



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.

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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).

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NEJRSP EDITORIAL: THE MULTI-SYSTEM IMPACT OF COVID-19 ON CHILDREN

FRANK GOMEZ, MA

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

While COVID restrictions have started to lift for Community Based Services, clinicians have had to continue to balance the need to provide critical mental health services while minimizing health risk to youths and families. Outreach therapists are now dealing with complex family issues related to the challenges of a post-holiday 2021 pandemic surge. The surge in COVID-19 cases has required a reassessment for in person mental health sessions and our role as mental health providers serving children during this time.

COVID-19 has had a multi-systemic impact for many families. These families have had to handle a baseline of anxiety and uncertainty around the virus. As an outreach family therapist, I have seen this collective change be overwhelming for many families. For some, it has involved a loss of control and a sense of vulnerability. Caregivers are now required to balance the typical challenges of parenting, keeping their children safe, supporting their children's mental health, and sustaining their work responsibilities (Masten & Motti-Stefanidi, 2020).

There have also been disruptions in children's environment for typical social emotional development. Closures of schools, youth's centers, childcare centers, and many other settings have been a part of an effort to contain the virus (Masten & Motti-Stefanidi, 2020). These environments are critical for social learning and emotional well-being in early adolescents (Spiteri, 2021). For some kids, these settings provide a structure to their days that they would otherwise not have. What's more, some of these youths live under chronic pre-existing strains, including structural racism and oppression, which have impacted families for several generations.

In the same storm, but not in the same boat.

It has become clear that the youth we serve are suffering the impact of the two pandemics, COVID-19 and systemic racism. Those with vulnerability related to the social determinants of health quickly became the victims of this virus, and the related disruption in typical social emotional development. Stressors related to prolonged isolation, anxiety, family loss of income/employment, the loss of a loved one, are all adverse childhood experiences. I have

noticed a theme of increased anxiety, depression, and irritability in young children. While these are some presenting concerns, it has become vital in my work to look at these cases through a trauma informed lens.

Young children's socio-emotional needs might be different as a result of the trauma they have endured during the pandemic. It has helped to keep in mind that these disruptions in socio-emotional development can result in presenting concerns. Play has been limited in many ways for young children, and some have physically separated from their peer group (Spiteri, 2021). There may have been a lack of emphasis in social-emotional development in young children these past two years. While this experience is subjective and developmentally bound, some kids might not have the tools to handle these changes.

As a caregiver myself, I have had to deal with these changes in my 9 year old daughter's life. While driving her to school after winter break, my daughter asked me why there were only 8 kids in her class when there are normally 23. She had a worried look while trying to understand why her classmates had stayed home to quarantine. It was important for me to acknowledge her experience and provide space to talk about this change. As her dad, I might not be able to protect my child from the effects of COVID-19. However, I can validate her experience and support in highlighting her reliance during this time.

What have your experiences been in working with young children during this time? Share your knowledge as we understand the multi-layered impact of COVID-19.

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COVID IMPACTS ON THE DEVELOPMENT OF PREGNANCY AND FAMILY: ONE CLINICIAN'S OBSERVATIONS

JENNIFER COLLINS, MSW

Western Maine Health

I have worked with children and families since I began in social work practice many years ago. One of the biggest changes I've observed in a person's life is when they decide to have a family. Prior to the COVID-19 pandemic, the pregnancy experience typically involved several stages for a person, from that first positive pregnancy test, to when they deliver and bring their child(ren) home. Throughout these stages (especially in modern society) systems could involve several micro, mezzo and macro components: partners, other children, educational interventions in a variety of ways, support groups, OB departments, and many other social and educational experiences, all designed to support the person and their family during this intense transition. Even with all this possible support and intervention, people having babies may still not be fully prepared until they are experiencing it directly. Then, for some families, intergenerational support from family and friends would lend another layer of accommodation for the new parent(s).

Before the COVID-19 pandemic, Postpartum Depression was prevalent, given the hormonal and social changes occurring in the body of the person delivering. As clinicians, it was a common practice to check in with the person throughout their pregnancy, delivery and postpartum phase (casually known as the 4th trimester now), to include their support person, ensuring appropriate attachment and behavioral health needs were addressed accordingly. We might suggest throughout the pregnancy, or post delivery, that an in-home support program (Maine Families or Early Head Start) be involved, allowing more support in the home directly. This allowed the post delivering person the opportunity to check in with a helping professional regarding new tasks like changing a diaper, proper swaddling, or how to care for a healing umbilical cord. It also supported education surrounding the developmental stage of a newborn and the family system. This was especially important for those new parent(s) who did not have family or friends available for support. Those home visiting programs are a crucial part of my pregnancy education and postpartum support for the patients I see in my practice.

In the years preceding COVID-19, wrap-around support for people having a baby was widely available and provided an opportunity for regular support and intervention in the home, something the medical and behavioral health communities were not able to provide.

This all changed dramatically in March, 2020 when COVID-19 shut our world down. However, babies still needed to be born and the care of both infant and pregnant person, could not be ignored or delayed. Abrupt changes in regulations modified the way people were able to attend pregnancy care and interventions, as well as their deliveries. No longer were partners allowed into routine appointments, ultrasounds or specialist appointments. If you are reading this article and have been pregnant, reflect back to the moment you saw your baby for the first time on that ultrasound screen, or got to hear their heartbeat on the doppler. What about that moment when you were expecting to see a heartbeat on the screen, but did not? Imagine having to experience these emotional moments by yourself, next to the Medical Assistant and OB Provider, void of your vital support person. This single change has impacted a pregnant person's experience in their pregnancy and I have seen an increase in depression and anxiety in pregnant people, and their partners, since this pandemic began.

In a recent journal article by Goyal and Selix (2021), this was confirmed by medical professionals in their own observations with pregnant and postpartum people. They explain: "Worldwide and nationwide travel restrictions due to COVID-19 have largely prevented family members from traveling to provide much needed postpartum social support leaving many women feeling isolated and alone, potentially contributing to risk of developing PAMD...isolation and decreased social support increase the risk of developing PAMD, specifically, postpartum depression" (Kim et al.; Slomian et al., 2019, as cited by Goyal & Selix, 2021).

Attachment has also been impacted with the restrictions involved with delivery and post-delivery. For many people having a baby, the hospital experience can be overwhelming and intense, with doctors and nurses present, contractions coming and going, and the potential for complications always looming. Prior to COVID, a person getting ready to deliver may have family and friends coming into the hospital, trying to share their support and excitement for the pending arrival of a little one. During the early stages of this pandemic, a laboring person had to be tested for COVID, come into their hospital room, masked and with one support person, who was not allowed to leave the hospital, unless they were not returning. Only when pregnant people were actively pushing, were they allowed to remove their masks, which is an experience no pregnant person wishes to navigate. People delivering a baby would then have an entourage of medical support people, masked and gowned in order to support with medical interventions and monitoring, lactation support, etc. This was a different experience than before COVID, when all you had to worry about was getting the baby sick and trying to keep an appropriate distance. Now, the worry is about a deadly virus that we knew little about at that time. In the beginning of COVID, if a mother tested positive for the virus, she might be separated from her baby, until no longer contagious. This had a potential impact on mothers and possibly a negative impact on their attachment in those beginning stages.

When I think about the challenges of COVID, one of the benefits for some families recovering after delivery with a new baby(ies), was the restriction of visitors at most hospitals. New parents were able to have isolated time together, with only interruptions from the medical team, not a flurry of visitors, wanting to observe this new arrival. For some of my patients, this was a positive impact as a result of COVID restrictions, which they implemented as a home rule as well. For other patients, that experience of celebrating a new baby and sharing this with family and friends was an expected norm that was not able to occur, without health risk to baby and family. COVID-19 has stripped away the expected norms for many people pregnant and their postpartum experience. There were limited baby showers to celebrate this pending arrival because gatherings

were potentially restricted. People visiting and supplying items for the baby and family were denied, due to the risk of COVID or packages had to be wiped clean, in order to keep the virus away from the home. For those pregnant people who had partners, COVID-19 may have brought the benefit of stay at home status, allowing more in-home support for longer periods of time, which would not have occurred, with a traditional family leave. For others, having support family/friends coming into the home was intermittent and involved the possibility of spreading the virus, which made it challenging for some families to get the support they needed in those early stages.

For many patients I have seen over these last twenty-two months, the COVID-19 pandemic has had a huge impact on the experience of pregnancy, delivery, and the postpartum period. I have seen new parents more anxious than in the past to take their infants out into the community, due to COVID-19. I have seen parents not allowing their families in to see the newborn, for fear or illness to both the baby and the grandparents, aunts, cousins, etc. I have seen more parents having to handle post delivery care for both themselves and their infant, isolated away from the one support person they had, because they had to return to work, if they even had a support person at home. In-home supports mentioned earlier, which were crucial for some parents in their initial adjustments, were (and still are) not fully available. In-person support and educational groups, where new parents were meeting one another, normalizing their experiences and finding a sense of community, are no longer available. Newborns are seeing more people in masks, possibly missing that important stage of facial expression and recognition, which is a vital part of their development. For some new parents, these changes have potentially impacted their attachment, both for the delivering person, along with their partners. This is especially true during pregnancy when partners were not allowed into appointments and missed these important milestones. Many of my patients have reported an increase in anxiety and depression, and generally feel overwhelmed by these experiences. As well, some partners report feeling overwhelmed knowing the pregnant or postpartum person may be struggling, leaving them feeling like they are missing important opportunities to help. I maintain worry about attachment between parents to their baby(ies), and to each other, during this continued pandemic, due to many moments of separation, isolation and overall lack of in-home support. These in-home supports were created to increase healthy attachment to the newborn, reduce isolation and the risk for shaken baby syndrome, as well as domestic violence. Without their regular interventions, we may be missing possible areas of concern and risk.

As COVID numbers were declining and vaccinations increasing at a steady rate, medical offices began to loosen their visitor policies, which allowed partners into appointments and were able to share in these milestone experiences once again. As well, partners were now able to support their loved one, when devastating news was discovered. The world has been experiencing this deadly virus for almost two years and its impacts are being realized more and more every day. We have limited data at this time on the long term impacts of the COVID-19 pandemic regarding attachment. According to the researchers, Zhang and Feei Ma, their study reported “moderate-to-severe stressful impact among Chinese pregnant women during the early stages of the COVID-19 pandemic, which high-lighted the strong need for heightened assessment of mental health among pregnant women” (Zang & Feei Ma, 2020, p. 348).

There is work that is being done to find new and creative ways to support new parents in their birthing experiences. Our particular community has been working to create on-line support groups, increase home visits by delivering needed items, and trying to have an outside visit, when

weather permits. Phone calls were a vital part of early intervention when the shut-down first occurred, which helped many people in their early postpartum weeks.

With the COVID-19 numbers beginning to increase at a rapid rate again, along with the onset of winter, I feel we will see restrictions like we did last year and this is concerning for new parents, preparing for the important change to their family. We have learned much over the last twenty-two months on how to be creative in our unconventional support to new parents, and the biopsychosocial concerns continue to be at the forefront of my work. My hope is that 2022 brings more solid interventions for COVID-19, and an increased number of vaccinations. Only then will we return to relying on those support interventions that statistically have been shown to increase attachment, develop safety for baby and parents, along with connecting other new parents to each other, creating a stronger sense of community overall.

I love this quote by Shannon Wiersbitzky, as it discusses the beautiful potential in how we impact and support the evolution and development of a baby's potential: "As babies we're born blank sheets of paper. Not a single mark. As we grow older, lines form, then colors and patterns. Before long that paper is all sorts of brilliant. Like a kaleidoscope, no two exactly alike." My lingering hope is that the impacts of COVID-19 have not left hardened lines of challenge, which may take away from the color of life being developed for our little ones born during this time. I am hopeful that helping professionals will continue to be creative in their approach to the development of children and families, allowing a positive and productive impact for the future.

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EQUITY IN THE AGENCY EXPERIENCE: A REFLECTION

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Author's Note: In order to protect confidentiality, names have been changed.

Caroline and I, at the time a wide-eyed 26-year-old, met for our first supervision at my agency on a Friday morning at 10.

It had been a whirlwind over the past few months. Texas, despite its reputation as a business-friendly, cost-efficient place to start adulthood, is actually really challenging to launch a career in anything human services-related. Its state government minimally invests in social infrastructure, so entry-level counseling jobs are often at small non-profits or private practices who hire two or three post-graduate therapists per summer. Folks who do land positions within state agencies are significantly overworked; I had friends who worked at local state-funded agencies who had between 60 and 80 families on their caseload, so while I was frustrated by the lack of responsiveness from jobs that I applied to in 2009 following my graduation, I also refused to completely destroy my energy levels at an agency.

By the end of 2009, it occurred to me that my best chances of continuing my career, after investing two years in a graduate program in marriage and family therapy, lay outside the state of Texas. I applied to therapy jobs throughout the United States and found a few job offers; my ex-wife agreed to seek out adventure in the city that would hire me—Boston, Seattle, St. Louis, and Washington D.C. We decided to accept the offer from the Boston-area company, an agency that promised the opportunity to work with a diversity of clientele and that would, contrary to other jobs, allow me to practice therapy from a diversity of theoretical perspectives while accruing practical hours for my license. Theoretical syncretism has always been a high value of mine. (It also helped that several of our best friends were simultaneously transplanting to Boston.)

In the first week of August, 2010, we packed our belongings into a U-Haul truck and, with the help of my friend Drew, drove two thousand miles from our cozy west Texas town to the big city of Boston. We got into Massachusetts Thursday at midnight, and spent a long weekend unloading said belongings into our apartment in north Quincy; I had wisely flown to Boston a

month earlier to procure a landing spot.

The first week was actually quite positive. The agency had about fifteen individuals and families waiting for me. Some, such as an early-20s Black man who was attempting to escape the shadow of a physically abusive relationship with his father, met with me in one of the twenty office cubicles. Others, such as a Puerto Rican family that lived on the third floor of a triple decker, required driving to their homes; with the assistance of my handy Tom Tom, I became quite familiar with South Shore geography.

There were some wonderful colleagues that I met my first week, some of whom are still good friends of mine. I was also fortunate to have a firm, yet compassionate boss, Melissa, who advocated for me in significant ways.

On Fridays at nine, the agency required new hires to attend a weekly training hosted by Pam, who brainstormed with us about identifying our favorite types of clients to work with and how we might build collaborative relationships with other support systems in the community to expand our caseload. While my graduate program gave me an outstanding initial framework by which to conceptualize therapy (one of my professors had all of my classmates repeat “Theory drives practice!”), it had failed to provide much insight on the business of therapy.

So Friday morning at 10, I entered my supervision meeting with Caroline excitedly, with my gray box with my client folders in hand, ready to talk about therapy.

Instead, Caroline asked me a series of questions that I was not prepared for.

Are you completing everything in the comprehensive assessment?

How are you doing the CANS (Child and Adolescent Needs) with your families?

What diagnosis are you giving this person?

Over the next year, Caroline, my supervisor, and I met to evaluate the quality of my paperwork. We brainstormed how to write treatment goals that had measurable outcomes. We discussed the nuanced differences in the intensities of anxiety and depression, such as what qualifies as moderate versus severe; Mass Health, at the time, would not reimburse for adjustment disorders. Caroline shared strategies to ensure that therapy lasted within the 12 sessions that Mass Health initially allowed, and when therapy required more than 12 sessions (for those in the contemplative stages of change and after, therapy almost always lasted more than 12 sessions), we determined the appropriate language to convince the insurance reviewers to approve more sessions. There was always time at the end of session for me to “do corrections”—to complete the blank spaces on the paperwork and to rewrite treatment objectives and diagnoses if the insurance company didn’t approve of the first draft.

People ask me about the culture shock that I experienced moving from Texas to New England. In a lot of ways, the move was easy for me; the progressive social values of New England and the authenticity, stereotypical drivenness, and independence of New Englanders aligned with my values more effectively than living in Texas.

The space that I experienced the most culture shock was during my Friday supervision meetings with Caroline. Caroline's friendliness and kindness saved me from becoming completely unhinged and leaving. I did confront her around the lack of systemic orientation and the unethical process of giving a diagnosis to someone within five sessions, but I eventually learned that Caroline was doing what the company asked her to do: ensure that the agency didn't subject itself to clawbacks from insurance companies, and that the agency didn't get sued from other sources. (The Child Behavioral Health Initiative, or CBHI, which my agency began to participate in during my second year, developed out of a multi-million dollar lawsuit, and the anxiety that individual agencies could also be sued was palpable during that time.)

Supervision with Caroline introduced me to the fact that managed care has made therapy a game where therapists and other healthcare professionals have to strategize and politically convince employees at insurance companies, masters of bureaucracy yet often lacking knowledge about the process of therapy (or other tips of medicine), to open the purse strings and continue to fund the mental health process of that particular individual and/or family. Fortunately, I grew up in an education system that taught me to take standardized testing against the test, rather than as a reflection of concepts and objective statistics, so I learned well how to write paperwork that would please the gods of the insurance companies.

However, despite the in-service trainings that my agency did (I especially appreciated the training we did on non-directive and filial play therapy), they refused to push back too strongly against the system of managed care; whenever an organization creates this relationship with managed care, therapy can never primarily be a process to provide support, understanding, and healing to communities in need.

In the last few years, agencies in Massachusetts have distinguished between administrative supervision and clinical supervision, so that pre-licensed therapists can achieve the supervision requirements for their license and not use their already small salaries to fund it. However, the systems of supervision within agencies in Massachusetts are significantly woeful.

During my first year in 2010, the supervision that I received was strictly administrative. I received little feedback about the quality of therapy that I provided; the independence that I craved after graduate school was given to me in spades, and I made more than my fair share of mistakes with clients, including getting triangulated into chaotic family systems, overfunctioning for the systems I worked with, despite my best implementation of postmodern principles, and avoiding conflict and hard conversations whenever I could. Clients were suffering and consistently stuck in first-order change; while part of this is on par with being a new clinician, I can't help but wonder how therapy may have been different had I received the supervisory support that I obtained in graduate school.

I did eventually receive clinical supervision; for my second and third years at my agency, three different people provided supervision for me. One was a woman who was incredibly kind, yet I found myself teaching her family therapy concepts, rather than the other way around, as we worked through some of the most complex family systems in our communities. Unsurprisingly, many of the supervisors hired to work with family therapists (LMFT-candidates and otherwise) have minimal experience practicing therapy from a systemic lens. One supervisor provided decent guidance about how to work with couples, but she was asked to leave the agency two months into our working together.

I did find a fantastic supervisor in Kim, who I worked with for over a year. Kim was a former staff therapist for the agency, and provided excellent feedback on building more effective therapist-client relationships, which centered around letting the client direct the session instead of forcing my own agenda. Kim was studying to become an Internal Family Systems (IFS)-certified therapist during our time together, and incorporated systemic principles, through the lens of Dick Schwartz, into our supervision.

As amazing as Kim was, she also had no formalized training in clinical supervision. Neither did my first two supervisors, nor, to my knowledge, many of the other supervisors at my and other agencies in Massachusetts. There is no requirement in Massachusetts for supervisors to have prior education or certification in supervising and training therapists, other than that they have been licensed for three years and, for LMFTs, have supervised a minimum of two other family therapists (LMFT-candidates or otherwise). The Massachusetts Mental Health Counselors Association (MaMHCA) offers a supervisory certification program for LMHCs which provides a basis for administrative and clinical supervisory skills. While this certification is not required, it is encouraged that supervisors obtain formal training. But an encouragement is not a mandate.

Two years after I got licensed, my agency hired me as a contract supervisor to provide individual and group supervision to its employees, a position that, quite frankly, had no business being offered to me. For the next three and a half years, I did the best that I could to help my supervisees conceptualize their clients from a systemic perspective, and did some short-term trainings in family and postmodern theories. The agency and my supervisees both spoke highly of my work, despite receiving minimal professional training and feedback from the agency. I did take AAMFT's approved supervisor training during my second year in my new role, which provided a lot of useful administrative advice and methods for teaching systems theory to new therapists. I was grateful for the support and guidance of the supervision process; I filmed some of my individual and group sessions and watched them with my supervisor, which provided valuable insight. But the approved supervisor training was outside of the purview of the agency.

Supervision is an enormously important part of the growth and development of the therapist, and in graduate school, I received excellent supervision. One group supervisor played a game called "The Hat Game" where we had to randomly select systemic therapy principles from sheets of paper (written on pieces of paper and drawn from a hat) and present how we would address a therapeutic issue from that theoretical perspective. If I drew "narrative therapy" and I began to talk about Bowen's perspective, he would interrupt me and redirect me toward approaching the case from how Michael White would address the case. One of my supervisors exclusively used film during our sessions, and would pause my recording every thirty seconds to ask why I asked that particular question or help me evaluate my nonverbal presentation. Another supervisor explored self-of-therapy questions that I was far too anxious at the time to address. My only complaint with supervision was that I only got four months (one semester) with each supervisor; otherwise, I would argue that the supervision system within my graduate school is a model for what supervising and training new therapists should look like. As marriage and family therapists, we owe the creators and current directors of AAMFT's Approved Supervisor process a gigantic thank you for developing these systems.

There are some positive changes in improving the quality of supervision for postgraduate agency therapists. The Child Behavioral Health Knowledge Center, for instance, recently connected some local agencies with the Yale Program on Supervision and hosts content and

single-session webinars that provide tools to supervisors. The individual skill development plan on their website, for instance, is a useful document to help organize goals and directions. They also describe a field observation process, which enables the supervisor to witness the therapist providing family therapy in the homes of clients. However, there's no statewide formalized process for training supervisors to work with agency clinicians in Massachusetts, not one that's analogous to the Approved Supervisor Training for AAMFT or the American Association for Sexuality Educators, Counselors, and Therapists (AASECT).

The practice of booking our newest clinicians with the most challenging, complex family and social systems, and gauging therapeutic success by the quantity of practicum hours and the quality of their administrative paperwork, without investing in methods to supervise therapists around the complications of their cases and the psychological challenges that arise sets therapists, their clients, and future clients up to fail.

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My ex used to say, “The field of marriage and family therapy doesn't take care of the marriages and families of its therapists.” She was right. Entry levels of therapy (which includes social workers, mental health counselors, and psychologists) have elements of indentured servitude to it. To be fair, many sectors of internships are unpaid; the currency collected is the experience and prestige that you can put on your resume with the hope of getting paid handsomely later in life. In graduate school, the internship hours enable you to take the national exam that accompanies your license, and ultimately, with the appropriate number of supervision hours, become a state Board-approved psychotherapist. Graduate school and the agency experience taught me to do whatever it takes, including a full year of work that was a five figure financial net negative, to get that ultimate form of currency: my license in marriage and family therapy.

I settled, because if I wanted to practice my calling ethically, I had no other choice.

Supervision is one of many elements within the contemporary agency system that sets precedents for future therapists to struggle occupationally, financially, and psychologically. Starting in April, 2022, the editorial team of the New England Journal for Relational and Systemic Practice will host “Equity in the Agency Experience: Dream or Reality?” Each month, we will have an hour discussion about how to best support our newest therapists. We hope these conversations will help fill the gaps created by agencies' utilization of the productivity model, which states that success is predicated on the quantity of work, rather than the quality, and the medical model, which limits therapists' ability to engage with the complexities and depths of human experience and the relational processes that create said experience.

We hope that Equity in the Agency Experience will bring two key groups of people together. First, in order to create equity for agency workers, collaboration between therapists and leadership teams at different agencies will be necessary. When agencies exist in their separate silos, therapists lack access to information, training, and support from outside of their agency, limiting the potential for innovation and growth. We hope to provide a space where different companies who are facing similar issues can work together to create fairer, more realistic, and more equitable work standards for our newest clinicians.

Second, there's a significant gap in the experiences of agency workers and private practice

clinicians that we hope this training addresses. In fact, there's a myth that the evolutionary journey of the successful therapist involves leaving agency work when you get licensed and moving into private practice, where there are fewer bureaucratic restrictions to practicing therapy. Licensed clinicians in private practice (especially White clinicians) are less likely to confront the intersection of classism and racism with behavioral health challenges than agency clinicians who commonly interact with consumers of community mental health services. Private practice clinicians, including myself, have the option to opt out of constrictive relationships with insurance companies in ways that agency workers lack. More importantly, agency workers often lack mentoring relationships with more established therapists, relationships that can provide insight for how to comprehensively succeed in a uniquely demanding profession.

Discussion topics will include:

- Challenging the productivity model
- Helping therapists engage with complex family systems, especially when if they didn't learn family therapy skills in graduate school.
- Self-care, and how agency systems create burnout
- Increasing income in the agency model
- The impact of documentation standards on identifying successful therapy
- Creating spaces for self-reflection

The future of our profession depends on our ability to develop systems to provide professional, emotional, and financial support for our post-graduate agency therapists. For more information about how you can join our conversations, visit us online: <https://www.neafast.org/equity-in-the-agency-experience>.



MY JOURNEY WITH NASW IN MY MISSION TO REQUIRE ANTIRACISM TRAINING FOR SOCIAL WORKERS

DONNA HARRIS-RICHARDS, MSW

Board Member: New England Association for Family and Systemic
Therapy

I've been asked to write about my experience and impressions in working with the NASW MA Chapter regarding my mission to support therapists in learning how to do antiracism work in the therapy room. My goal is to require social workers to be trained in an immersive, year-long model of 18 CEs in antiracism education over a two-year period of licensure requirements, followed by 6 CEs in subsequent two-year licensing cycles. My efforts, thus far in the spirit of collaboration across all mental health workers, particularly my own member organization of the NASW MA Chapter, have been met with lukewarm interest, at best. Perhaps it's my approach? Perhaps not. To answer this question, it's important to address events in a historical context.

Last summer, in June of 2021, the NASW finally publicly called itself out in the “NASW Report to the Profession on Racial Justice Priorities and Action” with a report entitled “Undoing Racism Through Social Work.” In an effort of accountability which can be read online currently, the NASW specifically cited their historic participation in building and running segregated settlement houses, blocking African Americans from gaining the right to vote, supporting eugenics theories and programs, helping recruit Black men into the infamous Tuskegee Experiment, participating in the removal of Native American children from their families and placement in boarding schools, being part of intake teams at Japanese internment camps during World War II, and “limited delivery of health care, mental health treatment and social services to people of color.”

Eight months prior to this NASW published report, in October of 2020, I attended the New England Association of Family and Systemic Therapy (NEAFST) presentation of the State of Therapy 2020 Conference; a collaborative, inspiring and compelling gathering of therapists, including LMFT, LMHC and LICSW providers. In the day-long antiracism portion of the training I signed up for, participants were called to commit to one action step in the work of dismantling racism. This work was for those of us with white privilege: a call to commit to the next steps of moving the needle further toward dismantling systemic racism and creating racial justice for BIPOC in a tangible way. That day, I committed to developing myself as a better ally, activist,

and advocate, with a strong desire to support others in having the kind of moving experience I had in the State of Therapy 2020. I wanted to keep the interest, curiosity, and support for myself and others alive in the form of gaining more knowledge, inspiration, and skills. As a social worker, sex therapist, and family systems therapist, I decided to pursue a dialogue with the NASW MA Chapter to encourage a mandate for a 6 CE antiracism training as a requirement for licensure. I began my journey, making many mistakes along the way, and quite sure I am still making them.

From inside these NEAFast antiracism Zoom training rooms, including State of Therapy 2020 and the NEAFast guided reflection group, “Moving Toward Antiracism,” hosted by Jennifer Driscoll, LMFT in 2021, I’ve witnessed a tremendous amount of shame and fear among therapists for having very little knowledge and skills regarding best practices with BIPOC clients and communities. I have come to understand that social workers are often acutely aware of their own marked deficits in the how-to of dismantling racism and oppression in the therapy room. Regrettably, we are not as far from the beginnings of social work as we might like to believe, when there are so many social workers who have done and continue to do international mission work. I have seen therapists become tearful in immersive trainings upon the realization that church mission work is often racist, in the form of white savior-ism. They were unaware and in the words of author Layla F. Saad, “Once you begin to see it, you can’t unsee it.”

I was acutely aware of micro-aggressions, and worse, occurring in so many places. On My NASW Community, a national website forum for social workers, I read a post from a young, Black, female social work student who reached out to this online community with her impressions that the social work licensing test seemed “oppressive.” In response, two white, social workers, one male from Maryland and one female from Arkansas, explicitly stated in the thread to the young student that “perhaps the test is not racist, but simply too hard.” A sea of 120 shocked and horrified responders spoke up and called them out. Quickly navigating through channels to report this to the NASW MA chapter, and requesting a moderator step in, I was promised that a report would be made. This was all happening on the heels of the former presidential administration's OMB director eliminating federal anti-racism training, a perpetuation of more white supremacy already so prevalent in Washington, and the deaths that same year of George Floyd in May of 2020, Breonna Taylor in March of 2020 and Ahmaud Arbery in February of 2020.

In December of 2020, in the email thread I initiated to the NASW MA Chapter, I expressed my significant concerns about racism within social work communities, and saw an intensifying need to require quality antiracism education. I wrote, “As an ally in the antiracist movement, I am...ethically compelled to call together those of us in the NASW who are allies in the change movement at such an important time in our history. My dream goal is to advocate for a mandatory, high-quality 6 CE-minimum antiracism training, such as was created in NEAFast's State of Therapy 2020 on October 2, 2020, with NASW requiring its licensed social workers, in the same way they are now requiring a mandatory training on domestic violence (D.V.) as of this year in 2020.” I was told that mandating any specific trainings, (such as the recent training requirement in D.V. for a one-time credit of 2 CEs) would take years in a court of law to pass, perhaps as many as seven or more years. I was told that sort of legislative change takes “a long time;” that the 2 CE required training in domestic violence was the result of a law that took many years of work and applied to many different licensed professions, including medical doctors, nurses, psychologists, and others. Along with that information, I was also told that antiracism can never be realized in one training, but over a lifetime. I was also aware that, to my knowledge, NASW was offering very limited, if any, trainings on how to access a developed skillset to address

racism and race in the therapy room. So I turned to my systems therapy colleague and NEAFAST Executive Director, Jeremiah Gibson, LMFT, CST.

Together, Jeremiah and I wanted to collaborate with the NASW MA Chapter, so with Jeremiah, as the Executive Director of NEAFAST, we requested a meeting to present our idea to help do our part in helping our colleagues, some of whom were suffering in silence. Our idea was not only to support these colleagues by offering trainings, but to model collaboration and unification among all therapists; Licensed Social Workers, Licensed Marriage and Family Therapists and Licensed Mental Health Counselors in our own home Commonwealth of MA, in the spirit of the Association of Social Work Boards (ASWB) mission to “advance safe, competent, and ethical practices to strengthen public protection” and ASWB’s vision “that all social workers...protect clients and client systems.” We got a meeting that following summer.

In the meantime, I created a petition and posted it on change.org, spread the word and encouraged my colleagues and the public, via the mechanism of licensing requirements, to help me create a bill to ultimately become a law (or so I thought that’s how it worked). Social workers, I felt, should have greater access to affordable, quality, immersive, educational and transformational experiences to develop themselves and their skills for the greater good of those we serve. Based on the outstanding 2021 year-long immersive NEAFAST training I was attending, I proposed one 18 CE intensive course, plus a minimum of 6 CEs in every two-year licensing cycle thereafter, to educate social work providers for best practices and better treatment outcomes. My dream is for all social workers with white privilege to acknowledge and understand, layer upon layer, how white silence, white apathy, and white fragility harms our clients, families and communities, particularly in this time of the COVID-19 pandemic. COVID-19 has devastated BIPOC communities with socioeconomic disparities and lack of access to quality health care. In the petition, I called for best social work practices, including both clinical and social justice work, to aim to dismantle systemic racist structures, reduce and resolve minority stress and genetic weathering (the deterioration of the health of African-American individuals, particularly Black women, due to cumulative exposure to socioeconomic disadvantage) on local, state and national levels for the optimal health and well-being of all communities.

At our long-anticipated meeting with the NASW MA Chapter, I presented our idea for a ready-made, inspiring, and collaborative day-long 6 CE course in the form of the NEAFAST State of Therapy 2020 Conference with highly effective speakers of color. The moving and powerful team of leaders included Lanisha Allen, Lisa Saunders, and Simone Matthews, emphasizing Self-of-the-Therapist work, a critical component supporting therapists in becoming developed agents of change. We also emphasized the opportunity for Massachusetts social workers and therapists to become leaders in the national charge for organizing change for social and racial equity and justice, (e.g., think Affordable Care Act, Labor Movement of the 1930s, this writer’s own diverse city of New Bedford as a major player in the Underground Railroad) with the idea to work inclusively with multiple licensing groups, MFTs and MSWs, joining forces to create significant change in a shared vision and mission of equity and justice for all. Understanding that the work of transformation is prolonged and immersive, Jeremiah and I were also ready to offer the 18 CE course “Moving Toward Antiracism.”

In response, NASW offered an invitation to follow up in the future for more discussions about NASW’s antiracism course offerings, hence my impression and memory of a lukewarm reception.

Thereafter, I received an email from the NASW MA Chapter requesting thoughts from social workers regarding whether antiracism and anti-oppression training should be required or suggested. You can guess my response, based on the enormous and widespread need I was observing amongst social workers and others who were sharing, sometimes tearfully, inside the NEAFAST Zoom training rooms.

In January of 2022, I received an email reporting that a mandate had been passed in September of 2021 requiring 2 CEs in antiracism training and 1 CE in anti-oppression training for social workers. This is certainly a move in the right direction, but a far cry from supporting the deep, reflective Self-of-the-Therapist work needed for providers of mental health to do effective antiracism work.

The NASW summertime symposium of 2022 has sixty-one course-offerings. Out of sixty-one, there are approximately six separate 1.5 CE trainings addressing racism. As far as I could see, none of the offerings utilizes phrases such as “Self-of-the-Therapist,” self-reflection or self-examination in the course descriptions. NEAFAST continues to offer, for the second year “Moving Toward Antiracism,” a guided reflection group, available for \$50 and 15 CEs beginning March 11, 2022. The word is out on the NASW email list serve. Another new offering by NEAFAST, beginning in February of 2022 is “Next Steps on the Journey: Moving Toward Antiracism Followup” hosted by Jennifer Driscoll, LMFT, to specifically address the urgent need many therapists have expressed to effectively learn how to address race, racism, and oppression in the therapy room.

Recently, when the NASW National call for proposals appeared via email, NEAFAST looked into submitting the immersive antiracism online trainings described herein, and found that the submission deadline of February 14, 2022 called for proposals that will be “presented live, in-person. Virtual presentations will not be accepted.” With COVID-19, NEAFAST trainings have been online only. For now, NEAFAST awaits opportunities to submit online training proposals to both the NASW National and the NASW MA Chapter.

In a spirit of accountability, the NASW has called for the individual to “do the work to understand white supremacy and the oppressive logic...through self-examination and reflection.” NASW calls for social workers to “hold ourselves accountable...facilitate genuine discussions across the organization...emphasize transformative solutions that impact multiple systems.” The NASW stated it strives to “create momentum towards systemic changes that reduce disparate outcomes by race” and “draw community attention to racial equity issues, raise awareness about the history and systems behind the issues.” I am calling for the facilitation of more than discussions, but clear next steps demonstrating inclusion and collaboration, organizing multiple organizations, such as NASW and NEAFAST in a unified movement, giving tools to all of the providers who support BIPOC.

Connecting the past to the present will hopefully pivot and propel us into a future that combines the power of systems working collaboratively. Social work has played an active part in racist practices and thankfully the organization has apologized and called itself out; indeed a first step and hopefully one of many. As you can see, my story speaks to white apathy and white fragility, written about by many, including Layla F. Saad in her book *Me and White Supremacy*. I hope that NASW will see the value in highly affordable and effective, immersive learning opportunities like the annual NEAFAST State of Therapy Conference, “Moving Toward

Antiracism,” and “Next Steps on the Journey: Moving Toward Antiracism Followup,” choosing to collaborate with us and encouraging their members to sign up.

As providers, we all have an ethical duty to develop competence which requires time and effort; acquiring knowledge and applying learned skills, not from the occasional training or workshop, but through one’s own ever-evolving development, utilizing Self-of-the-Therapist work and other facets of learning, such as gaining knowledge, collaborating, listening, and contributing. To echo my NASW MA colleague, it is true that this does not happen in one or two or three hours. There is, however, access to the NEAFAST prolonged and immersive format. With dedication to a productive process and commitment to providing ethical care, I remain hopeful that NASW will tap into the resources offered at NEAFAST “in order to protect clients and client systems” per the ASWB.

“Collaborative alliances involve (1) being honest even when it’s difficult, (2) not tampering with the truth...(3) confronting yourself...(4) operating from the best in you” (Schnarch, 2009). Keeping in mind the critical idea of differentiated truth-telling (Bowen, 1978), the NASW and all organizations of mental health providers, including NEAFAST, have a unilateral responsibility to call out protections of systems as they exist currently; systems that create barriers to optimal mental health due to the structure of systemic racism, which is complicit in the lack of access for BIPOC to quality health care, including for BIPOC healthcare providers, with whom we work alongside and refer to our therapy practices, and rely on for our own healthcare.

NASW quoted James Baldwin: “Not everything that is faced can be changed, but nothing can be changed until it is faced.” I hear the clock ticking and hope this piece will contribute to facilitating the much-needed change in systems, and a future where organizations, such as NEAFAST and NASW, work in collaboration together.

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SHAREVISION: INNOVATION FOR COMMUNITY HEALING

ELLEN LANDIS, PHD
Sharevision, Inc.

INTERVIEWER: DAVID HADDAD, EDD

David Haddad: Ellen Landis, welcome.

Ellen Landis: Thank you David.

David Haddad: To begin, if you wouldn't mind introducing yourself, tell us about your background and training.

Ellen Landis: Sure, I am the offspring of two activist parents, both involved in community action work at a lot of levels, as thinkers and doers. I earned degrees in dance, dance therapy, and eventually, a PhD in expressive arts therapies. I'm a Licensed Marriage and Family Therapist. My doctoral research and much of my work is geared towards the decrease and prevention of secondary trauma. I have been focused on supporting people in high capacity roles in organizations and peer groups for years. I like helping people who like to help people. Over the years, my professional development has included mediation, EMDR and brainspotting training. I was the clinical director of domestic violence and sexual assault programs for a couple of counties based in Springfield Massachusetts. I co-founded a counseling and consulting organization called Sharevision with my wife Lisa Thompson, Richard Baldwin and in collaboration with Lynn Hoffman. How is that for a start?

David Haddad: Yes, this is a great start. I just have to say for the people who may be reading this that you and I also worked together and go back many years ago. Most recently you have been working on a new project, Building a Resilient Essential Workforce, through your consulting organization, Sharevision. Could you tell us: what led to the origin of this idea?

Ellen Landis: Great years working with you, back when People's Bridge Action (PBA) merged with North Central Human Services. So, the Building a Resilient Essential Workforce project is a project that emerged from a desire to address the mental health issues brought on by the pandemic. As the pandemic began, I was ready to volunteer. I called our local medical reserve

corps which I was a member of years ago. This group gets called to serve when there is a local emergency or planned healthcare initiative.

I asked about their mental health response to the pandemic. There was nothing. The director, Lauren Davine, recognized the need and asked other medical reserve corps directors around the state if something already existed because we didn't want to reinvent the wheel if something was available. She couldn't find anything. Ultimately, I was connected with a local lead public health nurse, Jennifer Meyer, who was interested in seeking support for herself and her team due to the enormous stress they were facing as a result of the pandemic. The public health nurses had unending work hours, along with the challenge of parenting and the anger and fear of residents directed at them. I'm still volunteering with this group nearly two years later, [It's been under the leadership of a young and talented RN, Vivian Franklin for about a year and a half now.] Meyer also knew the school nurses were dealing with many of the same staggering issues; including working endless overtime hours. I was then connected with the city's lead school nurse Lisa Saffron. I've also been meeting with this group over multiple school years. Meanwhile, I continued to wonder about the statewide mental health response to the pandemic. I reached out to my local state senator's office. They also knew of no statewide program to address the mental health crisis. They connected me to someone working at Center for Health Information Analysis (CHIA) and the state's COVID Command Control Center. Through a series of interviews I became connected with another government office that's in charge, or has an umbrella role, in statewide analysis of healthcare research, data and programming all to improve patient safety.

David Haddad: So what is the name of this agency?

Ellen Landis: It's called the Betsy Lehman Center (BLC) for Patient Safety

David Haddad: Can you say something about your work with them?

Ellen Landis: Yes. Initially I learned the peer support programs they had been running in hospitals for doctors and nurses were shut down when the pandemic hit. They were closed out of hospitals just like the rest of us, no visitors allowed. Their peer support programs aim to care for providers as well as improving medical outcomes and bringing down rates of medical error.

David Haddad: So, initially the Lehman Center focused on medical providers versus mental health providers. So, would you say that your conversation was an attempt at expanding this to include behavioral healthcare?

Ellen Landis: When I met folks at BLC the focus was on COVID-19 frontline healthcare personnel and that included administrators. (They have many other initiatives as well.) I definitely talked about expanding the program based on the needs of everyone working in the hospitals and congregate care facilities. I think about the cleaning staff, PCAs and people who work in our morgues.

David Haddad: Okay, were these paid staff or volunteers like you?

Ellen Landis: Both. The amazing group was made up of Betsy Lehman staff and department heads working at other state agencies, the big Boston hospitals, McClean Hospital, Harvard (besides me, I serve as a private practitioner and another who recently retired from one of the big

David Haddad: Was the pilot something you developed, or was it a collaboration between the volunteer group?

Ellen Landis: It was a collaboration. I was part of this small group who took on the task of developing a model, handbook and facilitating a pilot group. I ran the first pilot study. There weren't as many pilot groups as we had hoped, since it was hard to get participants in the beginning.

David Haddad: What was that like for you?

Ellen Landis: It was challenging, and hard to believe the program might be dropped, especially knowing we could all see it was valuable for the participants. I felt the spirit of my parents, Lynn Hoffman, Dick Baldwin, Julia Byers and countless others who embody the idea that you don't just see a need and then walk away, you keep trying to do something. We all know there's an enormous need. Yes, I was vocal about continuing, at the very least, to offer another pilot group and pushing to build up the Betsy Lehman website, so people could find next step information on support groups. My local state senator, Joanne Comerford is the Chair of the Massachusetts Joint Committee on Public Health and also became the Chair of the Joint Committee on COVID-19, Emergency Preparedness and Management. She wanted written information on the program for Command Control on the state's progress, to pass the positive news, even though we had completed just one online group.

David Haddad: Very grassroots.

Ellen Landis: Yes, I was passing the state legislator's office emails requesting information to the Betsy Lehman Center to write it up, but they were so busy and for reasons unknown to me, they didn't get to it. I wrote up everything from my notes and I just kept passing on my brief reports including quotes from participants to the Betsy Lehman Center. I was hoping those documents might make it easy for them to respond to the Senator's requests for an executive summary. Then in June of 2021 the senator's office asked me to write up the program on an expanded scale. I turned dozens of pages of notes into a 4 page document. Turns out, there was an interest. Suddenly I found myself engaged in the legislative process trying to advocate, secure sponsors and cosponsors to fund an online peer support initiative for essential workers across the state.

David Haddad: So, shifting from volunteering on a committee to being engaged in a legislative process seems like quite the shift.

Ellen Landis: The shift was a big surprise to me, but ultimately very uplifting. I think our skills as counselors and listeners has something to do with the progress of this initiative. I asked questions, especially of past and present legislative aides and found their knowledge and skills really powerful. The gap between the needs of essential workers and programing is obvious. We know essential workers are very busy. We're talking about a population who makes everything from the lowest, minimum wage with no benefits to people who make high salaries in the medical field. Not everyone can afford to attend this sort of group even if it's free. With Building a Resilient Essential Workforce (BREW) we want to pay facilitators and participants. Many people need money to go towards a phone card or a babysitter. BREW support groups were not designed to happen during your professional shift.

David Haddad: So, there was a cost for the healthcare workers at the lowest end of the salary scales, and the funding was to help offset any financial obstacle that would prevent them from attending.

Ellen Landis: Yes, exactly, and because inviting people into non-work hours for professional development requires honoring their contributions and sacrifices. Money for policy and health research, increasing mental health emergency resilience preparedness and more are in the proposal. In the report I wrote for Senator Comerford the diagram outlining the flow, ultimately became the background for the Massachusetts American Rescue Plan Act Amendments, Building a Resilient Essential Workforce legislation. We partnered with the Global Resilience Institute out of Northeastern and DeeDee's Cry, an organization addressing mental health awareness among communities of color. We secured 16 House co-sponsors, and 25% of the state Senate co-sponsored the amendments. While we didn't get funded in this round, it definitely stirred proof of concept. We're being encouraged to not give up.

David Haddad: Wow, that's a great story for a first time grassroots lobbyists.

Ellen Landis: I prefer Activist and yes, while we didn't get funding, I'm so relieved to report that the Betsy Lehman Center got on board and went for ARPA (American Rescue Plan Act) funding to continue online peer support groups and that amendment did get funded.

David Haddad: Does this include behavioral health practitioners?

Ellen Landis: I think no, it does not. I believe this new funding is for medical staff in hospitals and nursing homes.

David Haddad: Behavioral health workers are in a whole range of places, hospitals, residential workers, home-based therapist, emergency services. So, this latest amendment can serve as a model for behavioral health.

Ellen Landis: I wholeheartedly agree.

David Haddad: So maybe that's a good segue to Sharevision, which was the basis for your support groups. Could you talk about the history of Sharevision and what makes it Sharevision?

Ellen Landis: Sharevision was developed by Lisa Thompson when she was a social work grad student, with Lynn Hoffman, legendary social worker and family therapist, Richard Baldwin, and the Family Services Outreach Team while working in Athol, Massachusetts, doing outreach family therapy beginning in 1987. The team was facing clients experiencing intergenerational domestic violence, child sexual abuse, substance abuse and poverty. There were no specialists working with this confluence of expertise at that time. Lynn Hoffman was consulting with the team in Athol. She incorporated ideas she had learned in Norway from Tom Anderson and his work with reflecting teams and his approach of participating rather than observing. Lynn led our team into an adaptation of supervision we call Sharevision. She switched the focus from herself as the supervisor and began the practice, during meetings, hearing from everyone rather than the one supervisor as cases were presented. So instead of the family therapist asking the supervisor how to handle a case, Lynn Hoffman said, "There's a lot of expertise in the room, let's hear from everyone. Let's hear from as many people as there are in the room about how to address the

situation.”

David Haddad: Yes, like the reflecting team, the individual asking for support or supervision, listens and takes what they feel is most helpful for them. I thought some of this process would be too constrained by the emphasis on time, and perhaps feel that the process would not be very productive, but as I recall observing and participating in Sharevision, the process was very productive. I recall a group of women you all were working with who had a common involvement with DCF because of domestic violence. In the course of this Sharevision support group, these women went from being recipients of service, to experts providing consultation to the district attorney’s office, the police and DCF.

Ellen Landis: Yes, that’s true, Catherine Taylor, led this program. Back in the 1980’s and 90’s. Lynn was determined to shift our group supervision dynamic from power over to power with. Later in our research we discussed and coined the phrase “communal inventiveness” to describe Sharevision. Lynn said Sharevision “removes toxicity from group meetings.” Instead of a facilitator being in charge deciding who speaks when, for how long and interprets what others are saying, and coalesces themes for the group, in Sharevision the focus is on each person’s contribution and the variety of ideas that emerge. So, yes, while Sharevision often has a facilitator (mostly serving as a time-keeper), the facilitator role can rotate so everyone in the group develops their leadership skills.

David Haddad: Yes, so in this example members of the Sharevision group, entered as victims of violence, and became expert consultants to DCF, the District Attorney’s office and police. Such a wonderful example of how participants in this process can reclaim the narrative that defines them.

Ellen Landis: It is. We have found that the quality of experience is so generative that people gain momentum with topics they bring up, from what we learn listening to others and with new perspectives and appreciation for those in the group. For example, while in groups with frontline nurses when PPE was extremely scarce, and some hospital regulations didn’t make sense to these nurses, they shared alternative ideas with each other. Participants encouraged each other, saying things like, ‘I spoke to my supervisor, HR, or union, about it’ or ‘I’ve never done anything like this, but I’m thinking about speaking with my hospital administrator or supervisor,’ and people did. You know, they felt better having spoken up in order to help out, and some had better results with workplace concerns. With Sharevision we don’t tell people what to do, or give advice. Instead, we share experience with “I” statements like, “I tried, I found, I felt, I dream, or my grandmother says.”

David Haddad: So, they were empowered by the conversation and ideas generated by the group.

Ellen Landis: I think so. Lynn and Lisa described it as “transformative exchange.” There’re benefits in having the chance to collaboratively reflect with colleagues who understand the work/life challenges and to exploring larger issues rather than leaving it at group venting. It builds incentive. That’s very much what we’re seeing now and we’ve seen it over and over again.

David Haddad: Can you say more about one experience that stands out?

Ellen Landis: After the Sandy Hook Elementary School massacre, I was brought in to work with the local NPR affiliate station. They were some of the first people to arrive at the school. We used Sharevision to debrief journalists and folks on the production team. They found the structure supportive as they connected in new ways with people they had worked with for years. We have come to realize it's a format for collaborative inquiry. It's easily adaptable for professional development and learning groups in many settings including schools, colleges, community, non-profit organizations, business groups. And given that it emerged from a home-based, trauma informed family therapy team in Athol, Massachusetts it speaks volumes to the power of innovation—which is exactly what I think we need given these unprecedented times.

David Haddad: You mentioned there was a structure, could you take us through a Sharevision process. What does that structure look like?

Ellen Landis: Great, these are fast paced meetings. We use a little bit of time to do a great deal. The process always begins by taking a moment for quiet, to breathe, to center, to just put the brakes on from all you've been doing, and prepare for the meeting you're now in. This is followed by a brief check in, maybe a minute to hear from each participant, something you want others to know about you. As we were developing this years ago, we included a check-in because we were making up what our colleagues were thinking and feeling based on our read of their facial expressions, body language and tone of voice. One might think another is mad at you and then react based on this imagined situation. The check-in gives participants a venue to lead the narrative about them. So, for instance we found out that a quality or tone was related to being up all night with a sick child or struggling with car trouble. Then, when using Sharevision as a support or consultation group, regardless of the number of people in the room, you divide up the time equally, so each person might just have five or ten minutes to describe a situation, ask a question and hear a response from other participants. Then the person who posed the question gets the last word. We can focus on listening rather than competitive speech where you're trying to figure out when to jump in to get a word in.

David Haddad: I see the relationship of the reflecting team here, posing the question and then listening to the wisdom of the group. Yet, ultimately, the person who asked the question decides what is useful to them.

Ellen Landis: Yes, this is not dialogue as usual, rather it is the sharing and gathering of multiple ideas and experiences. Sometimes an unusual or surprising response sparks a valuable direction or new focus.

David Haddad: Yes, here the speaker leaves the process with whatever ideas speaks to them, rather than a top-down expert-based model. So, the Sharevision process is an hour, what happens next?

Ellen Landis: The amount of time for the group is flexible. Meetings can happen in less than an hour, for an hour or go for a full day. If there is a smaller group, then participants can take longer or hear from everybody a second time. My experience has been that participants are motivated to keep to the time plan because the last person in the room has a topic or question; and the group is responsible and interested in everyone being heard. During the pandemic before closing I've started to ask people to think about self-care, inviting them to write down what they might do for themselves over the coming days. Often we end the meeting asking participants to name a take-

away from the group. This way we hear different viewpoints of the meeting. Also, we encourage people to talk outside the meeting. You can picture our team of family therapists having follow up ideas and information for each other.

David Haddad: As I was listening to how you describe Sharevision, I was thinking about applications to traditional supervision.

Ellen Landis: Yes, that's how it began. People with a lot of experience and interns meeting together and in a flattened hierarchy, asking questions and listening to a variety of responses. It's an alternative to supervision and not intended to replace it. It's a way to circulate and cultivate the wisdom in the room. It can be used for team building, with boards of directors, within behavioral healthcare, or support groups. In higher education, it's a great way to talk about ethics and standards in clinical practice, reading material and internships. Sharevision can be used in many different contexts, as the structure allows participants to put anything on the agenda, even conflict. It's a structure that can be applied as needed.

David Haddad: Yes. I like that, it's an alternative to Robert's Rules of Order, that are often used in public meeting spaces, and is much more intentional, where participants share the responsibility for what happens, rather than one person holding that responsibility.

Ellen Landis: I have wondered about that. For instance, could a town or city use it for committee work?

David Haddad: So, what's your vision for Sharevision?

Ellen Landis: First, we're working towards supporting people who have been most impacted by the pandemic. This includes offering more people of color the resource as participants, facilitators and trainers. I'd like to see training material developed by a diverse group. It would be great to have free, simple, fun, creative videos that demonstrate the format, and guidelines which include values of equity for leadership and participation. I picture all this on a website with people introducing new ways Sharevision is being used as well as adaptations to the process that suit different communities or situations. I envision this online hub as a public health resource. Right now, there are not enough free and accessible resources for the public on mental/behavioral health supports.

David Haddad: So true, and the pressure is enormous. So, Sharevision is a form of collaborative inquiry that can assist groups in taking care of members, whether they are clinicians, nursing, staff, teachers etc.

Ellen Landis: True, and we also have experience with youth. Here's another example, if you and a group of colleagues want to experiment with Sharevision, we would have a meeting online to get the experience. If participants find it helpful, they could then use the free handout we currently have on the web to convene a group. That way we can exponentially create resources to share.

David Haddad: I appreciate you talking about Sharevision as a form of participatory research. One of the conversations that NEAFast has started to have with its community is about the challenges in community behavioral health systems. For example, the productivity demands often leave little time for self-reflection. It seems that the Sharevision model might be a very useful tool

for these kinds of community conversations.

Ellen Landis: That's it! In this way you harness the concern, expertise and enthusiasm of the group members. It feels like there is synergy for this right now.

David Haddad: Having participated in many Sharevision in the past, and as you were talking I was recalling how uplifted I felt in these experiences. The energy of the participants was incredibly meaningful.

Ellen Landis: Yes, relevant, healing, educational. With many people looking for additional ways to deal with this mental health emergency, small groups are a good option. More people are looking for counseling than there are licensed clinicians. Let me add a little more here about my vision for next steps. I think a way to start training people how to facilitate Sharevision groups is part of a series of six groups which include a focus on the format and guidelines. Then these people would lead a new group and return to their original group for debriefing, learning and planning about facilitating a Sharevision series. This way we layer the support. It is not lost on me that those of us in community behavioral healthcare along with other essential workers are interwoven with each other. We rely on one another for our healthcare, for education, and with our joy & sorrow. Given the status of the country it seems that our collective task is to meaningfully uplift the spirit so that we can stay in the game. Whatever we can do to add value for the essential worker and their role, and engage new people towards these incredibly important jobs is of critical significance.

David Haddad: I appreciate the emphasis on the interconnection we share with each other. How we practice, show up in our lives is so important, and we all do better when we have the support of our community. Ellen, this has been a rich conversation. The combination of these engaging ideas and catching up with an old friend and colleague has been uplifting. Before we end, is there anything else that you would like to say?

Ellen Landis: I really want to thank you for this opportunity to reconnect, to talk about our legacy as family therapists and the creative potential that can come from it. As you can tell, I'm excited about the potential with Sharevision as a way for more people to build useful connections, to generate resources, and lift spirits. Giant gratitude for Jessica Avery, Nicole Bibber, Dr. Brandy Brooks, Tonay Burton, Julia Byers, Stephen Flynn, Deborah Muyskens, Sarah Patton, Tuti Scott, Linda Thompson, Lisa Thompson, and everyone who has pitched in to pave the way towards bringing Sharevision to the essential workforce and others who are most impacted and have given the most for the common good.



CONNECTING WITH MILITARY FAMILIES: AN INSIDER'S VIEW

JENNY D'OLYMPIA, PsyD
William James College

INTERVIEWER: JACQUELINE GAGLIARDI, MED

Jacqueline Gagliardi: Thank you for doing this interview, Jenny. Before we start, I'd like you to tell me a little bit about yourself in terms of your position at William James, because one of the things we want to talk about today is working with military families and the impact — and for clinicians who might come in contact with these families or individuals, to be aware of some of the things that would be helpful for them to know?

Jenny D'Olympia: Ok great. So I'm Dr. Jenny D'Olympia. I spent nine years in the military — five years active and four years in the reserves. I am also the spouse of a servicemember who has served for 22 years. While I was in the military, I earned my masters in Mental Health Counseling. After my time in the military, I worked at the Boston Vet Center as a Licensed Mental Health Counselor, and in the Brockton Med Center as well doing outreach to the first wave of veterans who were returning from Iraq and Afghanistan to help them gain access to their benefits and also counseling at the Vet Center, which is part of the Readjustment Counseling Service. Their primary focus is working with combat veterans and their families, as well as individuals who have experienced military sexual trauma or, service members who have experienced homelessness. But the Vet Center is a really great first place to go for individuals who are returning veterans. So I spent some time working there and then I returned to school at William James and I earned my doctorate in Clinical Psychology.

I have stayed on at William James and am the Director for the Military & Veterans Psychology Concentration as well as the Trained Vets to Treat Vets Program. The Military & Veterans Psychology Concentration is basically coursework that students who are either in the Counseling Program or in the Clinical PsyD Program do in addition to their general curriculum. It gives them additional information about military and veteran families, military and veteran culture, and different aspects of mental health related to that specific population to help them really understand and address that population and community better. The Trained Vets to Treat Vets Program is a program that is designed and supported by a grant through the Department of Massachusetts Veterans Services. In that program, we work closely with our military and veteran students throughout the school — regardless of their desire to work with veterans or not, we help

them build on their leadership skills that they have, that they bring to us. They come with significant life experiences that are often overlooked in the community, and we help them maximize any areas where they need additional growth and we add additional scaffolding to help them get from the front door to graduation. whatever that might be — each individual might need something a little bit different. But we're there to support them. And we're there also to teach the community about military and veteran specific topics.

Jacqueline Gagliardi: Yeah, so you were talking about the concentration and what you want the masters level students to...and I would imagine the doctoral level students too — to really know about this population. And so I'm wondering if we could talk a little bit about the military population and some of the issues that clinicians might face when they're working either individually or with family members. So maybe we could start with deployment?

Jenny D'Olympia: Sure. I think it might be better even to start with what is the military, and what's the difference between military and veteran status because I don't think that people in general know that. We have many different populations that you might encounter. One of them is active duty individuals: they wear a uniform everyday, they go to work for the government in their military uniform and they're in it for a particular period of time, and the whole time that's their only job. And they have families, and they have family support centers on the base, whatever base they're assigned to. if they're in the army, the navy, the air force, the marines, the coast guard, now the space force, all of these have a different way in which they prepare and go to war of which they support their people, and their families. I think that the most support is probably available for our active duty members because they have programs directed towards them. A lot of people live on the base or near the base, and are in a community of people who realize that military people are in the community because they know each other. But I think there aren't a lot of active duty bases in New England. We're more likely, probably, to run into people who are either veterans, or in the Active Duty, National Guard, and Reserves.

And so what are those? The Reserves and the National Guard are both groups of people who are in the military but most of them work, like, one weekend a month, two weeks a year. Although there are some full time positions within those programs, they're relatively small compared to an active duty community. The military family programs for them are not nearly as robust as they are for the active duty programs. So I think it's really important for people in the community to know that.

Let's talk about what a veteran is first. A veteran is someone who's done with their service, they are no longer wearing a uniform, or they did their service and now they're either in the Guard or the Reserves, so you could actually be in the Guard or the Reserves and be a veteran. But I think that what's important is when you're thinking in your mind "What does a veteran look like?" you sort of have to imagine in your mind what does that look like — and I think that oftentimes the image of what a veteran looks like is not what a veteran actually looks like. A veteran could be anyone in the community at any age, really. People could sign up and have left on their eighteenth birthday and be back at age 19, 20, 21. Veterans could be 21 or 22 years old; they could be 100 years old too. I think we often think about our older veterans as elderly males.

But we never think about our younger people, that they might be veterans; or our young people with families that are blending into the community — that they might be a veteran family. Or, that we often never think about the fact that there are a lot of women veterans as well. That

population I think often really gets overlooked by the system.

Jacqueline Gagliardi: You were saying that people in the National Guards...what are some of the issues that might come up for these families? Like, one that I'm thinking, when I've worked with families, is that they have I think one weekend...like, there's at least one or two weekends a month and how that might impact the family.

Jenny D'Olympia: That's usually about one weekend a month. I think that how that impacts the family is that one of the parents then is the single parent for that weekend. And it depends on what kind of family support system they have in their community. I think that's definitely something that comes up for our National Guard and Reserve families because that can really take a toll after 20, you know, 25 years of one weekend a month, two weeks a year. It can become a lot for a spouse, — not all spouses will really understand what that's all about.

Jacqueline Gagliardi: What are some of the other issues that clinicians might be faced with when working with, for example, veteran families? You made a really great point when I think of veterans, I think of people who are older, but a veteran could be 22 years old. So, what are some of the issues that might come up that would bring them to therapy not at a vet center?

Jenny D'Olympia: Anything that could come up for the general population could also come up for veterans. I think that the perception that we are a special population because it's like one of the only jobs. There are very few other jobs in the world where you sign up to commit to a role up to including your life. And so I think that takes a toll on them mentally, especially since the draft went away. Everyone who signs up is a volunteer.

And so I think that's important to note, and that more and more, as we became an all-volunteer force, and for the past 20 years we've been at war, the number of people in the community who are very connected to that is very small. And so the general community may not even be aware that, you know, this person went to war four times, or this person is in the National Guard and when they go to their drill weekends or they go for three months they may not go someplace else. They might be at war but be virtually at war in some capacity.

So things that could come up are depression, anxiety. I think specifically for our veterans who've experienced wartime experiences a disconnect: it's really hard to connect with their spouse. For example, being psychologically intimate with someone can be really difficult and they might push everyone away. So they might be really isolated and not even realize it.

I think there's two sort of ways you can come back: you can come back and be really invested in being connected with the military and veteran population; or you can come back and not want to identify with it at all. And so, then further isolating and not being connected to the community because losing that connection is really significant. I think what we can do to help is continue to let the community at large know that people who are veterans could be anybody. I think that when we restrict our celebration of, for example, Veterans Day to only celebrating the elderly veterans who are the WWII or Korean veterans — which they do in a lot of towns: they have celebrations for them and then all the other veterans get left out of being included in that celebration. And so they can sort of then think, "Well, I'm not really a veteran, or maybe there's nothing available for me until I'm an older WWII aged veteran as well."

I think another thing that comes up for families — for couples, specifically — is when you're in the military and you deploy, or you're connected to people when you're deployed in a way that...it's like they're your family once you've been in a really difficult situation together. Whenever you are in a really, really difficult situation where lives are on the line, you develop a connection with the people that you're there with. And then when you get back and try to reconnect with your spouse, your spouse may not understand that connection and may feel second to that connection. But it's not...it doesn't make the connection with the spouse less relevant; it's just that's a different connection that people are going to want to have which is going to help them maintain their mental health, really, to keep that connection.

If you think about a family like a puzzle, a bunch of puzzle pieces —, “You're going to do this, and you're going to do this, and this is my role, and I do the dishes, I do the cooking, and I plan all the doctors appointments, and you do the driving and the getting ready for school.” If one person leaves, even for the weekend, those pieces come out and they go shape themselves in a whole other way because they have a new role, new things that are important, new systems of values and morals even when you're in the civilian world. In the meantime, the family has to build up a new structure to fill up all those holes so that the puzzle is whole. And there might be some gaps they might be able to pull from the community, they might be able to pull from family members. If they don't have any family members available to help them, then that will also cause more strain on the family. So if we're talking about the stressor during a deployment, for example, that would be one of them.

Another one would be that individuals who are deployed, now, if they're in a warzone, have contact 24/7 with their family, whereas before we had all this virtual contact, all the emails, all the phone numbers, all the everything, people would write a letter, and it might not get home for a month or two months. And so they would be removed from the civilian world, from their family, and their family would be less dependent on them playing any parts of the roles they played before. Whereas now, there's a dual expectation that you're still going to be the whatever your role is in the family — the mother or the father, the brother or the sister, But now, you know, the expectations can be really hard that you have to play those roles in the family and you also have to be at war and have all of those responsibilities as well. This can be completely overwhelming to have both of those expectations being carried. So I think families who talk about it ahead of time, they talk about it during, they talk about it after. That's a lot more helpful for the families.

Jacqueline Gagliardi: Yeah, you were saying something and I was thinking you could actually do couples therapy with someone who's deployed. And how that could be both positive and negative, and I'm looking at your face as we talk about that...with shock. And so, what would be the fallout of that? Because I think as we're talking about it, the person who's deployed has so many responsibilities, and now they're also worried about maybe the kid at home who's not doing well at school or the expenses that they wouldn't have known about until they got a letter or something. People may think they're being innovative in deciding, “Well, you know, I could do couples therapy, especially if the couple's having trouble and they're deployed.” So what do you see...do you see any pros or do you see just cons for that?

Jenny D'Olympia: I don't know if there are any studies on that. I know there are some on doing individual work on, post-trauma in the war zone, like combat stress units doing some work individually with people. I think that addressing emotional trauma is as important and can be felt

as much as a physical trauma. I can't imagine that being good for either party because the one is in the war zone and they really need to pay attention to their job, not the family at that point. Because the decisions that they make are life or death, people's lives are on the line. Back home, those decisions are not necessarily on the same level of consequence. For instance, what your kid gets in trouble at school, whatever, they're not going to die from that. It seems like thinking about that structure, someone else should come in and be supportive and helpful in that moment. And when the spouse gets back, then they work on reintegrating and figuring out how to work that out again.

Jacqueline Gagliardi: Yeah, that makes lots of sense. I was also thinking about when military members come home, what are some of the signs for the partner to look for in terms of trauma, or, PTSD?

Jenny D'Olympia: Well, I think there a lot of symptoms. I think if they're really worried, they should help them get somebody to talk to or get them connected to other veterans so they can just sort of figure out the concerns. I think some concerns might be if they had thoughts of harming themselves or others, then they would definitely want to get someone to talk to. If they found that their spouse was totally disconnected and wasn't having any communication with any people outside the family, or maybe even not within the family, then they might need some help. If they're having nightmares every night and it doesn't go away or they become physically aroused whenever they have thoughts about, you know, they won't talk about it. If they don't talk about it with their spouse, though, I think that's really normal. I think a spouse might be really worried. When you're young in your first relationships, you're thinking, "I'm going to tell everything to my spouse and my spouse is going to tell everything to me." But there are certain things that you don't share with your spouse, not because you want to protect them from the terrible things that you've seen when you go to war. So it makes a lot of sense that they would not want their spouse to know about those things because they see the world in a different light. And that's why people sign up for the military: so not everybody has to see it like that.

Jacqueline Gagliardi: Yeah that's a great point. Do you have any other advice for clinicians who might be seeing military families?

Jenny D'Olympia: Yes. I think that, especially thinking about it systemically, the more support we can put in place for our military and veteran families, the better off they're going to be knowing that the community: not only this one therapist is there to support them, but all of these layers of military and veteran benefits. There are benefits at the state level, there are benefits at the federal level, and there are even local community and nonprofit benefits that are available all over the place. Navigating that I think is really the hardest part.

But knowing that if you have somebody in your office who is a military or a veteran person, then likely there are some benefits out there that they could take advantage of that might make their life a little bit easier. You can help them come to the realization that they put the time in and they earned those benefits. I think a lot of licensed clinicians don't want to help fill out forms and stuff like that, but I think that if — especially if you're working with a military or a veteran, and you're building trust and connection so that they come back and they get the help they need — you help them navigate that process, helping them find a form, or helping them fill the form out if they can't do it themselves right there with you, like, "What do you think we should put here?" I think that that is really good in terms of trust-building.

One person I worked with had thirty different jobs since he got back from Vietnam and he had always just felt like he can't do enough. He just felt like he never fit into any of those positions, and as it turns out, he had survived this terrible missile attack and he was the only one who had come out of that, and all these years he'd be like, "Not talking about that." He hadn't been able to keep a job or support his family. I helped him file his forms; I even helped him with the social security stuff because he just wasn't going to fill it out, so he brought it in, and I'm like, "Let's just fill it out and see what happens. Let's fill out this Veterans compensation claim. Let's tell them what happened and you can let them make the decision on if you're qualified for any benefits." And it came back, and he was 100% covered. He got paid back for this period of time, He became eligible for the community disability benefits that put him sort of in a place where he felt justified, but more "I did go through this really terrible thing." And the community was saying, "Yes, you did it. It was horrible."

Jacqueline Gagliardi: So appreciation? And recognition?

Jenny D'Olympia: Yeah. And validated. Validated is the word I was looking for. He felt validated. And once he got these benefits, then his daughter could go to school for free as part of this benefit. He had provided for her whatever he could at the time; now he could provide her with an education. And they got an apartment together, got a kitten. And he just felt like, "I've worked so hard, and now there's this." So, yeah, I think that just helping people open that door can really be huge.

Jacqueline Gagliardi: Yeah, so where would clinicians find these resources?

Jenny D'Olympia: They can go to the VA's website. The VA has them. Especially in Massachusetts, if they don't know who to talk to about it, every town has a veterans' agent in all of Massachusetts. Veterans who are having a hard time. If they don't have a job and they're having some income difficulties, there are even programs in every town in Massachusetts that'll help veterans cover their bills so they can get back on their feet again, help them cover unexpected bills. I think that's such a huge thing that's often overlooked because when people come in for therapy we think, "Oh, let's help them realize who they want to be, you know, and help them to become." But often I think it starts at a lower level sometimes, and if we overlook that lower level, we lose them to start with. So what I always look at is Maslow's Hierarchy of Needs and, starting down there at the bottom and what are those things that they need to get additional support. I'm also thinking about how else can they get connected in the community? What other things are out there that they can get connected to? Is there a veterans group that meets for coffee in town? Or is there like a running group for maybe younger veterans? Or is there anything at all that might be available in the community I think is good to connect them with.

Jacqueline Gagliardi: So in many ways it's really interesting, when you begin working with veterans, a way to join is by helping them with resources.

Jenny D'Olympia: Yes.

Jacqueline Gagliardi: Because sometimes all they might need is to feel better financially, feel validated, and also to have some social connections.

Jenny D'Olympia: Yes. Absolutely.

Jacqueline Gagliardi: Yeah, so that's really different than delving into their childhood, right? Or, their depression, because some of their depression might have to do with all these things you've talked about.

Jenny D'Olympia: Yes. Absolutely.

Jacqueline Gagliardi: Do you see a difference...different issues that vets might face in terms of gender or race when they come out of the military? Or experienced while they were in the military that might impact them?

Jenny D'Olympia: Well, I think one thing that the military has that the rest of the world and community doesn't have is equal pay for the same jobs. So it doesn't matter, right, what your race, religion, sex, ethnicity, or gender; you get paid the same amount at the same rank for the same job. There has been a huge change in the last ten years for women in the military specifically as they've lifted the explicit restriction of women in combat. I think that, even with that, knowing that and with that happening, women are working their way into every community in the military. But before that, they were explicitly forbidden to do certain jobs. Doesn't mean they weren't in combat. So if you just sort of think in your mind, "woman veteran", what kind of media things come up for you or what kind of experiences you think a woman veteran has, or is connected to? I think often the media talks about women veterans and military sexual trauma like in the same sentence more times than they don't. And so the assumption often for our women veterans is that they've experienced military sexual trauma. And I think that's a really important topic. But I think it's also important to realize if a man comes into your office, you don't assume he experienced military sexual trauma, but the male veterans experience it too because rape is about power and control. What we have to remember working with women veterans is that even if that was the case and they did experience sexual abuse, many experienced a fear that it might happen even if it didn't.

And also, many experienced a whole lot of other things not related to sexual trauma or assault. They also did wonderful things. They're also powerful warriors. They also carried weapons. They are very strong. And so assuming that women veterans were victims is not the full story but it seems to come up a lot in the media. And so, I like to bring up that there's other things that we have too. Some of us deployed with special operations forces and they were people...since, for a long time, women have been involved in roles in which they've experienced combat, and it's only just become official that they're allowed to do that. But thinking back, women were involved in roles where they were experiencing combat in combat zones for a long time.

Jacqueline Gagliardi: Yeah, that sounds like something you're really passionate about in terms of people being able to think about women in the military not only sometimes as victims of sexual assault but all the ways in which they are really strong and what they've gone through which is similar to what males have gone through.

Jenny D'Olympia: Yup, exactly. Similar or the same depending on the role they played. Absolutely.

Jacqueline Gagliardi: What do you think in terms of race?

Jenny D'Olympia: So, I don't know if you know this but 30% of the women in the military are

African American women. So they sign up at a significantly higher portion than they exist in the local community; their representation is much higher in the military. I think that's something to be aware of: that they often don't get enough respect for the commitment that they are making for our national security. I also think we have to wonder: Are we equally reaching out to the entire community to recruit people to be in the military? Is the military selecting specific people in particular communities? Or, are people in those communities, in different communities, seeking out, the military? So that we can make sure that we have equal representation across the board of people. I don't know if that makes sense. Because often a lot of people join the military because they have financial hardships, or they want to get out of a small town. Some people have talked about it being a deliberate targeting of people who need the military to function. I think we have to really pay attention to telling these stories to all of our communities because if we get so far removed that only a certain, 1% of the population volunteers to be in the military right now. 99% don't know anything about it. We have to really pay attention to our military and veteran people, and include them in the decision, include them in the community, in our legislation, all of that so that the decisions we make can take into account the consequences of war.

Jacqueline Gagliardi: Yeah. And so, being in the United States, even as clinicians, when people come home from war, there's information we need to know because we have no idea what the military members have gone through. And, again, I'm just thinking in terms of clinicians, how important it is to get some information about that. And also, how to help families who have also can't wait for their members to come home and sometimes actually are disappointed that the person who left isn't the person who comes back.

Jenny D'Olympia: I think they rarely are the person who comes back that left because you go away and you put on different armor, and you face the world in a way you never faced it before, and you're no longer who you were as a person. Everything changes because the moral and value structure you're dealing with when you're in the service versus when you're not is a lot different than the way you would be dealing with life in the community. So, not only does your family not recognize you when you get home, you don't recognize yourself because you expect to fall right back into what you were doing before, and that isn't necessarily always the case. It can be really hard to put those pieces back together even internally. And then complexities of fitting back into the personalities and relationships with all the people in your family.

Jacqueline Gagliardi: So, what I hear you saying is that you leave as one person and in many ways you come back as another.

Jenny D'Olympia: Exactly. I do think that happens. And that not being prepared for that or not, or continuing to expect to wake up tomorrow and find who you were before again, to be there can really be detrimental for your mental health because you're not going to wake up and be who you were before. You can't unsee what you've seen.

Jacqueline Gagliardi: Right. How can clinicians help with that?

Jenny D'Olympia: Personally, I like Internal Family Systems therapy as an approach for helping you introduce who you are now to who you were then. Like, internally, just having that sort of conversation and helping to reintegrate those parts that can be stuck.

Jacqueline Gagliardi: So that would be a really helpful approach?

Jenny D'Olympia: Yeah, I like that a lot.

Jacqueline Gagliardi: And how can clinicians help other family members of significant others recognize and deal with the fact that the person that left is not the same person?

Jenny D'Olympia: Well, I think they probably would have to go through a process of grieving. Pretty much, like, a grief therapy sort of protocol where you come to terms with, “This is new and we’re starting over and this is where we go from here. You know, what are the new expectations?” And hoping to reframe this, of, “This isn’t the end; it’s just a new beginning.”

Jacqueline Gagliardi: Yeah, that’s really helpful. Before we end, is there anything else that you can think of that would be helpful for clinicians who are working with the military population?

Jenny D'Olympia: Make no assumptions. Each individual, each family member, each family will have experienced all these events that have led them to where they are and that each one of those will be a little different. And what helps one might not help the other. So, I think it’s having an open mind and doing some research if you need to do some research, not expecting the military member or veteran to, for example, give you the context of the war. Oh, like asking a question, “What’s going on in such and such country? Why did they go to war there? I didn’t know we were at war there.” Like, those are the kinds of questions that you can do as a clinician outside the therapeutic relationship and so that you can inform yourself.

So, I would say: Be mindful of, if you’re asking questions, is it related to the therapy or your own curiosity? And if you’re working on the trauma with the family or the individual, I think the same thing goes because even if they have these terrible experiences, I think they don’t necessarily have to tell you all the nitty-gritty details of that in order to get help, in order to feel some relief or some self-compassion for where they’ve been and where they are. Because sometimes those details I think can actually muddy the waters and make it harder for people to function — especially in the relationship, because imagine talking about your traumatic wartime experiences with the person you love the most in the world, like, listening and witnessing that; I don’t know that that’s always going to be very helpful.

Jacqueline Gagliardi: And I have one more question for you that I just thought about. Are there differences for children, between their mom going off to war or their dad going off to war?

Jenny D'Olympia: That’s a great question. And is there research on that? I don’t know about that. I think that what’s most important is the kind of structure that’s available before, during, and after. And just like if there were a divorce or a separation, you would need to work out those terms so that it would be a seamless integration for the child and having the same expectations throughout. That’s what’s going to help the child the most. If the family has problems before deployment, they’re probably going to have the same and more after the deployment. So, if the relationship with the couple is not great, it’s going to keep being not great. But for families who have, who have a strong relationship and a strong family and a set sense of, “These are our rules. This is how we enforce our rules.” Because sometimes one parent has different rules than the other parent and then there’s this whole argument and discussion about that. So, it’s a lot easier when they do have that going on than if they don’t.

Let’s say you were working with a family and they were preparing for that, like, letting

them know, “If you’re ok, your kids are going to be ok. Like, they’re going to get through this. They’re going to experience things that other kids don’t experience. And there might be some hard times for them. There’s also going to be these pieces of resilience that they wouldn’t otherwise have.” And so, I think building on those strengths while also reducing those risk factors is really the way to focus with the family, with the couples, and with the children.

Jacqueline Gagliardi: Well, Jenny, thank you so much. I think you’ve given us a lot of information.

Jenny D’Olympia: Ok, great.

Jacqueline Gagliardi: I hope this helps clinicians who really are not familiar with the military or military issues that might come up for military members. So thank you very much.

Jenny D’Olympia: Thanks.



EXPRESSIVE THERAPY AND SYSTEMS THINKING

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INTERVIEWER: DAVID HADDAD, EdD

David Haddad: Thank you for agreeing to have this conversation. By way of introduction, your background is in Expressive Arts, and you have a doctorate from Lesley. You also teach and practice Family Therapy, and have been engaged in community work in Palestine, and other places around the world ... So perhaps we can begin with your saying something about expressive therapy. I think many people know the term ‘expressive therapy’ but would you share how you think about it? And how it is applied with the emergence of telehealth?

Yousef AlAjarma: Thank you, David. So, to begin with, as a discipline, expressive therapies are relatively new. It started in the 1970’s, in Massachusetts.

David Haddad: At Lesley, right?

Yousef AlAjarma: Yes, at Lesley. It was created by Shaun McNiff and Norma Canner, among others, who were thinking “How can we take the arts and apply them in psychotherapy?” These early expressive therapists understood that the arts have been around for thousands and thousands of years and have been the source of healing throughout history.

David Haddad: Yes, in all cultures...

Yousef AlAjarma: ...since the beginning of life as we know it. Consider the paintings in the caves and on rocks and stones that have been around forever. And people have used the arts in one form or another throughout the history for catharsis and self-healings, ritual dances, and music. We can see it in every culture. So as a discipline, integrating expressive arts in psychotherapy, it’s a newer approach, maybe forty-five years old. And within the expressive arts, there are many disciplines like art therapy, music therapy, dance/movement therapy, play therapy, drama/psychodrama... And when we say ‘expressive arts’ or ‘expressive therapy’ it’s that use of all those, together in one setting or in different settings as well. While individuals can specialize in various modalities like art therapy or music therapy, an expressive therapist would go on for more specialized training.

David Haddad: So, an expressive therapist can be a generalist...

Yousef AlAjarma: Yes, you can be a generalist, but also, many people in the expressive arts who become expressive therapists came from an expressive arts background. For example, I have an undergraduate degree in Social Work and then my masters and PhD in Expressive Arts. But with my undergrad in Social Work and Psychology, I wanted to do psychotherapy and I wanted to use the arts. So that's why I went that route. If I wanted to go to a music school for music therapy, or an art school for art therapy, I would not have gotten in since I didn't have the undergraduate credits. As someone who went to school in Palestine and Switzerland, I had to consider the country that could allow me to pursue my interests. For example, if you think about North America—the most straight forward way to go is a master's degree, but as an international student that's a problem when it comes to credentialing, as each country does different things. Like in Japan, for example, expressive therapies struggle to get the credentials under the U.S. regulations. Same with Europe, same with the Middle East, and Latin America, as well. So that's the discipline in general.

But when, also, we think about expressive art or expressive therapies, I think about the need, the client, that you're working with. And this is important because the fact that you are a generalist, and you are trained how to use the arts in different settings and with different populations, makes you a better fit to apply expressive arts with anyone, and in any setting.

David Haddad: Because it's collaborative?

Yousef AlAjarma: Yes exactly, thank you for using that term. I'll be using that more often. It's a collaboration with the client, whether that is a family, a group, or a community, not top down. The invitation is, "Let's all work on this together", or "let's see what will work here". "Do you like music?" "Yes." "Let's talk about music", "Let's talk about the kind of music that you like". "What kind of music makes you happy?". "What kind of music can be expressive for you?" "What kind of music, makes you sad or take you out of your sadness?" Same thing with any of the other art modalities. Psychodrama, for example, has been around since the 1920's, developed by Jacob Moreno. And it's still used widely around the world, and has direct applications to family therapy. So one can be an expressive therapist and use all of these aspects in a collaborative way. At the beginning of our conversation, you mentioned the challenges of COVID...

David Haddad: I have one question before you go into it. Can you say more about your path, you said you had your degree in social work and psychology—so, what was it about your experience that led you to be interested in art therapy?

Yousef AlAjarma: In my undergraduate school we had to do practicum and internships in the third and fourth year. In the first year, when I was doing the work, it was mainly with people with physical disabilities, like those who were involved in car accidents or were shot, mostly adults, and when I would go in and talk with them, talk therapy was limiting their ability to express what they were feeling. And at that time, I was looking for more tools for talking but I did not find more. I felt I would attempt to talk and then I would say, "I'm so sorry that you're going through this," and I found myself hitting a wall. And that was my experience in practicum. And I was so frustrated with the experience. Here these individuals are struggling, and I felt I could not do anything to help. On top of this, I was young, and it left me wondering I'm doing maybe the wrong thing or I'm not a right fit for this field."

David Haddad: And where were you? Was that in...you're talking about your undergraduate?

Yousef AlAjarma: I was in Palestine in the West Bank, I went to Bethlehem University, which has also one of the oldest social work programs in Palestine. In my fourth year at my internship, I was working with families and kids who were mostly under eight years old, and most of my clients at that time were coming because they were wetting the beds. So, bed-wetting was a big thing and I have all those five, six years old, and I would start talking with them and nothing was happening. At that time, I had a supervisor who was from Switzerland, and I went to her and said, "You know, I don't know if I'm a good fit for this field because nothing seems to be happening". And she said, "Have you ever tried to ask them to draw something?" And I looked at her as if she has ten heads, I'm thinking, I'm not an artist. I cannot— I draw stick figures. I don't know how to play any instruments. I grew up in poverty, so art is a privilege that I never had. And she said, "Well, just try it. Just try it. See if you can just do something and try it and come back. Let's talk about it after the session when you do that." So, I did that and asked one of the kids if they wanted to draw something. And I don't remember what they drew, but I do recall that we had a very nice conversation about the drawing. So, instead of me being stressed out about the thirty minutes of the session, now the kids were doing really something that they were really engaged in. We just talked about it. I think we created a story. I went back to my supervisor, got some supervision about it, and she, gave me some pointers, such as, "You know you can ask them about their favorite memory, about their favorite thing, things they want to do, about a fun thing, something with their families..." She essentially gave me permission to be curious in this way and added that you might also want to ask them to write a story, or write story with them. But you also start doing...maybe you want to ask them to write a story or write a story with them." This was the change for me, this was not just art, we were talking about bed wetting, we were talking about monsters, and about the things the kids are afraid for, trauma, shootings, war.

David Haddad: So, would you say that the symptoms you saw in these kids, like bed wetting, was a byproduct of the system in which they were in? The challenges of the system?

Yousef AlAjarma: Yes.

David Haddad: Ok. So perhaps that is a link to COVID. Can we speak to the mental health issues that we see emerging during COVID?

Yousef AlAjarma: Yes, kids would come in for bed-wetting but it's the trauma that they are going through. I did that work for almost a year and was very happy with the work. And then after I finished that work, I was working both with families and individuals. But I felt like I wanted more, I needed more of the arts." And that when I was introduced to the school in Switzerland that had a master's degree in expressive arts and was connected to Lesley. It was great for me, as it now allowed me to begin to put to words, what I only knew in action. This allowed me to use expressive arts more readily, which then put things in perspective. The statement that we always say in expressive arts is "low skills, high sensitivity." So, you don't have to have the skills in the arts, but you must be a highly sensitive, and collaborative if you want to use the arts in your clinical work. You want to be sensitive to the culture, you want to be sensitive to the age, you want to be sensitive to the gender, essentially understand the client in the context of their lived experience.

David Haddad: So, all those qualities that you speak of, are often not considered in many evidenced based, manualized treatments.

Yousef AlAjarma: Yes, so many are skills-based, the expertise of the clinician. With expressive arts, the task is to be present, guide the client through the process, let them guide you, let them be in the driver's seat, and then work together on the things that they're going through. Journaling becomes fun, writing becomes fun, art is uplifting and become something the client enjoys engaging in. And, in that way, working alongside clients, guiding them, that can enhance their lives, not just for the session, but for life. So, getting back to COVID...

David Haddad: Yes.

Yousef AlAjarma: If you would ask me two years ago, "Would expressive arts work online? Or would it work with, I don't know, in COVID times?" "Yes, but I'm not sure if I want to do it." I would not be as excited to use expressive arts. Now having done this work now for almost two years, I can see how beneficial it is, we can do it. It's limited, like all therapies might be, but it remains an opportunity for client and clinician to do art together. Over the past months we have seen the emergence of software and websites to do arts with the clients. Like a virtual sand tray, for example, that you can use with your clients. There are many apps that allow the clinician to draw and paint with clients. Videos that clients can make representing some aspect of their lives that can then be talked about in session. All these activities require mindfulness, breathing, and taken together, expressive arts can be incredible valuable during covid as people are more isolated. Simply walking in nature can be an expressive art, working in the garden, all of these can be incorporated into expressive arts.

David Haddad: So, getting people outside into the environment.

Yousef AlAjarma: Yes exactly, consider "Land art" or "earth art" has been around for thousands of years. Today if you go walking in nature, or strolling along a river, you're likely to see rocks piled on top of another that people have left...that is a form of land art.

David Haddad: Yes, since the pandemic began we have seen how getting out in nature, what has been referred by the trendy reference of "forest bathing" where people are going to just be in the forest and have the experience of being in nature. That in and of itself is healing. So introducing the idea of land art is another way of being in nature.

Yousef AlAjarma: Yes, and just to be clear when I speak about land art, I think of sculptures, or carvings, any physical activity, using your body. If you're doing drama or music, you're using your body there, like, even...people are carving things in the trees or putting things together there in the forest or when they are outside... It's part of art, it, it's a physical activity. And that's the basic model when it comes to art, or art practices: you are using your body all the time when you are doing arts. If you are painting, you are using your body. If you are moving, you are using your body. If you are doing drama or music, or something... you are always using your body, "Take this feeling out of your body and put it somewhere. Externalize the experience and then dialogue about it.

David Haddad: So, one thing I often hear from students or clinicians who try to incorporate expressive arts, is a feeling of getting stuck, where the activity falls flat. But I hear you making a distinction here, it seems like you're saying the clinicians needs to bring a philosophical understanding to the activity if they hope to maximize the full potential of expressive arts.

Yousef AlAjarma: Yes, well you are feeling stuck, what is the stuckness about? I think that's really important. If you are only using one thing—say every time the child comes in and you ask them to draw without any direction, then you must refine your directions. Asking them to draw may be a good start, but as time goes on, you need to be more focused, leading them in the process. For example, if you have a family come to you and all the time you give them the jenga game to play with and you are not structuring it in a way, then the family may wonder, “What are we doing here?” Even though just the act of playing jenga together and communicating about that is really important, but without direction, it can simply be more of the same.

David Haddad: So, say more about that. I hear many students, as well as clinicians talk about game playing with children, yet the clinician does not provide a structure. How would you, if you were going to give people, our readers general advice about using games in therapy, how would expressive therapy help them to think about structure?

Yousef AlAjarma: I would always start with the unknowing and the observer perspective, just looking at what's happening, and then I might wonder, how was the communication between family members? Who took the lead? And how did that feel? How did you feel when your spouse told you, ‘No, that would ruin the game,’ or ‘Don't take this one,?’ How do you think your child felt when you pulled that jenga piece and the whole thing fell down?” So, it's not about them just having fun, but an opportunity for connection and understanding.

David Haddad: It's the process.

Yousef AlAjarma: Yes, the process is really important. And some people...not every therapist or not everybody who uses the arts will believe in the process as well. So, some will tell you that people can process that on their own. I believe that process is an important part of the work. And to process it when people are there, helping them see the process that expressive arts reveals. So here you are really pointing that process out, for example, “The next time you do this at home when you are playing this game together, notice what happens and talk about it.”

David Haddad: So you're teaching them skills that they can then go back into their home and think about. And just the intention to notice brings up many other opportunities to talk about process, or what the family values.

Yousef AlAjarma: Yes, for example, in my family we used to play monopoly. And my son would be the best player, and suddenly he would say “You know what? Here, mom, dad, you can take my money.” We would always talk about what a wonderful quality he was demonstrating, but it was also an opportunity to talk about money. So, we might say, that is very generous of you, but you might need to keep some. So, in this example, I was not saying that as a therapeutic intervention, but when we incorporate this into therapy, we use play as an opportunity to recognize patterns, helping families cultivate resources for managing the complexities of life. In game playing, we might wonder what kind of attitude do members bring to the moment? Are they punishing, or bullying? What do others say when these behaviors show up? So often these behaviors are just incorporated into the play, as families are simply not aware.

David Haddad: Right, absolutely. So as a family therapist and teaching family therapy and supervising family therapists, that process observation is the essence of family therapy. Content is important but process is what we're looking at.

Yousef AlAjarma: Yes, And I love the arts with families because— with families so these art forms are non-threatening.

David Haddad: Yeah. What about with resistance? I know people talk about that where you have families coming in, they're under duress, and then you're asking them to engage in something... Could you say something about how you think about, resistance when that shows up in your experience working with families?

Yousef AlAjarma: I would say first to go with the resistance and see what it is, and if they're resisting something, why are they resisting that? So, if I'm introducing, say a family drawing task—to ask everybody...we have a big piece of paper, and let's all get on the floor or on the table and the direction to everyone is to create a family portrait of something of a family memory. And if somebody then says something like “Oh, this is dumb,” in the beginning, I might say “Ok, what's dumb about it? And why do you think it's dumb? “Oh, I'm not an artist,” I can say that it doesn't require talent, or let's do it and we can destroy it after. It will be up to you. But ultimately, it's all about the process, not the product. So that, that, that's another key in expressive arts: process versus product.

David Haddad: Right, so they're resistance is just an opportunity to explore their understanding skills, and also their willingness to go along with something to find a new solution.

Yousef AlAjarma: Yes, I recall working with a family, we were not even doing any art. I asked them to think about, to come up with a memory that they all did together. And they start brainstorming things that they agree about, and they came up with a memory when they were driving across the country. And the interesting part was—that each of them has a different memory of that drive. They had disagreements about things: “No, we did not do that, we did this”, or “we went to that place.” And here the process was made clear. How is it that the family went through the same experience and had such different memories? What happens to those individual differences? In these memories we can see who aligns with who, we see coalitions, and triangulation. During this kind of non-threatening activity, we see conflict arise and then the family talks about it. While not clearly expressive arts, it becomes art when the therapist helps the family deepen the story.

David Haddad: It reminds me of one of the axioms of structural therapy that we can see how families process by watching how they organize, structural patterns, who talks to whom...

Yousef AlAjarma: Sure. In music you can ask them to talk about their favorite music or wonder if there are any favorite songs. Is there any kind of genre of music that the people can relate to? Is there any movie or tv show that they all can relate to and what's that about? And bring in more of the common things. So, the arts can bring so much of what is common between people, and in this way, increasing connection.

David Haddad: Thank you for sharing that. So, I am aware that we have a few moments left and I wanted to make sure I ask you about your international experience, having worked in Palestine, Israel, and Haiti. I'm wondering if you might make some observations about the type of challenges that kids are facing in some of the places that you have worked.

Yousef AlAjarma: Yes. Even though there may be different circumstances and cultures, when it

comes to trauma and stress, I see lots of similarities. You can see the same signs; you can see kids withdraw, you can see them having nightmares, you can see them have behavioral issues. They come to therapy through bullying...I mean there are so many problems. And I would say, across the globe, you see similarities. How to work with them in each culture requires sensitivity, to ensure that you are doing something that really works within that culture. One example I have used is a guided meditation. I might begin: "Picture a red color," and then, "Picture a red delicious apple." So, I did this for many years and a few years back I was doing a training in Palestine, and I was saying this, and it was a certain difficult time and when I said, "Picture the color red," some people had some resistance with that, and we had to talk about it after I asked, "How was the guided meditation or imagery?" And people responded by saying, "It really was tough." When we explored this further, I learned that many of them had been witnesses to war trauma, and the color red brought up memories of blood, about suicide, about issues that they were not ready to deal with. Here, their difficulty with the exercise, became an opportunity to learn about their reaction to the trauma.

We did some similar work in Haiti, Guatemala, Hong Kong, and Canada. In Palestine, for many years I worked with refugees who have all suffered trauma, and the one common thread across all this was the need to make each intervention culturally appropriate, and sensitive to the context in which the client is embedded. Yet in all of these diverse cultures, people have their music; across all cultures people can relate to music—as long as you bring them the right music, or they choose their own music. In Haiti, for example, we used to ask people to sing and do the traditional dances that they enjoyed or inspired them. In this way the experience is theirs, shaped by their music, their lived experience. "This music is ours and we can use it." So, we would do that with the dances, we'd use music, we'd play games that are culturally appropriate and it's their own games. For example, the game hide and go seek is one game that children across the globe play, but with different variations. So, I would not just assume, if I say, "hide and go seek" people understand what that is. We would brainstorm together and I might wonder, "Can we talk about games or things that you do to make you comfortable?" And people will list those. "Oh yeah, that's in my culture. We have that as well. In my culture we have that." Movements is another example, people across the globe have movement and dance as part of their experience. They will put their hands up to say stop, or come closer, or praying to God, it really doesn't matter what you call it, the client names it and the clinician joins in the experience.

David Haddad: Here the clinician is open, and curious...

Yusef AlAjarma: Yes. And when you are curious in this way, it is collaborative. The clinician enjoys, and feels the connection, and they clients feel seen and validated. So, in my international work as well as when I am working with clients in my office, I start by being curious, and wanting to know more.

David Haddad: Right, taking a stance of not knowing....

Yusef AlAjarma: "Tell me more. Educate me more on the arts or the things that you do." For example, when I do my individual work here or family work, I generally bring ten different kinds of markers, ten different kinds of oil pastels, two or three kinds of clay—which in reality, if you go somewhere else, especially other countries or other places, you'll only find one kind of clay, one kind of markers, and maybe one kind of paper as well. So, you want this to be accessible for people and for people to know that they can do this at any time they want. You don't have to get

the air-dry clay to do this. You want this experience to be accessible to them, even when you're not around.

David Haddad: As we come to the end of our time today, I hear you reminding us that as we prepare to use an art technique in session, let the activity, whatever it is, emerge from what your client values.

Yousef AlAjarma: Yes. And you can also use the art as an assessment as well. In my work with the groups, I would give them a big piece of paper or small pieces of paper, and it's ask to create something "Why are you here? What brings you here? Or how will this be the most beneficial group for you?" And I would have them do that and then come together and talk about it.

David Haddad: So, everybody, so everyone is invited to write something or draw something.

Yousef AlAjarma: Yes, there are many ways to use arts in assessments.

David Haddad: So, you're saying both narrative as well as more traditional arts could be used in some form of assessment.

Yousef AlAjarma: Yes, and in each case, whenever possible, I want to let the client take the lead, to invite them to tell you what kind of arts they enjoy and are willing to try. To introduce something that is outside of their comfort zone. If it is too unusual, they might get stuck.

David Haddad: Well, thank you so much for this conversation, Yousef, you have been very gracious with your time, and I found the conversation very engaging, I hope you did as well.

Yousef AlAjarma: Yeah, it is always uplifting when we learn about each other.