it's very isolating and I'm finding myself having to engage in my own processing outside of supervision more than I ever would because I don't have the camaraderie of the treatment team. I can't see my peer in the hallway and say, "Hey, I'm seeing this client. Have you talked to this family?" I have to now set up a Zoom meeting, take a block of time in my day,

and it's now become double the work, triple the work, to engage in.

Frank Gomez: I second that. I think there was something very valuable about having peers going through the same experience. Something that now we don't have as much. I did want to speak to something that I've been helping newer clinicians with, and it's like developing rituals to stay present in session even in virtual times, because as we train and do the in-person stuff, you develop these little calming things in session so that you can be present for your clients. And for new clinicians that are not having that first experience in-person, I think it looks different, and that's been a conversation: "How do I stay present even though all this is going on through this virtual medium?" So that has been part of the conversation. What do we do in between, also, to stay present with families?

Beverly Ibeh: That's a great point, Frank. I have been thinking a lot about how we slow down over telehealth versus how it might've come more naturally in person...to just be together with a client. Does it feel more intolerable to sit silently now over Zoom, and just to be with a client, or does it feel more intolerable than before in your office you could've sat for 45 or 50min quietly and just been together?

Frank Gomez: I think there's still this thought that you can add clients back-to-back and not have that affect you, just because you're at home and you're able to… But I've been used to already using that time in between to slow myself down and ground myself before I go into a next session. And I think that the practice of being present in the session and what's in between sessions is not talked about enough, especially for new clinicians.

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The Experience of a Person of Color in a White Profession

PORSCHE LOCKETT, MA; JACQUELINE GAGLIARDI, MEd

Jacqueline (Jackie) Gagliardi: We can read many articles about white fragility that are written about this topic, but we don't often see stories of people actually practicing and experiencing what it's like as a person of color in a white profession. So, I want to thank you, Porsche, for doing this interview, and it's really exciting for us to be working together like this. So the first question is how did you first become interested in becoming a therapist?

Porsche Lockett: So, when I was younger I knew that therapy was a thing, I knew that it was important. I went to therapy as a kid. Throughout my life, I've gone to therapy, and I knew it was important. However, it just felt weird connecting sometimes because all of the therapists I would see were white. And it wasn't wrong or bad, it just felt like I had to be zipped up and present a certain way. So, you know, that joke of therapists become therapists because they need therapy...and I was like, "Oh, absolutely not." Like, I just decided this on my own accord and just knew that I would be great at helping people. My family is why I'm a therapist and decided to join a program specifically for couples and family; that says a lot. So I knew I cared about people, I knew there was something different.

Growing up in a religious, Black family in the South, I knew that there was something more than just saying, "Pray about it." Or just deciding not to acknowledge feelings or talk about things. And I think that comes from a historical hardship that Black people have faced, and it's like, "You have freedom. You have a roof over your head. No one is trying to take anything from you so your life is good."

However, it diminished or did not make space for emotions and feelings and being sad. And it's not that it's totally ignored or not an option, however, it's uncomfortable. There's not much space for it. And these things did not equate to not being loved. It doesn't mean that you're not loved in your family, it doesn't mean that you're not cared about. However, you know, on the contrary, love is expressed by showing someone how to be resilient, and being resilient means that you put things on the shelf. And so, I decided that there needed to be more people and therapists

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that look like me. And being a POC does not give me the merit of assuming that I will work well with anyone of color; it just gives people the option to say, "Hey, we're represented here. It's okay. This is safe too."

Jackie: Thanks Porsche. I'm really glad that you explained also why African Americans don't necessarily want to go to therapy. I'm wondering if you could talk about your journey to becoming a therapist. Because I know we talked a little bit about in undergrad, how you were discouraged from going on.

Porsche: Yeah. So I started off my college career in business because I was like, "Well, I'll be an accountant. I can make money from that." You know, my mom wanted me to be a doctor or an engineer or an architect. I do not like bodily fluids and the other stuff did not seem as fun. And so I went into business accounting. So I got into an accounting program and was so unamused. I was like, "If this is boring now I would not imagine it gets better after graduating."

So I actually had psychology as my minor because I was interested in people and why people do what they do and why things happen; and why does depression exist or why do eating disorders happen? And why does anxiety take place? Or why do we feel sadness in our bodies? Or why are we sad about things that didn't happen to us but happened to other people? And so once I realized that I was more passionate about that, I flip flopped and made psychology my major and business my minor.

And I went through my program, and I was definitely the minority. I was occasionally the only Black person in my class at times—and this is in college—or one of two or three people.

As I was going through it, it was interesting because I understood what was going on; however, I am not a strong test taker. I am better at writing a paper or having a discussion or, you know, putting things into practice. And so, I was also just trying to figure out, like, "What does this look like? What happens?" Or even feeling uncomfortable in class, being called on as the only Black person to be a Black representative and answer a question or speak to a theory—which I often thought was inappropriate, however, that's how it went, that's how it goes, and that's how it still is for many students.

And so it was my senior year and I was having a couple of health issues. That year was a bit harder. I was at class, I showed up, I did what I was supposed to do, and I completed the class; I was so grateful.

And so, since my grades were in, I knew I was graduating, so I decided to confront a couple of the professors in my program. And there was one professor that...he, of course was an older white gentleman, and was just so dismissive of me throughout the process. And I confronted him, and I said, "You know, I feel like you think I'm lazy. Or like I'm not dedicated or like I'm not committed to the work. And like I'm just another college student coming through."

I said, "I really hope that you do not project that onto other students. Maybe I should've said this earlier, but I have health issues. But I didn't say anything because I didn't want to be stigmatized or categorized or labeled as lazy or not being a good student. And the energy and the lack of regard that you projected was really discouraging and I hope that you don't do that to

other people.

I found out he was retiring, and I said, "It's probably a good idea that you're retiring. You know, you have said you're a man who loves God. And I am a person, I am a woman who loves God. But being around you did not feel that way; it felt very opposite."

And this man just starts crying. And I have been accepted into a graduate school in Boston and that is where I'm going. I said, "I'm pretty sure you didn't expect that. But I am dedicated to doing this work." And there was a point where this same person had told me that I probably would be better suited in a different profession. That not many people in the profession looked like me. Not many people did the work I wanted to do.

I said, "Well, isn't that a good reason for me to do so? Wouldn't that be a good reason for me to become a therapist?" And I don't know where that gentleman is or what he did after that. And I knew that at that point I was going to leave that experience behind. And I decided that I was going to grad school in the North, that I was tired of the South.

And yes, the North has its racism in a different way; however, I was just over the South. I was like, "I can't. I can't imagine I can do this work and feel the way I'm feeling in these different places. And something has to change."

So, back when it was Massachusetts School of Professional Psychology, I decided, "Ok, that's what I'm going to do, that's where I'm going to go." And it was the best decision ever. I would not have chosen to go to another program. I looked at other programs, interviewed, and I feel like I ended up...not ended up; I feel like I arrived at the place I was supposed to be at.

It was the first time that I spoke to a professor who did not look like me, and when I told them my experience they were appalled. I didn't know that was an option. And it was the first place that I feel I got to show up as who I was. And to learn to do the work that, as cliché as it was, that I needed for myself as a person, so then I could be the person who could then go and help other people.

And so, although it can be tiring, it can be draining—especially for someone like me who is a sensitive person, which is not a bad thing, which is something I had to learn—someone like me who's an empath and feels everything deeply, widely, overwhelmingly—I'm so grateful that I get to do this work and be a good representation of therapists, a person who helps people, a healer. And so that is what my journey to being a therapist was like.

Jackie: Wow, I'm so glad that you ended up having a good experience in grad school after you had such a bad experience in undergrad. What has it been like for you as a Black woman to see our profession attempt to address antiracism?

Porsche: It has been an interesting process that...I'm an over-analyzer, so on the one hand it's like, "Great, this is great, let's talk about it."

And on the other hand, it's like, "Ok, but you have to remove your whiteness. You really have to because your whiteness is the thing that still separates you from seeing what's truly going on. Yes, you are white. It is ok, accept that and be fine with it. And move through it because holding onto what happened in the past, what happened historically, only keeps you at a "Woe is

me" place. And it blocks the work that can be done. It really does.

And I see people trying and I see people's intentions, and I think that if people were quiet and still and listened more than always trying to have their perspective heard, they would learn a lot more.

Jackie: What do you mean by that: "Having their perspective heard?"

Porsche: In the sense of...sometimes people come to work out their own issues instead of showing up to learn. And I think you should work through your emotions and feelings. However, certain conversations are not for that.

Jackie: That sounds to me like white fragility.

Porsche: Yes.

Jackie: So what's the difference between that and honestly wanting to be an ally and help make change?

Porsche: It's a double-edge sword. It's two things you have to do at one time. Like, for example, being a Black woman, I have to make peace with the fact that I'm a Black therapist and have to show up in very white spaces, but that that does not diminish my responsibility in the time of work I need to do. So I work through one, and I work through the other, and they're parallel to one another. However, they both impact each other.

Jackie: So, what would be your recommendation in terms of, for example, white people trying to understand themselves? Are you saying that they're trying to understand themselves in regards to history of racism and that sort of thing and their part in it? And what should they be doing differently?

Porsche: I think that there is the space of acknowledging, "This is my role. This is how it's impacted me. This is the history of my culture, my lineage, whatever it may be." Ok, that is there, that is what's happened. However, lingering in that space and dwelling in it, in the, "I can't believe that happened. It's so unfortunate. And this sucks and how do we make it better?" All of that sucks. All of that is not fun. Great. But staying in that space does not help progress. How do we make it better is the part you should be focusing on.

Jackie: So understanding all the stuff about antiracism is like the theory, but what I hear you say is, "Let's get to the practice."

Porsche: Yes, exactly. If we are focusing on the theory all the time—and I know that is the basis of our careers, our industry, what we do—it's going to keep us stagnant. Theory is wonderful. But

if you're not using that information to actually project forward then what are you doing? You're just staying stagnant, and you're staying in the cycle. And so, this cycle that has existed for hundreds of years and decades, and has looked very different and it's still the same rat race. So that means that something has to be done different. A part of the circle needs to be broken so that a new trajectory can take place.

Porsche: Yeah. Actions speak louder than words. So you can speak about how bad and sucky it was, but nobody really cares if you're not taking any action.

Jackie: So that brings me to another question: How do you think our profession could be more active in, for example, helping Black therapists?

Porsche: Being willing to listen and to learn. And when I say listen and learn, I think that can come along without debate. Everything in our field does not have to be a debate.

Jackie: So when you say listen and learn, exactly what do you mean by that?

Porsche: Listen and learn. Listening to Black therapists about what Black people experience and their pain and what they're facing and not always questioning, "Well, why do you feel that way? Should we start over with reading the books again?" And understanding that when a Black person comes to therapy, it's a victory in and of itself.

Jackie: How can this white profession hear the voices of Black therapists better?

Porsche: So, it does tie into what I was saying earlier. I think learning from Black therapists about people of color who are in therapy, so that they can also be a safe space for those Black clients, that would help. Because right now as a Black therapist, I feel overwhelmed with the caseload. There's not enough Black therapists, but there's still Black people who need therapy. So if white therapists—even white therapists who I would consider to be racist or, you know, any of these things—to be intentional about being culturally competent.

I talk to some of my colleagues about, "Oh, this is a really good training. It's about working with people of color." And I'm like, "Oh, this is great. I haven't seen anybody sign up to do it." And so, dealing with your whiteness so you can move past your whatever shame, guilt, neglect you may be feeling, or helplessness or hopelessness you may be feeling...moving through that so that you can also work with people of color who need a safe space. Because Black therapists are tapped out and full.

Jackie: So I know that at William James College, we have an undergrad program for African American students. And we've been very proactive about having a really diverse population. And I'm wondering how we can increase that in other academic settings so that there are enough Black and Brown therapists?

Porsche: I think that universities as a whole need to be more intentional. We have kids who are undecided about their career track, or they even have someone who is kind of itching at being interested in psychology. Nurturing that curiosity, that desire. Letting them know, "Yeah, do you want to be a therapist? Well, this is what it takes." Right up front instead of making people get to their senior year and guess-working it.

Jackie: So from the beginning, even in undergrad, educating about their career direction.

Porsche: Yes, and what it looks like to get from point a to point b. I felt like there was information I had to go digging for that other kids were just provided with. I knew at a certain point, I was like, "Ok, I want to be a therapist. What does that look like?" And I had a professor say, "Well, you have to get a masters degree and I don't know if that's a part of your trajectory."

Jackie: So encourage instead of discourage.

Porsche: Absolutely. And informing them, "Okay, this might sound overwhelming, but you've got to finish undergrad, you do have to go to a graduate program, and you go through that process and that's what it looks like to get the education to be a therapist and it is worth it."

Jackie: Yeah. I don't know if this is part of the same question, but what feedback would you give to Black therapy undergraduate and graduate students?

Porsche: Undergraduate students, I would say, "Do not get discouraged. What you're learning right now may feel mundane and it feels like, 'Ok, so this is how I'm going to help people?' It is; at that point you are working on the philosophies, the foundations, the theories, and then when you get to grad school it is a different space. It is a space to evaluate yourself, it is a space to evaluate what population of people you want to help. And you learn the practicals and the fundamentals. And then you go into your practicum and your internship and you get to see the people. You get to see the work. And this is where you get to define what your career will be. And it's ok.

Jackie: I think that's great advice. What do you think are some ways that our profession can make therapy more accessible to Black couples and families?

Porsche: One, becoming culturally competent and marketing that. So, I often read people's Psychology Today, especially people who work with couples. Making it clear that you work with couples of all kinds, or whatever you specialize in. So if you're working with a Black family, understanding the cultural dynamics that come in with being a Black family which also impact the couple. Because there's a high chance that both members in that relationship had big T and little t trauma, have these dynamics within their families that had to be challenged, and they are trying to create a new legacy and a new behavior and a new narrative in this marriage, in this relationship, in this family. But to do that you have to be culturally competent.

Jackie: You know, I'm really struck by what you say, is that most white therapists don't advertise that they'll see people of color. I do see people of color, but they come to me through other referrals. But I don't advertise like at AAMFT Therapist Locator or Psychology Today, as a person who sees diverse populations. That is such a great idea, Porsche.

Porsche: Because it's already scary looking for a therapist. Psychology Today is overwhelming. Calling your insurance company is overwhelming. Talking to your PCP is overwhelming. It makes it a lot easier when a client can look at your website or your Psychology Today copyright and see, "Oh ok, I can see their line of thinking, I can already see where they stand." And that one makes it a little bit easier for them to go ahead and reach out to you and see if you are their soul therapist.

Jackie: That's a really great pointer. Thank you.

Porsche: You're welcome.

Jackie: So are there any differences in working with white clients from working with Black and Brown clients?

Porsche: From an approach stance? No. Because skills are skills are skills, and approaches are approaches are approaches.

However, for me, I would say my energy and my perspectives shift. When I work with clients who are white I have to remind myself that the same generational and ancestral traumas that you work with Black clients are normally not going to be what you're treating with your white families and couples and individuals.

So I have to remind myself, like, "Okay Porsche, if they say that it's just this, you've turned over every rock and looked at everything, it is just that. It's not trauma-based, there is no trauma back there. This is just breakdown in communication or awkward dynamic. It's not because this person had this in their mom or their dad or this that and the other, because I'm always like, 'No, there has to be more. There is more.'" And it's like, "Oh, no, nuh uh. This infidelity was strictly because you felt insecure. Okay, you felt insecure because of how you were raised in your family. But it wasn't because there was this cultural trauma and generational trauma. Okay, alright."

So being aware of that within myself has been very helpful, and I'm like, "Oh, okay, Porsche. It doesn't negate, and it doesn't mean it's different, however, it's ok to take it at face value; whatever needs to present itself will and it will be okay."

I know that when I was in my practicum internship it was very different because the first year I worked in an underprivileged community. I was in Lawrence, MA and it was a lot of trauma, a lot more putting out fires. And then my next year I was in Wakefield, and it was so different. And I was like, "So where are the fires?" And they were like, "No, we just need to work on these social skills."I'm like, "So, nothing's burning down? There's no trauma?" "Oh, well, they did have this one bad experience." And I'm like, "I'm not trying to diminish your trauma, however, okay...that's...alright."

And then, once I graduated school, I lived overseas for a year, came back, and went back to Lawrence. I didn't do it on purpose, but I was just drawn there. And those strong Williams James ties, the office that I worked at, there were eight of us, and it was not intentional. Some of us were interns, some of us were—like myself—practicing clinicians, and some of us had graduated like a year apart from each other. It was a very odd year.

I was back in a place of like, "Okay, we're working on trauma; that's what we're doing. High alert everyday." And then, more recently, I went to another practice in Danvers, and I was like, "Ok, alright, this is like Wakefield again. Alright. This is interesting. There's no trauma. Ok, we're back to no trauma. Ok."

I know I'm naming cities, and I'm naming cities because it was different. When I was in Lawrence, it was people of color; when I was in Wakefield and Danvers it was all white. And now that I'm in private practice I have a split; it's 50/50. And it's been so interesting finding the balance in showing up.

And I'm like, "Okay Porsche, you got this; you have the skills to show up in this space with both people of color and people who are white, and it's fine. You can do it." And it's a mind shift that I have to have. So again, my approach and my skills are the same, however, the conversations and the energy and the background and the perspective does have to shift.

Jackie: Yeah, that has to shift, but what I hear you saying is that you're culturally competent and sensitive.

Porsche: I try to be, yes. Because as a Black person, what cultural competency looks like for me is being aware of whiteness and what that looks like and what that dynamic is like. That's what I have to be aware of. And it's interesting. It is very interesting having those two paradigms I feel like going on in my head at one time.

Jackie: Yeah, I can imagine. You know, I was impressed. Before we started the interview, you were saying how you've helped other therapists start forming a practice, you've developed a peer supervision group, and you really stay in touch with a lot of your colleagues. How do you end up getting people to help other people?

Porsche: So it's a mix. I had not intended on being in private practice but had a poor experience being at an organization I wasn't at for very long and decided to move into private practice.

I was helped by a wonderful friend of mine who was like, "Yeah, look just do it." She had done it and was like, "Yeah, this is what needs to happen." And so once I got into it, I just had this conviction—maybe as a woman and a person of color—a conviction that you should have your own. Why not be your own boss? Why not work for yourself?

And so I could've easily started a group practice, brought people in, trained them and all that jazz, but I just had the conviction of "each one teach one." "If I teach you how to do this, you can then decide what you want to do. If you want to be in a group practice, that's because you decided to be in one; if you want to be in private practice, that's because that's what you decided

for yourself."

At this point, a lot of the people that I've helped have been friends in my close circle. I just have lucked up and have a majority of my close circle of friends are therapists. I would say out of my eight really close friends I think six of them are therapists. A lot of them are therapists, which feels like such a blessing and which feels so wonderful.

So in my head I was like, "Oh, these are my friends. I'm going to give them this information because I want them to be great too." They're like, "Let's do a group practice." And I'm like, "You can get more money being your own entity, and we just share an office space, how about that?" And they're like, "Oh, oh yeah, that works too. We can just split the rent, and split utilities, and share referrals, but you can be your whole own business." And they're like, "I didn't even think about it like that." It's like, "See, yes, we can do that." And that's what happened.

Then I just met other colleagues and they were like, "Can you help me?" And I was like, "Absolutely, sure." And then you sent over a fellow William James alumni and I was like, "Absolutely." This person happens to be a Black man and I was like, "Yes. He needs to be his own business first and foremost." And so I have talked to many friends and even my own coach, and they're like, "So, thanks for doing this for free with us. Thank you. But you really should make this a business. Like you should charge people." And I was like, "Who would I charge? All the people I've helped are friends? I wouldn't charge you guys!"

And so I thought about it and I was like, "You know, that could be a nice little side gig: get people started into private practice." So yeah, that's how it's happened thus far.

Jackie: Yeah, yeah, you're right. That might be another specialty of yours. I can't thank you enough. This has been an unbelievable experience, even for me; you even gave me some suggestions that I hadn't really thought about. And it's just amazing to watch how you've grown as a former student of mine. I know you really well and have always admired your zest for life and your dedication to the profession. So thank you very much!