NEJRSP

NEW ENGLAND JOURNAL OF RELATIONAL & SYSTEMIC PRACTICE

Volume 2
Number 3
September 2022

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

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

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

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Editorial: Creating a More Intentional Behavioral Healthcare System

DAVID HADDAD, EdD; JEREMIAH GIBSON, MMFT
Editorial Team – *New England Journal of Relational and Systemic Practice*

In a recent *New England Journal for Relational and Systemic Practice* editorial, the authors invited us to think about psychotherapy as a commodity. From an economic perspective, commodities are understood as the raw materials used in the production of goods, while a product is the finished good. Commodities include concrete items—physical materials needed to design said finished good—and abstract items—time, energy, morale, and other intangible qualities.

So, what exactly are the raw materials that might go into creating a smarter, more intentional behavioral healthcare system?

One of the challenges with the field of psychotherapy is that the majority of the commodifiable items are abstract. Unlike the field of medicine, which has a variety of medical devices, psychopharmaceutical concoctions, and architectural structures (read: hospitals) to help diagnose, provide spaces for healing, and measure progress, the fields of psychology and psychotherapy rely on the subjective experience and reporting of clients and dialogical processes between client, client systems, and professional. While the psychological community has developed numerous assessment tools to track responses to trauma and constructs such as anxiety and depression, the process of change is prone to recidivism, especially when the field of psychology invests in first-order change, such as psychometric testing and coping skills, which may be more measurable, but are less consistent in providing the long-term change that second-order change, making changes to the family system (however we define family), can be.

For trauma survivors, for instance, we have a decent understanding of the neurological processes that lead to panic attacks, pain, and other symptoms. However, the variables that create such conditions are infinite, particularly given the uncertainty that exists in the lives of humans, and inconsistent, as one context may create physiological symptoms of anxiety one day, but not the next.

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And that's before we get to the process of family and relational therapy, in which the variables increase between two-fold and ten-fold, depending on the number of people in the immediate family system.

Some of the abstract commodities in the field of psychotherapy are characterological. Therapists who practice effective empathy, nonjudgmentally, and curiosity are more likely to be successful. In fact, Lisa Grencavage and John Norcross (1990) discovered that approximately 40% of clientele who experienced positive change as the result of psychotherapy gave credit to the therapeutic relationship, while only 15% gave credit to a specific intervention or series of interventions; through this research, they invite therapists to explore the common factors of change, centered around developing a positive therapeutic alliance, development of a safe space for exploration and catharsis, and processes for accessing hope. Scott Miller and others (2013) have designed assessments for therapists to evaluate the therapeutic relationship, providing therapist and client with a collaborative process for exploring psychological growth and success.

But there are other abstract commodities that have been ignored and avoided in our profession. Take time, for instance. A billable hour of therapy is not limited to the 45-60 minutes that a professional spends with a client; it includes reading, continuing education, treatment planning, construction of case notes, rest and recovery.

Energy is another abstract commodity that many in our community find lacking, especially given the increase of demand for therapeutic services as a result of the COVID-19 pandemic. We predict this demand will continue for the next decade as families recover from the systemic adjustments (including, but not limited to educational, social, and technological systems) necessitated by the pandemic. Therapists in community mental health agencies are expected to see between 26-32 clients per week in order to maintain healthcare benefits, a process that preceded, but was also enhanced by the pandemic; now, many therapists in private practice have had periods of keeping similar caseloads. Therapists are leaving the profession in droves, and many of the therapists that remain understandably have minimal energy to engage in the development of the field of psychotherapy.

So what if we extended the work of Grencavage, Norcross, and Miller into the construction of the profession of psychotherapy? What if we thought of commodity as a behavioral healthcare system that provides a compassionate and effective experience for the clients it serves, as well as one that is responsible for the commodities that facilitate positive holistic lives of clinicians and staff who provide the care?

I can't imagine that there would be much disagreement on the benefit of such a system, yet to accomplish such a goal requires an agreement that there are things that we can do that move us towards the goal of creating a smarter, more effective system. What are the relational practices that might move a behavioral system in that direction? How do we identify and practice these qualities together?

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Still Unsafe in American Schools

OLIVIA DAMAS

Editor's Note: NEJRSP is committed to publishing voices from throughout our community, and throughout our systemic hierarchies, including non-prfofessionals.

My name is Olivia Damas. I'm 15 years old and I will be entering my sophomore year of high school.

According to the Washington Post, there have been 311,000 students who have been exposed to school shootings since Columbine in 1999 (St. George, 2022). In my 15 years of life, there have been 251 school shootings in the United States. According to analysis, black students make up 16.6% of the student population; however they experience school shootings at twice that rate (33%). Not only am I a student who's concerned about their safety, but also I have to remain cognizant that as a student of color, my risk of exposure to gun violence in school significantly increases.

For 40+ hours a week and 180 days in the school year, I, like thousands of other students in the U.S., remain fearful about going to school.

I'm afraid. That is not okay.

The night I received news about the tragic shooting of 19 innocent kids and two teachers in Uvalde, Texas, I cried and mourned the precious lives lost before agonizing over how this horror of a massacre could happen yet again. I was so petrified that I tried to fake a stomachache so I wouldn't have to go to school the next day. Maybe the stomachache wasn't so fake after all, however, because for the next few weeks my stomach was in pain from the overload of anxiety I had for the eight hours of a school day. I didn't even want to participate in afternoon activities or sports because it meant being in the building longer than what was absolutely necessary. To me, even one minute in a school facility could be the difference between life or death.

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After Uvalde, the entire direction of the remainder of the school year was shifted. A part of me wished we could go back to the online learning we had during the COVID pandemic. At least then safety would be guaranteed.

There were several occasions where I jumped or screamed at the sound of a loud noise during class, petrified that the "school shooter drill" training we received would be put to use. The hypervigilance I held felt like a toxic combination of déjà vu and PTSD, and it was exhausting. My grades started to drop because I couldn't fully focus in class, and even school itself didn't feel real, but more like a simulation in which we were being prepared for an ambush attack. The threat came in from everywhere: strangers, classmates, the non-bulletproof glass of doors and windows, and even the time outside campus. I felt trapped.

To add fire to fury, the school bus in my area had to be stopped during mid-afternoon drop off because a student's hit-list got exposed.

Now that school shootings have been executed so many times and in so many different ways, I think people are starting to see that mass murder as an option. A last resort maybe, but an option nonetheless. I've even heard "jokes"about it on my own school campus. People say things like, "You should wear red tomorrow," or even say to just not come to school the next day at all.

Just like that, education and safety were snatched in a flash. Even during my summer camp at a boarding school, a student had to be sent home for bringing a gun and threatening someone with it.

Instead of English class, I was in a corner holding my friend's hand and holding my breath as we were squished against a corner where the shooter wouldn't see us. I distinctly remember thinking two main things:

1) "This is not normal."
2) "This should not be happening."

I felt the need to remind myself not to get comfortable with the situation because comfortability wouldn't bring change. To run a drill is to train for a particular reaction in a situation. A fire drill is designed to help people survive in the event of a fire, but not necessarily how to prevent a fire. An active shooter drill is to prepare us to protect ourselves when a shooter enters our school with an assault rifle that was specifically designed for mass killings. Trying to reassure students that they will be safer by practicing the active shooter drill is like you asking me to believe that we can remove all the water from the ocean floor with a cotton swab.

Before Uvalde, I had hoped that by the time my two-year-old sister was in high school like me, shootings would cease completely and she would be safe. Now that even elementary schools can't be trusted, my concerns for her starting preschool have skyrocketed.

I know I'm not alone in my concerns over our safety; however, I often feel helpless and unheard by the larger groups who are capable of making lasting changes. Instead of focusing on a reactive response, how about we start looking at ways to prevent further shootings?

I encourage parents, educators, community members, and everyone who comes in contact with a youth to be attentive. Listen to the needs of the children, care for them, attend to them, and seek help for them. After all, it does take a village to raise a child. Let's support each other so we can have a safer world for all.

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CONSIDERING THE PHENOMENON OF VIOLENCE IN BLACK AND BROWN COMMUNITIES

LAWRENCE STEVENSON, BS

ALEX L. PIETERSE, PhD

Introduction: The United States of America (US) has a long history of racialized violence including the abhorrent historical record of genocide perpetrated against Native Americans, the violence of slavery and lynching and stated sanctioned violence in the form of police brutality (Ihaza, 2020). Couched in this historical record is the individual and community-based violence and the notable role of gun culture within the US (Branas et al., 2021). The narrative associated with community violence and mass shooting often reflect dominant racialized narratives which in turn influence how society views and reacts to violence as it occurs both in regard to mass shootings and racialized communities (Doxbury et al., 2018). The following interview therefore documents the perspective of an individual involved in violence intervention.

Lawrence Stevenson (LS), BS, is interviewed by Alex L. Pieterse (ALP), PhD.

Lawrence Stevenson has worked for the last decade in areas of trauma response, racial equity, and violence prevention. He holds a BS in Psychology and Public Services from the Commonwealth Honors College at the University of Massachusetts Amherst. Currently, he is a Doctoral student in Counseling Psychology at the Boston College Lynch School of Education and is a Research Assistant at the Institute for the Study of Race and Culture. His research interest lay at the intersection of racial trauma and community violence.

Dr. Alex L. Pieterse is an Associate Professor and Director of the Institute for the Study of Race and Culture at Boston College. He received his Ph.D. in Counseling Psychology from Teachers College, Columbia University. Dr. Pieterse's scholarship focuses on psychosocial aspects of race and racism, racial trauma, and anti-racism training and advocacy. He is also a licensed psychologist and maintains a psychotherapy practice working with individuals and couples.

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Alex L. Pieterse: Please introduce yourself and provide your background?

Lawrence Stevenson: My name is Lawrence Stevenson. For the past 8 years, I have embedded myself in community working in Boston's urban neighborhoods providing on the ground mental health support for predominantly Black and Brown people.

In the beginning of my career, I worked as a therapeutic mentor and was a member of an in-home therapy team for young people struggling with a variety of different mental health issues including severe depression, anxiety, and Post-Traumatic Stress Disorder.

For the last five years, I have worked with communities of homicide survivors at the Louis D Brown Peace Institute In Boston. I served as a Survivor Support Coordinator and crisis manager for families and communities impacted by murder, trauma, grief, and loss. I sat with families 24 to 72 hours after homicide to provide psychological first aid, and stabilization and walk them through the funeral and burial process and then continue to walk with them on their healing journey as a community advocate and care coordinator. During my time at the Peach Institute, I received mentorship from leaders in the field like Chaplain Tina Chery, Ruth Rollins, and Lisa Fliegel. In this role, I also served as a member of the Boston area neighborhood trauma team, a network of providers who respond to homicide in the city.

I'm engaged in policy advocacy through the Massachusetts coalition to prevent gun violence, a coalition focused on advocating for legislative change for common sense gun laws, juvenile justice reform, mental health, and other legislation at the root cause of gun violence. I myself am a survivor of homicide– I lost my cousin and 2003, my older brother in 2017, and grew up in a community impacted by murder, trauma, grief and loss.

Currently, I am a first-year doctoral student in the counseling psychology program at Boston College. My primary research interest is on racial trauma and race-based stress, particularly how racial trauma intersects with the cycles of violence experienced by BIPOC people in America.

Alex L. Pieterse: How are communities of color responding to the growing number of mass shootings—at least "growing" in terms of media coverage?

Lawrence Stevenson: First, for context, I like that you said "growing in terms of media coverage." I don't know how the rates of mass shootings have increased compared to other forms of violence, but I do see it being broadcast more in the media. I think as a country we are in a political conversation about gun laws and safety and I think folks are becoming more aware that violence is a public health issue, which is important. I've noticed how as psychologists we are asking more questions about the impacts of mass shootings, because as a field, we have a history of directing our attention mirroring the current political topic of the day. I think engaging in this discourse is important.

At the same time, I challenge us to expand the conversation around mass shootings to include broader experiences of interpersonal violence. The fact is, mass shootings only account for a small portion of the overall number of homicide that happen nationally, while in urban areas whose residents are primarily Black, Latinx, or other people of color, such as Philadelphia, rates of interpersonal community violence are much higher, impacting many more people.

Alex L. Pieterse: To back up, what is community violence and how does it differ from Mass shootings?

Lawrence Stevenson: Community violence is a type of interpersonal violence in which one person causes harm to another or a small group of people. Such violence is not connected to a domestic dispute, but between people who belong to the same community. This type of incident is thought to primarily be associated with individuals in a "gang," which sometimes is true, but it also can occur between individuals in a community caught in general conflict. Mass shooting is another category of interpersonal violence that usually happens in a public setting in which one person will cause harm to four or more people.

Alex L. Pieterse: Why is important that we move beyond a discussion about mass shootings and center on the impact of community violence?

Lawrence Stevenson: It is important to center the experiences of survivors of community violence, because if not, we could perpetuate the idea of "good" victims versus "bad" victims. The reason mass shootings are so publicized is connected to society's acknowledgement that those victims are innocent—we see them as good victims who deserve sympathy and intervention. By comparison, victims of community violence are often stigmatized as having contributed to their own murder. Families of these victims often hear things like, "He was always hanging with the wrong crowd," and communities can buy into false narratives, like the idea of black-on-black crime. There is no such thing as black-on-black crime, only crimes of proximity. These narratives are racialized and paint communities of color as less deserving of sympathy or support. In other words, victims of homicide are seen as "bad victims" and this stigmatization is a major barrier from the issue of community violence getting the awareness and response it needs. Judy Herman talks about how "bearing witness" to the suffering of victims of violence is the most essential pathway toward healing for those victims. As a society, centering on those most impacted is not only how we support the process of healing, but it is how we begin to reverse injustice.

Alex L. Pieterse: What do you view as the primary source or cause of community violence?

Lawrence Stevenson: I believe the primary cause of community violence is racial and systemic oppression and the systemic abuse and violence into which people of color are born. Oppression, by it's nature, is a form of violence. As such, when people are born into oppression, they're born into cycles of violence. Systemic oppression creates an environment where people are in a constant state of extreme mental unrest. This pervasive trauma can cause bodily responses that mimic those

in war zones. People in war zones will move like they are in war zones out of protection.

Additionally, systemic oppression can lead to the internalization of dehumanizing messages like Black men as "super predators." This internalization of dehumanization can lead to a situation where someone does not think twice about the consequence of putting their life or freedom at risk.

Alex L. Pieterse: What are the current systems of support set up for families and communities impacted by community violence?

Lawrence Stevenson: Nationally, there is the HAVI network (Health Alliance for Violence Intervention), which is a national network of hospital-based violence intervention programs. However, many communities around the country have a mix of community-based and hospital-based intervention systems that support survivors of homicide. In Boston, there is a network called the neighborhood trauma team, and this trauma team responds to violence on the family level and the community level. On the community level, there's a homicide a group of responders that will come on the scene and conduct Psychological First Aid for any witnesses in the community who might have witnessed the crime and are given a number for the Hotline, a 24-hour service that connects individuals impacted by witnessing community violence to emotional support. In the days after a shooting, the NTT canvasses the neighborhood where they go door knocking to ask people if they have been impacted and provides them with stabilization and a list of resources. On the family level, after a homicide, the first line of support is hospital-based programs. The hospitals provide the families compassion, provide them with basic next steps, and then gives the family information for the primary community-based program, the Louis D Brown Peace Institute. The Peace Institute is recognized as the hub for emotional and practical support when it comes to community violence. While at the Peace Institute, families will meet with a survivor support coordinator in the first 24 to 72 hours after homicide to receive emotional and practical support. Survivor Support Coordinators will ensure that families are connected to the network, police officers, and their assigned victim witness advocate within the court system. Coordinators will also fill out victim compensation and help them navigate the funeral process. After the crisis management period is over, the Peacei institute will stay on as a case manager and make referrals to other community based programs, health centers, and clinicians for ongoing support and trauma/grief intervention.

Alex L. Pieterse: What do you see as essential knowledge for responding to violence within the Black community? How does bearing witness play a role?

Lawrence Stevenson: I think it's important to understand trauma and how trauma can impact individuals and communities. I think it's important to understand the primary elements of grief, and how they impact individuals as well as communities. When someone loses a loved one to homicide, it breaks their ability to trust, which makes the first and primary role of the clinicians

and helpers to support that person in redeveloping their relationship with trust and empowerment. This happens through being honest with survivors, making commitments and keeping them, and setting strong boundaries. I think it's important to understand that these families are experiencing the weight of a variety of systems of oppression. As such, the most helpful role a clinician or helper can take to support their survivor is by helping navigate various systems. This might look like writing a letter of support, showing up to a provider's or a DCF meeting, and processing challenges that they face when trying to interact with systems like the court or education system. For instance, does your survivor know that it's important that they get the name and number of the person that you last talked to before leaving the phone call? Or the survivor might say something like, “These systems don't help me,” and you might help them to process that by going a little deeper into what it mean to receive help from a system, and what it means to keep having to trust or keep making the effort to utilize systems, because they have the resources they need. And when systems do let survivors down, it can be the role of the practitioners to convene providers and hold systems accountable. Lastly, when it comes to individuals, make sure that you are using interventions that are rooted in community healing and cultural responsiveness.

Alex L. Pieterse: What opportunities do researchers and practitioners have to respond on the community and systemic level?

Lawrence Stevenson: On the community level, I think it is critical to get involved in some of those local coalitions and networks and find out who in your community is doing that work. I know just by working in the field it's been hard to find clinicians who are accepting clients, so being present for those organizations. In a similar vein, are there opportunities to provide forums on what it means to be traumatized, and get psychological first aid as it responds as it relates to trauma and grief? Are there community forums where people who are experiencing violence or who are reactive to the news and how mass shootings are being portrayed in the news and getting support or psychoeducation? On the systemic level, I think psychologists can contribute to advocacy for common-sense gun laws and legislating change as it relates to root causes of violence: Thinking about juvenile justice reform, and getting on coalitions, getting involved with “March for Our Lives” and talking to local officials about what laws they're trying to pass that support liberation of community. Are there skills or research findings they can provide to support the legislation that supports legislative advocacy? At a systemic level, researchers and psychologists can contribute to research projects that address how Black communities and communities of color are impacted by gun violence and how practitioners can continue to respond—and use best practices—for families and communities impacted by murder, trauma, grief, and loss.

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Working with the Queer Community: An Interview with Jess Stahl

JACQUELINE GAGLIARDI, MA
Editorial Team – *New England Journal of Relational and Systemic Practice*

Jacqueline Gagliardi: Hi Jess. Congratulations on the LBGTQIA+ concentration you developed. I am curious both about the concentration and information that would be helpful when working with LBGTQIA+ clients. How many courses are required and what does the content of the courses look like?

Jess Stahl: Thank you so much, Jackie! I'm happy to talk about both the concentration and best practices when working with LGBTQIA+ clients. Our concentration is available to students in all programs at William James College (PsyD in Clinical Psychology, MA in Clinical Mental Health Counseling, MA/CAGS in School Psychology, MA or PsyD in Organizational & Leadership Psychology). The concentration includes 3 required courses, 3 credits each, for a total of 9 credits. Courses are offered synchronously via Zoom to make them more accessible to students from different programs with varied schedules. All courses are also open to all students as single electives on a space available basis.

In the *Foundations in LGBTQIA+ Mental Health* course, students become knowledgeable about current research regarding LGBTQIA+ affirmative research and practice in the fields of counseling, psychology, and education. This course addresses relevant LGBTQIA+ historical context, the impact of LGBTQIA+ identities on lifespan development, and common issues faced by members of the LGBTQIA+ community and their families.

In the *Interventions When Working With LGBTQIA+ People and Their Families* course, students learn about specific therapeutic approaches when working with members of the LGBTQIA+ community and their families. The course begins with a broad discussion of treatment issues when working with this population (e.g., disaffirming therapy, evidence-based professional practice, affirmative counseling). Subsequently the literature on best practices for working with subgroups within the LGBTQIA+ population (e.g., gay men, lesbians, bisexual & pansexual people, transgender and gender non-conforming people, intersex people, asexual & two-spirit people, among others) is discussed.

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Finally, in the *LGBTQIA+ Intersectionality, Public Policy, and Advocacy* course, students learn about the intersectionality between LGBTQIA+ identities and other minority identities such as race, social class, immigration status, veteran status, age, and disability. In addition, students learn about how to be effective social justice advocates for the LGBTQIA+ community (i.e., channels for advocacy and effecting and/or promoting public policy).

Jacqueline Gagliardi: It sounds like a great program. I read on the WJC site that LGBTQIA+ individuals are between two and four times more likely than heterosexual and cisgender individuals to experience mental health problems or to seriously consider or attempt suicide. This is a profound number compared to heterosexual and cisgender individuals. I am wondering what you think some of the issues are that contribute to such a high number of mental health problems, compared to heterosexual and cisgender individuals?

Jess Stahl: We are really excited about this concentration and the services our students will be able to provide to this very underserved population.

Although there are probably lots of answers to your great question about the suicide risks for LGBTQIA+ people, the impact of stigma (Frost, 2011) and minority stress (Meyer, 2013) are most often cited as causes. Basically, these theories describe how LGBTQIA+ people, as members of a marginalized group, routinely experience stigma, along with environmental and external stressful events as a result of their LGBTQIA+ status (e.g., discrimination, microaggressions, stereotypes, etc.). The anticipation and expectation of the stigma and stressful events can result in vigilance, hiding one's identity, and/or avoidance of experiences where one might be rejected. This can mean that LGBTQIA+ people have fewer sources of support to reach out to when they are feeling distress. Also, negative attitudes and prejudice from society are internalized which effects individuals' ability to cope with stressful events and reduces resilience in the face of negative events. In short, LGBTQIA+ people are much more vulnerable to suicide and metal health issues because of their experiences with chronic stress and marginalization.

Jacqueline Gagliardi: What may be helpful information for clinicians to be aware of when working with an LGBTQIA+ client?

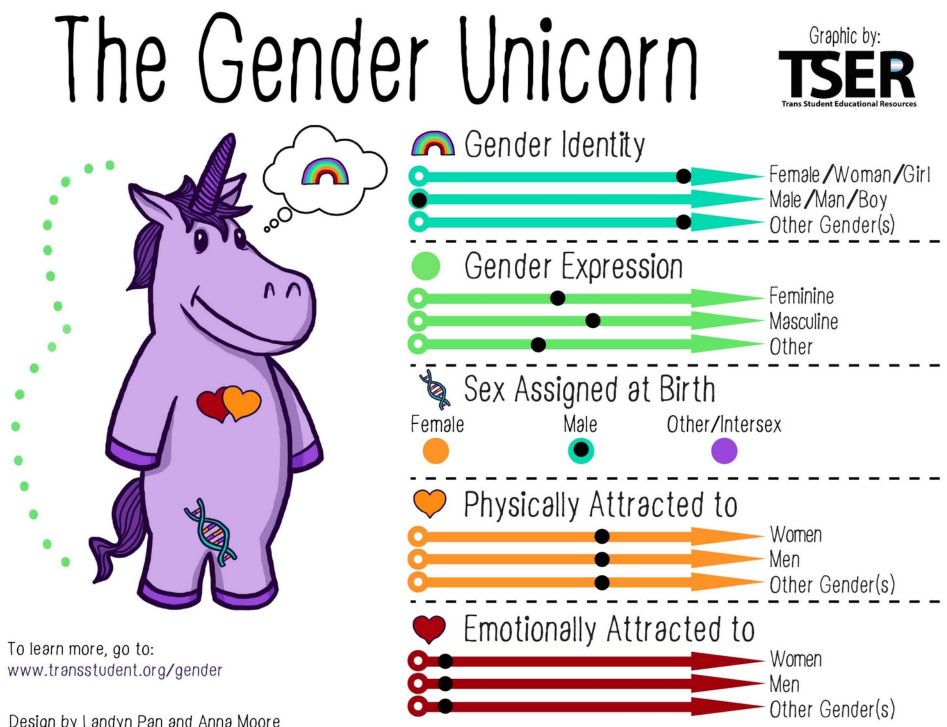
Jess Stahl: That's a big question, and the one that is really the crux of the 3 courses in our concentration. But as a starting point, I think it is very important for clinicians to know the ways in which sex assigned at birth, gender identity, gender expression, and emotional, physical, and sexual attraction all differ and operate independently. A great infographic that depicts these differences is the Gender Unicorn (Trans Student Educational Resources). It is important especially when treating clients who identify as transgender or gender non-conforming that clinicians use the name and pronouns that the client uses for themselves. Clinicians can have items for these things on intake forms or just begin sessions by introducing themselves with the name they want clients to use for them, identify their own pronouns, and then ask the client for their names and pronouns. Doing this routinely with all clients is a way of making it clear that one is not making assumptions

about a client's names/pronouns based on their presentation.

The next thing that is important for clinicians to know is the importance of providing an affirming space for clients. Affirmative LGBTQIA+ counseling is an approach that views of LGBTQ identities and relationships positively and addresses ways in which LGBTQIA+ clients' lives have been negatively influenced by homophobia, transphobia, and heterosexism. Affirmative counseling is needed because of the stigmatization and oppression experienced by LGBTQIA+ people. It begins with general multicultural competence. Related to LGBTQIA+ identities specifically, this means awareness of one's own privileged and stigmatized identities as well as one's biases as they relate to gender identity and sexual orientation. It also involves knowledge about and recognition of affectional and gender development as life-long and normative, attending to the intersectionality of client's identities, placing the counseling relationship in the social/historical context, and acknowledging power differences between the client and counselor. In terms of skills, the affirmative counseling approach involves understanding and resisting heterosexism/cis-sexism and heterosexual/cisgender privilege, combating LGBTQIA+ microaggressions when they are encountered, and celebrating the experiences of LGBTQIA+ people. The goal is to work collaboratively to foster wellness and empowerment through clinical interventions, advocacy and social justice work (Ginicola et al, 2017; DeBord et al., 2017).

Jacqueline Gagliardi: Thanks Jess that is useful information. Would you speak a little bit more about the Gender Unicorn. What exactly is it?

Jess Stahl: Below is the image of the Gender Unicorn. It depicts the definitions of terms related to gender and sexual orientation.



Regarding gender, sex assigned at birth is depicted with DNA at the genitals to represent how typically one's sex assigned at birth is determined by a combination of anatomy, hormones, and chromosomes; the assignment given is usually male, female, or other/intersex. For people who are intersex, there is some component of anatomy, hormones, and chromosomes that does not "match" or clearly fit with either male or female (e.g., individuals who are born with XXY chromosomes or androgen insensitivity syndrome in which one's chromosomes are XY but one's body does not respond to testosterone in utero and thus genitally appears female at birth). Gender identity is depicted with a rainbow from the unicorn's head because gender identity refers to one's internal sense of how much one is male/man/boy, female/woman/girl, and/or another gender. Finally, gender expression/presentation is depicted with green dots around the unicorn's body to represent the physical manifestation of one's gender identity through clothing, hairstyle, voice, body, shape, etc.

Sexual orientation is depicted by two separate hearts – one for physical attraction and the other for emotional attraction. Sexual and emotional attraction can operate independently from one another, and one can be sexually or emotionally attracted to men, women, and/or other gender(s).

It is important to know these distinctions because our culture typically assumes that these different components of identity "match" in some way, i.e., that those who are assigned male at birth identify as male, express their gender as male, and are emotionally and sexually attracted to women. However, we know from LGBTQIA+ people that knowing one of these components of identity for someone has no bearing on the others.

Jacqueline Gagliardi: Thanks, Jess, this is so interesting. I am wondering how a clinician might utilize this image?

Jess Stahl: The image was developed for psychoeducational purposes, especially in teaching people (clinicians as well as the general public) about the differences between sex assigned at birth, gender expression, gender identity, and sexual orientation. So, it can be used clinically to provide psychoeducation.

However, it can also be used to help clients explore and verbalize the ways in which they identify. For example, we can ask clients to place a mark on each line that best represents how they identify in this moment. We can also explain and acknowledge that any time we complete the Gender Unicorn, it is really just a representation of how we feel in this moment because all of these identities can fluctuate. That is why they are represented by a continuum. This can be very validating and reassuring for clients who do not identify as heterosexual and/or cisgender because our culture really teaches that gender identity and gender expression should match sex assigned at birth, that one's gender identity (and to a lesser extent gender expression) should be stable, and that sexual orientation is a unidimensional construct in which heterosexuality is assumed.

Jacqueline Gagliardi: This seems like a helpful image for both the client and the clinician. It also seems like it would be useful when working with the client and their family. Jess, I was wondering if you have advice for clinicians who are working with parents who children at a young age are expressing they want to be or dress like their opposite sex assigned at birth.

Jess Stahl: Yes, the Gender Unicorn is an image that can be helpful in a number of ways.

That is a great question about working with a family with a gender non-conforming child. The best advice we can give anyone close to or working with a gender variant child is to provide that child with support in their gender-related exploration and identities. For many families this begins with providing psychoeducation about the differences between sex assigned at birth, gender expression, and gender identity. In addition to discussing the Gender Unicorn, we can talk with families about how it is normal for children play with gender expression, and it is a cultural construct that specific expressions are associated with a particular sex assigned at birth. We can also provide psychoeducation about the impact of parents' supportive vs. rejecting behaviors on the well-being of their gender non-conforming child.

SAMHSA has an excellent free and downloadable resource guide for helping Families Support their LGBT Children (SAMHSA, 2014). I really recommend that clinicians read it. That guide reviews research which indicates that family support is protective against youth suicidality, depression, and substance abuse. Family support also promotes social support, self-esteem, and overall health. Rejecting behaviors significantly increase the risk of negative outcomes for youth, including depression, suicide, substance abuse, and other health risks. Even when families have beliefs that conflict with acceptance of LGBT identities or behavior, we can meet families "where they are," and join with them in the common goal of protecting the well-being of their child.

Jacqueline Gagliardi: Thanks, Jess, for the resources. My last question has to do with therapy with LGBTQIA couples. I imagine they come for various issues. Do you have any suggestions when working with this population?

Jess Stahl: You are very welcome! Yes, LGBTQIA couples come to therapy for a wide range of issues, many of which are similar to what heterosexual couples struggle with (e.g., parenting challenges, intimacy issues, managing finances, managing relationships with extended family, etc.). However, there are several unique things that should be taken into consideration when working with LGBTQIA couples (Patterson, 2017).

First, it is important to think about the legal situation of LGBT couples. The Supreme Court decision Obergefell v. Hodges (2015) legalized marriage equality nationwide, and this provided married same-gender couples with the same legal rights as cisgender-heterosexual couples. However, as we discussed earlier, the minority stress model indicates that LGBTQIA+ couples still routinely experience discrimination and microaggressions, which can put additional

strain on relationships. One area in which legal protection for LGBTQIA+ people varies quite a bit is in relation to workplace discrimination. Although many states and jurisdictions do prohibit discrimination on the basis of sexual orientation and gender identity, some only have protections for sexual orientation (but not gender identity), and some do not have protections for either. (The Human Rights Campaign and the Movement Advancement Project have great maps depicting the protections in each state.)

In places with fewer workplace discrimination protection, and in places with legislation aimed at limiting the legal rights of transgender individuals, how open or "out" to be about their relationship and their identities is a central issue for couples. Each member of the couple must consider how safe it is to be open about their identities and their relationship status in each of the settings they are in. Based on the way they are each impacted by the legal landscape, in addition to the individuals' own histories around their minority identities, members of the couple may disagree about the costs and benefits of disclosure. Negotiation of these issues related to disclosure is something that couples therapists should attend to.

Regarding division of labor, one thing to be aware of is that same-sex couples are generally much more egalitarian than heterosexual couples. It is much more common that both members of the couple equally participate in both paid and unpaid labor. In addition, household tasks tend to be divided on the basis of preference and skill, rather than by gender.

Although negotiations about sexuality and intimacy are common for all couples, it is important to be aware of cultural values within the LGBTQIA+ community that impact these issues. Specifically, lesbian women most often favor monogamy as the standard for couple relationships, while gay male couple may be less committed to monogamy and may make explicit agreements that permit non-monogamy within the context of their relationship. In general, these agreements have not been found to impact relationship quality.

Finally, as couples look at parenthood, there are many unique issues to consider. Couples will first need to agree how to have children (i.e., try to have biological children vs. adoption or fostering). If couples want to have biological children, then they must decide whose genetic material will be used to create each child, how to obtain the genetic material they do not have within their relationship (e.g., how gay men will find eggs and how lesbians will find sperm), and in whose body the child will be gestated. State laws vary in terms of how favorable they are for surrogacy, which may be an important consideration for gay male couples. Lesbian couples may have to navigate finding sperm banks that are willing to work with them, as some may not. If the couple wants to adopt or foster children, they may have to navigate laws that prohibit same-sex couples from adopting children or being foster parents. Once they announce their prospective parenthood, couples may be faced with intrusive questions from others about how their family was created or which parent is the "real" parent. In some situations, only one of the adults may be given legal parental status. Thus, many same-sex couples who did not become parents via adoption

may choose to do second-parent adoptions of the children they planned and conceived together because adoption papers have stronger legal standing regarding parenthood than do birth certificates. When couples live in jurisdictions that are less favorable to them as parents, they are faced with the question about how to navigate the laws in their jurisdiction or moving to a jurisdiction with more favorable laws. For example, couples need to consider where they will feel safe as a family, where there may be other families like their own, schools that will be inclusive of their family configuration, etc. All of this inevitably causes additional stress on couple relationships, and attending to all of these questions is paramount to effectively working with couples.

Jacqueline Gagliardi: Jess, thanks so much for this information and your program seems extremely interesting. I appreciate you taking the time to meet with me and share this valuable information.

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NEJRSP
NEW ENGLAND JOURNAL OF
RELATIONAL & SYSTEMIC PRACTICE

EQUITY IN THE AGENCY EXPERIENCE: SUPPORTING SUPERVISORS IN COMMUNITY MENTAL HEALTH CENTERS

JALESA FRYE, MA; RACHAEL GAY, MSW; JEREMIAH GIBSON, MMFT; AMELIA HASBUN, MA; PORSCHE LOCKETT, MA

Editor's Note: This transcript was recorded on August 17, 2022 as part of NEAFAST's year-long series Equity in the Agency Experience. Porsche Lockett, MA, was the facilitator for this conversation.

Jeremiah Gibson: I'm Jeremiah Gibson. I'm the Executive Director for the New England Association for Family & Systemic Therapy (NEAFAST). Thanks so much for joining our monthly conversation about how we, as a group of mental health practitioners can influence, impact, and hopefully improve the practice of mental health currently being practiced by those in a multitude of settings. This is a workshop that focuses specifically on agency clinicians.

Many of our agency clinicians are new therapists, recent graduates with Masters degrees, so these are folks who have unique needs around training, getting used to the ins-and-outs of the work, maintaining a professional caseload, and working with a diversity of clientele. And that's before we get to the standards and requirements put on them by MassHealth, documentation standards, the productivity model, and other topics that we have discussed and will discuss in Equity in the Agency Experience.

Central to and overseeing all of this are clinical supervisors. Supervisors play such an important role in the functioning of agencies. I want to introduce you all to our panelists: Rachael Gay, Jalesa Frye, Amelia Hasbun. I'm going to join this panel too because I have a few years of experience in supervision at South Bay. And our facilitator for today is Porsche Lockett.

Porsche Lockett: Thank you so much, Jeremiah, and thank you so much for everyone attending today. I am Porsche Lockett. I am a Clinical Supervisor at The Home for Little Wanderers. I'm a Licensed Mental Health Counselor and I'm also in private practice as well.Today we are going to consider several questions from the lens of the clinical supervisor. And so, the first question that I have for our panelists is: What are some of the trainings you have received to become a supervisor?

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Jalesa Frye: Hi, everybody. My name is Jalesa Frye. I am a Supervisor at The Home for Little Wanderers in Boston. I've been a Supervisor there for four years now. I will have to say when I first started, I actually did not receive any training at all. I transitioned from my previous role as an IHT Clinician, In-Home Family Clinician, and I was put into a supervisor position. It was kind of sink-or-swim at that point. When I began I was given a supervisors' training which was more like how to be a manager, how to support staff and company policy, with the goal of ultimately finding one's management style. So, it was more about finding who you are as a manager, what your style is, and how you can be respectful of everybody's style that you're managing and be able to identify those styles. And so, that training was provided by The Home for Little Wanderers I would say about two years into my position. And that was my training.

Rachael Gay: I can jump in. My name is Rachael, I'm also at The Home for Little Wanderers and have only been a Clinician Coordinator for one year. I think that interestingly my experience feels pretty similar to Jalesa's and it was four years later. I will say that my training did come right when I started. I think that training was built out by our training program and, again, echoing what Jalesa's shared, a lot of the training was how to be a manager, and I had to seek additional trainings elsewhere for how to engage in clinical supervision. I had good clinical supervision and good models for that but no training on how to develop that style on my own. We do have one online training that's offered on reflective supervision practices which is a practice we embody at The Home. That was just one online training that I took.

Amelia Hasbun: I'm Amelia. I was in community mental health at Behavioral Health Network for a few years. And then I actually left from there and I'm now in a group practice that had independent contractors but we moved to a system where now it's a bit different, and people now have salaries and things like that. I was given the opportunity to do supervision, something I had never done before. I'm brand new and I did not receive any training and I have been figuring it out along the way. But, thankfully, because of CANS, I would get emails alerting me to CANS training, and I have been doing them. And so, one of these training sessions included the Assessment in Clinical Understanding, which was very helpful, as it connected me with other clinical supervisors, so we were able to collaborate, and support each other. And so, I went through that training to review my own ways of assessing and then also to help supervisees with their assessments.

Other than that, I have been on my own. I do seek supervision from other supervisors that I've had in the past, which has been immensely helpful; I stay in touch with an LMFT Supervisor who retired from Behavioral Health Network. We regularly meet, and she kind of gives me a lot of guidance. And then, in relation to paperwork and figuring out how to get guidance around that, I do have somebody else that I work with within the practice where we're trying to figure out ways to make the paperwork more efficient. Ultimately getting the necessary guidance has been very challenging.

Jeremiah Gibson: Hi everyone, my name is Jeremiah Gibson. I worked at South Bay for seven years, three years as a therapist, In-Home Therapist, and then four years at the Dorchester office as a Supervisor. My role was a little bit different: South Bay had a distinction between Administrative Supervisor and Clinical Supervisor. So, I was technically on the books but not really paid staff or anything like that. I got 1099s, not W-2s, and was seen as a consultant. So, one of the things that I think will be important for us to talk about as we go along is the distinction between clinical supervision and administrative supervision. I strictly did clinical supervision; I didn't oversee the paperwork or any of the documentation standards that agency workers have to oversee. Thank goodness, because that is not my gift.

Regarding the training, I did not receive any training from the organization, but I did five years ago the American Association for Marriage & Family Therapy (AAMFT)'s approved supervisor training which I took at a weeklong conference at the AAMFT Conference in Atlanta. And that was a 30 CE program, 15 face-to-face, 15 internet. It was a really good training program but I had to pay for it out-of-pocket since I wasn't a W-2 employee at South Bay. The supervision training at AAMFT tends to focus a little bit more on the administrative supervision stuff: how to oversee documentation and the like, and less so around how to help clinicians conceptualize cases, how to address transference, countertransference, self-of-therapist issues, things like that. Like the other three panelists, I was much on my own for that.

Porsche Lockett: Thank you for that. So, the next question I want to ask is: how did the training you received, or lack of training you received impacted how you function as a supervisor today?

Rachael Gay: A lot of how I show up as a clinical supervisor comes from an eclectic approach, because it's being pulled from different areas of learning. I had multiple supervisors, as is often the case in community-based work, the result of high turnover. And I'm wondering, "What did I appreciate about this person as a supervisor, and how do I want to bring that into my own practice?" So, I think the modeling I received from other skilled supervisors and how I want to show up in that is the most helpful.

I also think it invites our staff to give us the feedback about what is, and is not working for them; I think that has been more the primary model, on-the-ground learning exploring what didn't go well this week, and then focus on following up in our next meeting," versus, being equipped with a toolbox of things that I bring every week. It feels more like I'm adapting my style as I go.

Amelia Hasbun: I would add that not having consistent supervision training meant that I was essentially changing what I'm trying week to week. In some ways it reminds me a little bit of graduate training where you're learning about different models and you're trying something different depending on that week's teaching. And, depending on the feedback that I get from my former supervisor—and, again, I see her about once a month—I kind of head into the next month

trying different things. So, I suppose it's like trial-and-error; definitely not that efficient of a way of doing things.

Organizing clinical tools for clinicians has also been very challenging. I guess I feel like I'm going in a lot of different directions at once because the paperwork aspect gets mixed in, and trying to help clinicians with their paperwork and meet standards with their paperwork—that's a huge chunk. And then, of course, dealing with clients and everything that comes up with them, and fielding client calls that come in when they're not comfortable talking with their clinicians. And then, helping clinicians in accessing trainings that they want to pursue that I may not know about, and also, when they're expressing interest to me that they want more supervision in a particular model that I'm not too familiar with, and trying to find resources for them or refer to somebody else that I may know that they can consult with.

So, again, all of this to say, I guess I just find myself being pulled in a lot of different directions and trying to figure out: "How can I best balance this? How can I build a relationship with these clinicians? How can I build trust with them? How can they come to me and know that I support them and I care about them genuinely? Also, how can we get your paperwork done? And for it to be correct? And how can I hold you accountable for that? And how can we help your clients?" So, it's just being pulled in so many different places.

Jeremiah Gibson: Yeah, that's a lot of different roles. Hats off to you, Amelia, and Rachael and Jalesa and Porsche for navigating all of the components of supervision that you do. I got lucky that my role was strictly limited to clinical work. And even then, my experience was that the agency kind of cut me loose and didn't give me very much oversight, which I think is both confident-building, and I look back at the Jeremiah of five years ago and I'm like, "Y'all are crazy for trusting me as much as you did." Because there's a lot of wisdom and skills that I've picked up in the last five years that I would do a lot differently: everything from thinking and conceptualizing casework differently, to including conversations about race and class and gender into conversations. I did receive supervision of supervision as part of AAMFT's process through my boss. That was helpful. I recorded a couple of my supervision sessions. Those were painful to watch, as all recorded evaluative work should be. So, those were helpful. And then also I was in supervision as a Certified Sex Therapist towards the second half of my time at South Bay. So, I really paid attention to the way that that supervisor connected with me, built supervision structures, and then toward the end of my time at South Bay, I tried to model that. But I didn't really have any sort of checks and balances or too much oversight of that.

Porsche Lockett: So, the next question I have for you all: When there's a crisis within communities of color, how do you respond to the clientele and to your employees that have been impacted to support them in that time?

Jeremiah Gibson: Can I share a story of what not to do? So, five or six years ago, there was a big opioid crisis and attention to the opioid crisis that was happening on the Cape. And the Cape is primarily in working class white communities. And so we watched a documentary in one of my groups. And I'm thinking, "Oh, I'm doing really good. I am talking about a really important topic and bringing film into it." And one of the members of my group, as an African American woman, raised her hand and pretty angrily, understandably, said, "Uh, Jeremiah, the opioid epidemic, heroin epidemic, has been impacting my Black communities for years and years and years. And you're only showing this video because this is something that's impacted white communities and now it's finally getting attention." And I'm like, "Guilty." And at that particular time, I had very few resources and people in my life to talk about the intersectionality of issues, in this particular instance, substance use within different sectors, different types of community. And then I also failed to consider media coverage and the way that our professional communities talk more about things that happen in white communities and not much about things that happen in non-white communities. So, I wanted to out myself to begin that conversation.

Jalesa Frye: So, I think as a supervisor of color who mostly supervises clinicians not of color, I see where the clinicians and clients are, what perspective and lenses they're bringing so that when they go into the homes they're not doing more harm. So, that might be checking their biases or sometimes being the person that they have to ask questions to—things that they might not know. And while I do not own the Black experience for everybody, I do try to give perspective that they might not have so that they're not using their families as a knowledge-base. I try to give them whatever context I can and just supervise them the best way that I can so that they're not going into Black and Brown homes doing more harm or feeling that white savior complex and bringing that into homes of people of color.

Rachael Gay: It's interesting we're at the same agency and just the opposite where as a white supervisor, all of the people I supervise are people of color. And so, I have found, doing a lot of checking on myself of when I'm showing up in white saviorism, asking myself: "When am I not naming things that need to be named?" I think for a while, my team and I were processing and naming a new thing that is showing up. And my team and I got to this moment of like, "We appreciate you naming it, and trust us when we bring it to you and share when we want this centered in our experience". I think that was a really helpful learning moment for me. I know a couple of months ago around where there were a few mass shootings, I was continuing to name it and advocating to the higher-ups: "How are we giving productivity reductions? Like we are expecting people to show up at work when communities of color are being harmed everyday?" I think it was an interesting learning moment to learn my staff didn't ask for that, they will let me know what they're asking for.

And so, it's this balance of: "How are we making agency-wide decisions and also making those decisions informed by our staff too and not centering voices that are like mine?" And I think, too, when my staff are working with white families that is a unique position to be in for myself of

naming, "How can I show up in support for those white families? And how can I step in to, you know, do some of that labor that might not be yours to hold and shouldn't be yours to hold?"

Amelia Hasbun: I think there are so many different things that come to my mind with this. It's really important to me that we have some kind of a space to talk about things if we want to. Ideally, I was hoping people where I'm working right now would want to meet as a group to be able to talk about difficult things. People didn't really seem to jump onto that idea, but we do have an online thread for tragedies. I put on this thread things that are happening in hopes that people will respond. Out of all of the threads, I am the only one, except maybe two other emails. So, what I'm noticing is a lot of people aren't feeling comfortable to talk about difficult topics, especially when it comes to tragedies within communities of color. And I think that within individual supervision, I'm noticing people are a little bit more comfortable to talk about challenging things if I bring it up. I wish that this could be a bigger conversation that would include all of us, but there seems to be some kind of tip-toeing.

I've also been struggling some with the goodness of fit for clients and clinicians and wanting to be respectful that: "Ok, yes, we can all push ourselves, and technically a clinician can address some of this stuff with clients if they're being triggered in a way that might be appropriate. But do they have to and do they need to and do we need to be putting clinicians through that? Not really, I don't think. So, what else can we do to support the clinician and make sure that as a whole we have their back too and knowing that, no, you are not going to be assigned someone different because you're not happy with them for this reason, you know? That's really not okay.

What I'm noticing is a lot of clinicians just questioning what's ok and not ok to bring up with their clients. I don't think that there are too many rights or wrongs, but I think that people deserve to not be traumatized by their clients and to have some space to do what's right for them and to protect themselves in some way. And I don't think that a lot of the time clinicians do protect themselves; we're usually kind of thinking about the clients first. But there's also a line with that I feel.

Porsche Lockett: Thank you so much for sharing all of those wonderful perspectives. I think those are so awesome. I would like to add to what Jalesa and Rachael have shared because we are clinical supervisors at the same location. I am a clinical supervisor with a whole team of people of color. Although we are all of color, we're all different backgrounds; we come from all different experiences and different impacts in society—which one, is something to account for. The second piece is as a therapist of color, as a woman of color, and as a clinical supervisor of color, there are moments that are large and big for people.

So, when we have tragedy, I can say that myself—and I can speak for the folks on my team—that sometimes we have just been so overexposed and oversaturated with these experiences and

with these moments in our communities where we have learned how to move through space and time and keep going. We may look up: "Is there anything I can do? Nope, okay, keep moving forward." And sometimes there's space where that's not healthy because then there's a portion of hurt trauma that is not being worked through. And then there's a time when it's like, "This is normal. This happens often." And sometimes the response from others is shock:, "Oh wait, this is an experience that you feel often? This is a pain that you feel often? And you still have to move through the world in a way that does not allow you to take space and time?"

And so, for me as a clinical supervisor, it's helping my team first, check in, "How are you feeling about this? Where are you? Do you need to put it on the shelf, leave it on the shelf? Do you need to look at it? And also, then what do you do for your families? Are they wanting to talk about it? No? Ok, was it someone that they knee? Did it happen in their neighborhood? Is it scaring them from going out into the world?" And so, those are the questions that I ask my team. As a supervisor of a team of color I am always taking their pulse: "Ok, where on the scale or on the spectrum are you with this?" So, I just wanted to add that third component with having the other two perspectives of my colleagues as well.

So, we have a few minutes before we wind down. So, I would love it if you all could add a tip or snippet that you would pay forward to a clinical supervisor—someone who was in a position of training others—that you feel like, "If I had had this little nugget beforehand this would've really been great."

Jalesa Frye: I think if I had been trained more to manage conflict. Let me explain what I mean by that. When you have a team of people, people might witness something and think one thing. Then, rumors and perception starts to come in, and people hold a perception that is not accurate, and then that inaccurate perception causes conflict. And as much as you would like to tell your team like, "What is happening is being managed between that person," you can't give details, as much as they want, because it's private amongst that employee. And I think at times that causes a lot of conflict because people don't see what's going on behind the scenes; all they think is, "Well, this person is doing this," and then that creates conflict within trying to manage all of these different people and the perceptions that they have. And so, I wish that I knew three years ago how to do that. I wish that there was training or something around managing conflict.

Amelia Hasbun: I think that this is going to sound very basic, but for me it's true. I think just looking back, I wish that I had been meeting clinicians just as a person-to-person and joining with them just like I do with my clients more. I'm so new to this and I think that speaks to how much training I need. Just thinking of models of supervision and joining with your clinicians and getting to know them a little bit and building a relationship first before anything else so that when there are experiencing a crisis of some kind, we have something to pull on, and that we know a little bit about what helps us get through the day and coping strategies within their family or whatever that might be. There are people that can help them, and it's important to know a little bit about the

support system that's available.

I think I gave in a lot to the pressure that is built into the system, "Figure this out and get their paperwork done and have it meet this criteria now," that I skipped over thinking, "Oh yeah, I can build these relationships. It'll happen over time." But really, it won't because then I'm going backwards and am often left wondering, "Well, what are you going to do to take care of yourself tonight?" But had that all been built in from the start, and I had given myself permission to slow things down, then we could think about balancing the needs of the individual, and the system a little bit more gracefully.

Jeremiah Gibson: I definitely second, Amelia, your comment about community: find community, build relationships. One of the things NEAFAST has invested in for the coming year or two is building more peer consultation groups, and I'm highly invested in having one of those consultation groups being for supervisors. To add to that, I would encourage folks to say that the needs of your clients and then also the needs of the therapist supersede the needs of the agency. I'm told this is why I was never hired as an administrative supervisor, because that's not a particularly popular opinion within the agencies; I think my organization knew that I had that perspective but kind of still wanted me to be a part of their team. Figuring out how to navigate that the needs of the client, the needs of the family system, the needs of the therapist are going to clash with what the agency needs and encouraging folks to lean into what's best for the family system and the therapeutic relationship.

Rachael Gay: I would probably say that learning that feedback and evaluation is a two-way street. Maybe evaluations are on the mind because it's staff evaluation time at our organization, but I think agency structure creates so many opportunities for supervisors and managers to give our staff feedback and very little opportunity for staff to give feedback to supervisors and managers. And I think creating multiple avenues to do that can reduce the power dynamic of the fear of, "Do you have any feedback for me?" That's a scary environment to give your supervisor feedback, so I've been looking to really lean into supervision reflection forms and utilizing reverse evaluations, which can be another task in a busy week. I think I supervise a team of experts in what they do as well and so, I'm no expert and I just value their feedback. And it's not just that we're supporting them; it's that they're supporting us as well.

Jeremiah Gibson: Can I ask a question to the group? And, Porsche, I'm curious about your feedback on this, too. If there is one element of support that you wish that your agency gave you in being a more effective supervisor, what do you wish that element would be?

Porsche Lockett: One, I will say that this is my first official position as a Clinical Supervisor and so honestly I feel very lucky. Rachael, Jalesa, and two of our other colleagues and myself: I think that we're a wonderful team. I went into this work wanting to give back to clinicians so that more clinicians would become licensed so that we would then have more licensed clinicians to provide more help and care for people. So, for me it has been a really good experience as far as community

work. And I know that that's not necessarily always the case, and I know working for organizations can be hard. I support what Jeremiah says about clients and supervisors being priorities and I find that to be very important.

However, the other piece that I find difficult is being in community is in private practice. That solo part and having a clinician who might be contracting for me, I have found that kind of clinical supervision work a little more difficult because I am the agency and I also care about your wellbeing and I also care about the client. And so, that feels a little bit more stressful for me as opposed to working in an agency.

Rachael Gay: I believe Jalesa spoke a bit to this but I would definitely value and benefit… So, in In-Home Therapy it's a dyadic model so it's often two people working together, and I really could use support in how to mitigate conflict, support compromise, support collaboration. I think particularly when we step into family systems, we become a part of their family system and often that shows up with both clinicians. And I really struggle to figure out how to support that work. And it can be hard I think in particular when you supervise one person and another supervisor supervises another person because we're both supporting our team members and they are having challenges within a family system that is having challenges. And so, that systemic support I think would be so helpful because I think that conflict comes up all the time.

Amelia Hasbun: I think it was Rachael that mentioned something about this. Feeling supported in allowing clinicians to have flexibility in reduced productivity if they're going through something or, again, if there's something that's happening that's so big that people can't really show up and be present with people, that that would be okay. And, again, having moments to allow for productivity to take a backseat when it comes to things that are just so much more important. And I just feel that there's such an emphasis on that that it gets in the way so I suppose a support in prioritizing clinician care.

Porsche Lockett: Thank you for that. I wanted to ask: How do clinical supervisors take care of themselves in order to continue doing this work? Because working with clinicians and also being a clinician who works with other folks, where does the time and space come in for yourself?

Jeremiah Gibson: Can I ask another version of that, Porsche? I want to be careful about asking in this process. How can we create a system within agency work that allows for that question to happen? That allows for self-care to happen? With supervisors being people who are leading the charge in advocating for that; advocating for, Amelia, what you're talking about. Because my direct answer to your question… I haven't seen it practiced, unfortunately.

Jalesa Frye: I would have to say for our agency for The Home for Little Wanderers, because we are productivity based, I think supervisors could be better at self-care when our staff is better at self-care. And I think what hinders them is these increase-in-productivity numbers continuously

going up and up and up. And we're requiring more and more from them. And while as supervisors we don't have to meet productivity, we have to support our staff who are scrambling to meet productivity. So, finding ways to help them be creative. And I think the productivity model in itself is not conducive to self-care, because even when they go on vacation they're still technically responsible for productivity so now we're asking them to make up their time and work harder in these other weeks to manage taking a week off. And that is not fair and our staff has been complaining and asking and advocating for it, and we've been doing the same, and there's been no budge. And it really starts with CBHI, the whole CBHI model. We're not mad at upper management for imposing it on us; it's a CBHI problem. And Massachusetts needs to address that model and how that, you know, trickles down to your bottom line workers.

Amelia Hasbun: Yeah, I think that's a beautiful answer. I really support everything that you said there.

Porsche Lockett: I think continuing to advocate is really important. And I know that that can also feel like running up against a brick wall sometimes. And so, I wonder if, as we are in our different agencies and different organizations, we continue to make a splash and more noise, if at some point it will be seen, then it'll be something that is seen across the board. Because I'm sure the folks who run these agencies at some point are talking to each other, just like we have a space to hold for each other, that hopefully these ripples will be seen at the same time. That's a desire that I have.

So, if we don't have any more questions, we're going to begin to wind down. We're going to pass it over to Jeremiah so he can tie it up. Thank you so much for coming and holding space for everyone today.

Jeremiah Gibson: Yeah, and I want to echo what Amelia said. Jalesa, thank you so much for the way that you summarized what you did. One of the reasons that we're recording this session is that we can have this on file so that as NEAFAST grows, as we get more numbers, more influence, we can refer to this document and refer to this in a professional journal context and hopefully use this as a way to influence some of the decisions that get made about where money goes, where money stays, things like that. So, you're absolutely correct that it's definitely an upper level issue. Thank you all so much for being a part of this conversation.

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NEW ENGLAND JOURNAL OF
RELATIONAL & SYSTEMIC PRACTICE

ATTENTION AND MINDFULNESS: AN INTERVIEW WITH PATTI HOLLAND

DAVID HADDAD, EdD
Editorial Team – *New England Journal of Relational and Systemic Practice*

Patti Holland, M.S., C.R.C. is an Assistant Professor of the Practice of Behavioral and Social Sciences and Assistant Director for the Mindfulness in Public Health & Medicine initiatives at the Mindfulness Center at Brown University. In addition to teaching MBSR, Patti works on Mindfulness in Healthcare, partnering with social service providers, healthcare organizations and systems to implement mindfulness-based trainings, programs and interventions tailored to meet the organization's unique needs and challenges to promote positive impact on the health and wellbeing of staff and organizational culture. Prior to teaching mindfulness full time, Patti worked for over 30 years in the field of psychiatric rehabilitation as a clinician, non-profit agency administrator, consultant and in public policy as an Assistant Director for the New Jersey Division of Mental Health.

David Haddad: Welcome Patti Holland. Thank you for agreeing to talk with me today about mindfulness. I want to begin by reading something that is currently posted on the NEAFAST website, something that might set the tone for our conversation,

Patti Holland: Ok, sounds good.

David Haddad: Schools are increasingly becoming crisis centers. We have lost a million citizens to Covid and rising. Children and adolescents are suffering with two-year loss of social development and those hundreds of daily in-person micro-encounters that define who we are. Pediatric emergency rooms are filling up with suicidal teens. Families are struggling with guilt over grandparents who died alone in a hospital bed. The right to have freedom over our own bodies is under attack. The Florida Board of Health is sending threatening letters to therapists warning them not to treat families with trans kids under 18. Teachers, nurses, and doctors are either leaving their professions, or taking extended leaves of absence. For every newly licensed psychotherapist, we lose three to attrition, burnout, low wages, and vicarious trauma.

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Patti Holland: I feel flattened just by listening to that.

David Haddad: Yes, I agree it is a lot to take in. So, with this statement in mind, it seems timely and appropriate that we might talk about what role mindfulness might play in how we deal with this the challenges that the behavioral health community faces. Perhaps by way of introduction, you might share something about your path to mindfulness. As I thought about this topic, I thought you were perfect. Long time meditation practitioner, teacher of meditation, and with background in public sector behavioral health

Patti Holland: Yes, happy to. So professionally, I was interested in social work and then, while I was in school, I started working at a community agency that provided housing for people with serious mental illness. I just sort of stumbled into this because one of my social work professors was married to a woman who ran an agency, and he knew I was looking for work to help pay for college. I wound up there and that experience really catalyzed my career. The experience of working in a residential program, being with people with serious conditions, working where they are living, hanging out and preparing meals and going on outings together. I had thought I wanted to pursue what I thought was traditional therapy. But through this experience, I realized I wanted to be involved with people in more pragmatic ways, and so that led to graduate study in psychiatric rehabilitation through Boston University. And then for 35 years I stayed in that field, at this intersection of community social services, working to create opportunities, and access, specifically around housing, employment and education for people living with serious mental illness. And I circled that entire field. I worked as a practitioner, and then, through a little bit of frustration, I moved up to agency administrator. I started to think about, how these programs are developed? I joined faculty at the University of medicine and dentistry at Rutgers, at the time in their department of psych rehab because no one was training staff to work with consumers in this collaborative way

David Haddad: Yes, this was the recovery model?

Patti Holland: Yes, ultimately it was, but at the time, the field was changing, and I was feeling frustrated, so I went back to an agency because I wanted to learn more, and I was also very interested in affordable housing and the lack of affordable housing and access for people that were typically disenfranchised. And it was here that I started to wonder who's making the rules and the regulations about how policy and public dollars are spent. At that time many States were starting to be sued under the Olmstead Act, for various ways of not providing services or unconstitutionally segregating people with mental illness. I was living in the State of New Jersey at the time, and NJ had been sued, and so I was recruited to come into the division of mental health there as the assistant director to help steer that state service system towards one that was more community-based recovery oriented, focusing on supportive housing and rehabilitation services, helping people achieve their life goals, not simply be defined by their illness. So that's professionally, personally, and just before college I was first introduced to meditation. I had always

considered myself a contemplative kid, but also an anxious one. So meditation was very attractive to me. I was formally introduced to meditation through the Zen tradition in Rochester NY where I was living at the time, and I found it very helpful.

David Haddad: In what way?

Patti Holland: It was miraculous to me that I could somehow have control of where I put my attention. That had never occurred to me before. I felt so pushed and pulled, and that led to a 35 year meditation practice, both studying Buddhism and Buddhist psychology, but also other traditions like Shaivism, all of these were looking at the question of what does it mean to be human, and how can we live fully as human beings, while also recognizing the innate goodness, the innate wholesomeness that lies covered up through our life experiences?

David Haddad: So, during this period, we see mindfulness going mainstream.

Patti Holland: Yes, my contemplative practice and professional lives were fairly separate, although I was teaching meditation at the time, and working in the public sector I was just really aware of the challenges of this work. This is obviously well before the current crisis that we're experiencing with burnout, but I was really aware of how hard this work is for so many, and how alone a lot of staff are. Direct care staff in community agencies are particularly close to my heart, because I personally spent so much time in that work.

David Haddad: Can you say more about that?

Patti Holland: Direct care staff in community agencies spend a lot of time with individuals in personal settings—where someone lives, supporting them on a job or in school, meeting people where they sleep on the street. And these can be very challenging situations, and often staff do not have the support that they need to take care of themselves. So, I wanted to find a way to bring what I was experiencing and learning through my contemplative practices in my life with my professional world, and that's when I heard about John Kabat-Zinn and the program Mindfulness Based Stress Reduction at the UMass Medical School. I had moved back to Massachusetts at the time, so I went up to check out the program and I could see what a nice job MBSR did aligning these ancient contemplative practices of mindfulness in a very accessible way, within the context of contemporary and daily life. Jon Kabat-Zinn was teaching people how to turn within and become familiar, and present to their moment-to-moment experience, to also see ways that see all the ways that we might contribute to our own distress. So, this was very exciting to me, and led to me transitioning to teaching mindfulness, full-time, and particularly evidence-based programs.

David Haddad: There are so many mindfulness programs, can you say a bit more about what you teach?

Patti Holland: I teach MBSR mindfulness-based stress reduction, which is the foundation for many of the evidence based mindfulness programs and has 40 years of research into it's impact on various health conditions. I also teach the second most widely research program, Mindfulness based cognitive therapy, MBCT, specifically for individuals living with recurrent depression and anxiety. I teach these programs personally, and I also train teachers to teach them, and today I do that through Brown University Center for mindfulness and the School of Professional Studies.

David Haddad: Thanks for that Patti, I wonder if we might drill down a bit more and consider how mindfulness might be useful for an individual practitioner, or within an agency, with someone who doesn't necessarily have a meditation practice? I think more generally we are talking about the focus of attention. So much of our attention could be drawn into an attempt to manage the crisis, and there's lots of that right now. So much competing for our attention, and without some way to monitor how our attention is being used, so many of us experience burnout or something close to that. So how have you and your colleagues been thinking about this?

Patti Holland: Well, as you know, mindfulness is so popular right now. Many people consider these mindfulness-based programs with strong evidence, like MBSR, MBCT (mindfulness based cognitive therapy), as third generation behavioral approaches. Marsha Linehan created another highly effective, widely research mindfulness informed program - dialectical behavioral therapy, DBT. Acceptance and Commitment Therapy in an individual approach and also has a strong evidence base. So, there is clearly something here that can help us both personally, and professionally in our work with clients.

David Haddad: So, when you think about mindfulness, you're speaking of present moment awareness.

Patti Holland: Yes, I think that's really important because as human beings, we're constantly perceiving through our 5 senses, and the mind, and we're constantly trying to make sense of all of that. And we're biologically wired to be on the lookout for threats and we tend to have an approach or avoidance way of meeting our experiences. This is further complicated by the influences of our past conditioning and experience, our family experiences, community and cultural experiences. As you know, we bring all of our experiences to our work and the organizations we work in.

We all have habitual ways we interpret and manage stressful situations; our bodies respond automatically with the fight/flight and freeze reactions. Organizational cultural sets or deeply influences the tone and what is expected and rewarded. As clinicians, care givers and helping professionals, we want to support others, to reduce suffering and distress. We can easily put aside, or ignore our needs. When we start to get overwhelmed, we can tend to put our heads down and work on getting through the day without paying attention to how all of this has been exacerbated during the Covid crisis, particularly for healthcare workers and teachers. It can feel like there is no

time, or encouragement to pause, pay attention to what you are experiencing, to what is going on around you, with the person you are with so that you respond instead of automatically reacting from a place of stress or overwhelm. Often, there is no practice of turning inside to check out how you're doing, checking in with yourself or what is going on in mind, body and heart.

David Haddad: When you say check in with yourself, what do you mean?

Patti Holland: I am thinking about how we can soothe and calm our nervous systems. We have to be able to see what's going on in our mind and body to give ourselves a moment to catch our breaths. Interrupt reactivity that's building if possible. Take a moment to calm and center ourselves, soothe and calm our nervous systems. Step out of the flight/flight/freeze mode. We can put our hand to our heart, check in and interrupt that cycle, interrupt that process so that we can replenish, renew, and also connect with why we're doing what we're doing.

David Haddad: Going back to what you had said earlier, when you first started out in rehab, you talked about living, cooking, and hanging out with residents, the experience of seeing them every day, quite personal. And so, it made me think about working with clients. If clinicians are not paying attention to the experience of simple being present with another human, how much is lost. So much of what we might think of as a case presentation is stripped of the personal, the feeling qualities, and speaks more objectively.

Patti Holland: Yes, mindfulness is continuing to come back to our present moment experience so we can become aware of what we are thinking, feeling and sensing in the body. We can discern if we are projecting something onto the other person, not fully listening in an open and open hearted way. We can notice if the processes of transference and countertransference are present. Do we feel centered in ourselves and in attunement with the person we're with?

So, the invitation is to just pause so we can experience the moment. We don't always know what's going on when we are activated, so when we pause, this creates space and safety for the other person we are with. By making this space, it also allows us to see that person more clearly in this moment, and perhaps for him or her to see themselves more clearly in the moment as well.

David Haddad: I recall when you came into my class and presented on mindfulness. Many in my class had never done any formal mindfulness so you invited people to just be quiet and be with each other in this space together, the present moment.

Patti Holland: Yes, we always start with the present moment. One of the neuroscientists and addiction psychiatrists that I work with, Dr. Judson Brewer works a lot with mindfulness in the arena of habit change in addiction, stressful eating and anxiety and depression, and those sorts of things. One of the things that he often says that I really like is many moments, many times. So, this can begin with simply checking in with yourself during the day, just focusing on the breath,

coming to an awareness of your feet on the ground. Whatever it is, all our senses are a doorway to the present moment. So even before you start a session, a meeting, a zoom call, take a moment, just feel your hands on the computer, and bring your attention to the present moment. there's something very palpable about the experience of presence.

David Haddad: So that is it is just taking a moment to let go of what we have been thinking, or at least to notice.

Patti Holland: Yes, sounds easy and yet it can also feel very vulnerable, because then you might also come in contact with how sad or scared or tired that you are. Right now, the research is not conclusive about length of time to practice, for example 10 minutes a day, 40-min? In the evidence programs that I teach, we provide formal training in a systematic and somewhat intense manner—40 minutes, 6 days a week. And then we work with participants to tailor these practices to what works for them in their daily lives. What practices do they resonate with?

For example, focusing on the sensations of breathing or some other anchor that feels accessible, safe and neutral. Like sound or a touchpoint such as feet on the floor. We practice body scan meditation. Mindfulness movement and open awareness where you are open and receptive to the various objects that come to attention such as thoughts, body sensations, sound, the presence of emotion, if your eyes are open to something in your visual field. These different ways of formally practicing cultivate concentration, focus, flexibility of attention, greater awareness of our bodies, a sense of wholeness. Not just living in our heads, thinking, thinking, thinking. We offer choices in how to practice. As we practice like this, we come to see our habitual ways of reacting and interpreting our experience.

I said earlier that right now, the research is not conclusive about length of practice, but it is very conclusive about regularity of practices, in terms of some of the health and wellbeing benefits we're seeing.

David Haddad: It sounds a lot like exercising, with the key being practice, and in this way, we cultivate awareness, or our capacity to pay attention. This reminds me of someone you introduced me to, the cognitive scientist Shauna Shapiro who offers a frame for how to cultivate this quality, intention, attention, and attitude.

Patti Holland: Yes, Dr. Shapiro talks about 3 axioms in mindfulness. There's intention, a purposefulness to it, An intention to become aware of our present moment experience. Stepping out of automatic pilot and coming into the present. Once we have an intention, we then aim our attention in a particular direction. What is it we're paying attention to? What is it we're attending to whether it's internal or external. Training our attention in the present moment. And the third is attitude. How are we paying attention? Can we be with our experience in a kind, non-judgmental way.

And then as important as those axioms are, we add a relational piece. So not only are we noticing what we attend to, but we are also how we are experiencing what we are relating to which speaks to the attitude we want to bring to this experience. So, for example, how is my mind relating to my body; I know that when my body feels tense, my mind starts to wonder what's going on when my mind starts wondering about things and starts racing, then my body gets tense. How am I in relationship to others, to my community, humanity. When we wake up and are present, we can realize how interconnected we are with others and the environment, our world. We become aware of our reactions and when present we are able to see what is going on between people. So, in this way, mindfulness see more clearly what our present moment experience is and also how we're relating to it, how we are interpreting what we are perceiving.

We can discern at that moment, is this helpful? Is this beneficial? Without an attitude of curiosity, or compassion, we could easily fall into the trap of feeling badly about ourselves for not doing a better job. Mindfulness provides a window for us to see what's happening more clearly, without judgement.

David Haddad: There is so much in what you just shared. Earlier you gave an example of being in a zoom meeting, which is so timely, as so much behavioral health is happening online. While introduced during the pandemic, there is every reason to believe that this might continue. This can be so challenging. I hear from students, and clinicians that they often feel overwhelmed at their inability to adequately respond to their client's needs. So, when you invite us to consider a moment of mindfulness just before a zoom meeting with a client, can be so generous and healing. You're inviting us to simply ask the question, what is the goal here? What is my intention? You know you talked about being in a Zoom meeting. As you know, so much therapy is now being conducted online, and I expect that will continue. But when we're working with the most challenging clients, something I often hear from students, and clinicians is they sometimes feel overwhelmed by their inability to respond to their client's needs, to offer something helpful.

Patti Holland: Yes, and I think one of the kindest things, and most healing things we can offer another person is our full openhearted attention. I can remember when I was working in the community, doing home visits, and sometimes wondering is this safe? Am I safe? Are they safe? Will they be ok with all the possible challenges we encounter just in life? But ultimately, until I can recognize that I'm really scared, I may not know what to do. You know we'll be scrambling trying to figure out what to do for the other and as a result, we'll miss what's happening. Mindfulness invites us to just settle in for a moment, and just take a moment and acknowledge to ourselves that I'm not quite sure what to do, and in doing so, open up to perhaps a more creative way of responding that's not fear based. The pause can also reconnect us with innate trust and our skill, and training.

David Haddad: This makes me think about a doctoral study that I was involved in where the student was studying intellectual humility. In her research study she found that health professions

are lower in intellectual humility then some of the other professions she studied. I initially thought that would be higher, but one of her conclusions was that clinical training does not necessarily train us in humility, and the combination of high and demanding caseloads magnifies a need to know what to do.

Patti Holland: Yes, I think it's innate in being human that we want to control, predict, know, do and fix. Recognize problems and fix them. So not knowing just feels weak and unskilled, and unsafe, and yet sitting with someone, and just acknowledging that you're not quite sure what to do, but staying in relation to them, staying connected to them and open to them, we can open to the potential to decide together what the next steps are. Ultimately, I think we under appreciate the power of just simply attending to another person. Attending without having to fix them. If we're attending in a way that only notices the problem that needs to be fixed, or something that needs to be acted on, or we're so aware of all the other patients or all the other people that we need to meet that day, we may be left feeling like we are rushing through the experience. Then I think we missed the present moment. Ron Epstein, who's a physician at the University of Rochester, wrote a book titled Attending. In this book he talked about a study on Physician burnout that has really stayed with me. It was a small study, less than 700 physicians. One of the ways that he was interpreting the study is that if physicians could connect with something that they found personally meaningful in their work, just 20% of the time that can have a mitigating effect on the harmful effects of stress. But the caveat is that you must be present for that. I think the experience of physicians in this study is quite similar to behavioral health clinicians who are struggling with the bureaucracy and administrative burdens in their practice. So, while they're meeting with the patients, the provider is also thinking of many administrative demands on their attention and may not be present to their own moment to moment experience, ultimately limiting the resources they bring to the task.

David Haddad: I am glad you mentioned Ron Epstein's book. One of the things I most appreciated about his book is his inviting the reader to think about what a more mindfulness-based health system would look like. Although he was speaking of a medical system, it was easy for me to translate that to a behavioral health system and many of the issues seem quite similar. In his book he talks about how systems think together, he calls this collective mind. So, do you have any thoughts about how mindfulness, or thinking together in this way could impact policy? How do these qualities help us to think together?

Patti Holland: Yeah, it's a good question that I'm giving a lot of thought to, and I don't know as I have a clear answer. There are complex, intersecting systems and structures – individuals, families, communities who need or want services that are relevant to their daily lives, effective and they participate in designing these. There are individual clinicians, healthcare practitioners, staff. Organizations. Service Systems. Regulatory and reimbursement structures. All of these need to be represented and engaged in service design, delivery and evaluation.

I think there's people that have given way more thought to this to me, but one thing I do feel sure about is that it starts at the individual level, so moving from the individual to the larger system. Consider actions like starting a meeting with a moment of mindfulness, or to just come to the breath. You know it doesn't need to be any kind of tradition or religious base, but simply first connect with ourselves and connect with our shared intentions and aspirations. Ultimately it is helpful to stop and reflect on why we are working in a helping or healing profession. Then the questions could be how we move forward and build in moments where we allow for respectful dialogue and disagreement. We can build these practices into meetings, building it into policies, I think building on what's been built in the community. In the days of building recovery-oriented service systems, for example, there was a partnership with the individuals receiving services right and really building on those relationships, working collaboratively with the consumers.

David Haddad: Yes, in family systems there is a model based on collaboration, working in partnership with clients, with the understanding that they are the experts in their personal experience. Our clients can tell us if something is beneficial, we have to make space for their voices to be heard.

Patti Holland: Yes, and that requires a certain kind of deep listening, the kind of presence where we're seeing our clients as partners or leaders with wisdom and experience about what is helpful and not helpful. Earlier you were talking about intellectual humility, and I think that is so important. It is the recognition that I bring from my training, my experience, and my background. All of us have blind spots, which means we miss a lot of what might be helpful for people living in different types of communities and cultures and backgrounds that I come from. We need to allow ourselves to be vulnerable. To acknowledge when we don't know. To be open to learning from others. So, we need to hear from people about what their experience is, and we need to be open to listening to that, which is why I think it always starts with the individual because if we're not able to tap into just acknowledging where we feel unsure and uncertain, we are disconnected from our own experience, and the present moment.

David Haddad: In reading Ronald Epstein's book I recall the study that you were talking about earlier where, if I remember correctly, his study had physicians just meet and talk about their experiences with their clients. Not about their medical problems, but about their experience of connecting with this other human being. It's not about supervision, it's about just tuning into the experience of this human encounter. This seems to be cultivating the capacity for presence.

Patti Holland: I think his study speaks to how tribal we tend to be. Physicians talk to physicians, nurses to nurses, social workers to other social workers. There is that shared experience and community. And, much of our training, whether implicitly or explicitly encourages us to compartmentalize, to not acknowledge that we are unsure, and from there, it doesn't always feel safe to admit mistakes. There is little space for this. Epstein's study tells us there needs to be space for acknowledging I'm doing the best that I can in the moment, and a recognition that on some

level it may not be good enough. That I need help. That I can be competent and still need help. These are not mutually exclusive.

David Haddad: In the history of family therapy Gregory Bateson is often referred to as the father of family therapy as he introduced systems thinking. He, like Epstein, talked about mind as a social phenomenon that we create together, as opposed to mind as being inside the individual. Mindfulness seems similar in that it is a reminder that we are all connected, all part of the same system, and mindfulness is a way of remembering that I'm creating this web of knowledge, together with people and as you have been saying, it begins with the individual.

Patti Holland: Yes, so getting back to public policy, what I was working in state government, and then as a consultant, I worked for several years at this intersection of community services, and particularly affordable housing at the local, state and national level. What I found was that the systems that were most supportive and had the best policy and funding sources were those that involved individual consumers.

These were clinicians and policy makers who were able to acknowledge a personal experience for connection with mental illness. So, a policy maker or an administrator was able to say, I understand this firsthand. From this perspective, there is no longer a sense of separation, and otherness is dissolved, and there is a coming together, and a reminder that we are all part of the same system and interconnected.

David Haddad: So, what I hear you saying is, whether it's at the level of policy, individuals' team, or staff meetings, we're looking to foster our connection, first with ourselves and then with others. We do this by making space, reconnecting with ourselves.

Patti Holland: Yeah, and I think mindfulness practice supports us to recognizing that my experiences of being human are no different than any other human. Jon Kabat-Zinn the founder of MBSR used to say there's more right as long as you're breathing. There's more right with you than there is wrong with you no matter what's wrong with you, and we are more connected than we know.

David Haddad: Such a compelling thought. I guess my takeaway from our conversation today is that mindfulness can be a dedicated practice that people can have, and, as we're talking about it here, we can think of mindfulness as an attitude, guided by one's intention to be more present. In this way, mindfulness can be about making space in our day to check in with ourselves. what happening here?

Patti Holland: Yes, mindfulness is ultimately a way of living our life. Of present moment wakefulness, heartfulness. There are skills that we can cultivate through practice that can help us answer the question, how do I want to be in my life?

David Haddad: Earlier in our conversation you spoke about the neuroscientist Judd Brewer, who described mindfulness, or cultivating the skill of mindfulness as many moments, many times. Such a useful way of thinking about mindfulness as a practice, like working out or any other skill.

Patti Holland: Yes, in one of my classes someone shared that each morning was the same as he prepared to take his daughter to school on his way to work. He was also feeling bad about not being able to spend more time with the daughter. He would put the car seat in the car. and it was this fight, because she's 4 and struggling trying to get out of the seat, and he's trying to get her in the car. And so, it starts. Every morning as he was going out, it would start the same way, feel stressed, so then he started practicing mindfulness. So, one morning, he started as usual, he was feeling stressed, anticipating the same struggle to get his daughter in the car. She is struggling, he is getting agitated, and he is starting to feel guilty. He then shared that the sun was just coming up, and he noticed these little snowflakes frozen on the top of his car, and at that moment, he noticed that his mood shifted. This caught him off guard and he thought, how cool is that. And then he had the awareness that he did not have to have this daily struggle, he could take some time each morning to come to the present moment. He recognized that this was a skill he could cultivate.

David Haddad: That is a great story, a reminder, as you have been saying that it starts with the individual. Even in organizations that don't actively support mindfulness, or organizations that are stressful, employees can use mindfulness to stay tuned into their own state, which ultimately supports their ability to make informed and discriminating choices. Patti, I see from our time that we are close to the end of the time we allotted for this conversation. I wonder if there's any final thoughts you would like to add, something we may have overlooked that you would like to speak. What final thoughts would you like to leave us with?

Patti Holland: I guess in closing I would like to invite people to experiment for themselves, to explore how mindfulness could be useful for them. It might already be commitments that they have in organizations that they belong to, and to groups that they belong to, but bringing more intentionality into practices that support them to acknowledge and be with what their actual experiences, so that they can you know what's important for them. When we tap into taking care of ourselves, we naturally touch our deep desire to care for our community. So, the invitation is to give it a try, build mindfulness into their day where they can. Just give it a try and see what you can discover.

David Haddad: Thank you Patti for sharing your time and thinking today. Very engaging

Patti Holland: This has been wonderful. Thank you, David.

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In Memoriam: Steve as a Teacher

GREG BODINE, MSW

Editor's Note: This is one of two articles written by graduates of the Narrative Therapy Initiative's Training Program following the death of Steve Gaddis, in the spring of 2022. These words were spoken at Steve's Celebration of Life on Sunday, May 29, 2002.

I first met Steve Gaddis as a student in Boston College's Graduate School for Social Work. His Narrative Therapy class was one of the most competitive to get into in the whole program. I had heard of his Narrative Therapy class, particularly that it was one that addressed the politics of social justice in ways that went beyond the important, but lacking-in-X claims of valuing cultural diversity and considering social determinants of health. I remember waiting over my laptop, watching the seconds tick towards registration time, course code ready, anxious and hopeful. I sighed in relief and exclaimed joy at the same time. I got in.

Steve touched a lot of lives in his lifetime, and there are no doubt countless people who have learned something meaningful from him. But there was something special about meeting Steve in the classroom that calls to be shared. If you've not had the official opportunity to have Steve as your teacher, I want to share with you what it was like to be in a Steve class. For me, it was unlike any learning experience I had had in my life.

On the first day of the course, I walked into the classroom and saw Steve sitting there in the front, smiling his warm Steve-smile, the desks arranged around him in a casual semi-circle. It was summer, and Steve was dressed in his shorts, breezy button-up short-sleeve, and outdoorsy hiking sneakers.

Once folks got settled, Steve welcomed us to the class and expressed a genuine gratitude for our presence. The acknowledgment was deeply sincere. He was not going to take for granted what we were caring about by attending this particular class.

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He then let us know that it was his tradition to start each class by putting on a song for everyone to listen to together. He invited us to pay attention to whatever might stand out to us or move us in our experience of listening. So we sat together, letting this song he had selected wash over us.

Once the song had finished, Steve made space for every person in the room to share a bit about where they were transported to in their listening. One by one, each person took their turn to share, and I already felt, in the first few minutes of the class, like I was getting to know my classmates in a different kind of way. I remember being struck by how we all had heard the same song, but had such different reflections. I really liked seeing how other people's responses were so different than mine.

I'd taken a bunch of graduate classes by that point, so I remember thinking: Okay, that was a pretty cool introductory "grounding exercise." "*But I know what comes next. Now we'll review the syllabus and get to the 'instruction,' which will allow us to transition into the 'real' learning, where the teacher in the front of the room tells all the students what they should know in order to be good therapists and do well in the class.*"

But this is when it started to become very clear that Steve was not your typical professor.

Steve, being in no rush, began his power point slides. The first was simply a photo of him as a little boy. He started to talk about his life and personal history, his struggles and painful experiences of abuse as a boy, his time before meeting Narrative Therapy and what it meant to him when he finally did. He shared about how this narrative worldview that we would be learning about together came to be so important to him. He spoke about how therapy in his life had harmed him as a young person, despite therapists' good intentions, and shared stories linked to how he came to understand his life's purpose: "to be a therapist who doesn't suck."

Steve was now nearly in tears with urgency, those tears reflecting the pain he experienced in his own life and how much it mattered to him that we meet people in respectful ways. He went on to express how absolutely crucial it is that we take up our responsibility to help people who are hurting and suffering from the effects of injustice seriously, and that he believes we are called to do this with accountability, curiosity, and a commitment to dignifying every person we meet.

"Okay," I thought. *"This is getting real."*

The next slide is a photo of him and Ashley, who he introduced to us as his wife and best friend. He introduced us to the idea that each person is a relational achievement, not an individual one. He told us that much of what was possible for him to do and be in his life was made possible because of his relationship with Ashley. I mean, have you ever been introduced to a teacher's life partner in the first few slides of a class before? Has any teacher paused to acknowledge upfront that who they are as a person is made possible because of their most precious relationships?

I hadn't before, and I haven't since. I've never seen any teacher be so real and vulnerable right out of the gate. In the first 30 minutes of our first class, I already knew more about Steve than I have ever known about any of my teachers, ever. This class was already unlike any other class I have ever taken. I couldn't have really told you why at the time, but I was already feeling more at home and more eager to learn in this class than in any other I had experienced.

But I *still* am expecting these to be brief detours before the real lecture starts. I'm just waiting for Steve to pass out the syllabus, go over the assignments and readings, and begin talking about Narrative Therapy and how we're supposed do it.

But no. Next we're told that we are going to do Introductions. We're going to meet the people who we will be learning alongside for the next nine weeks. Steve organized us into small groups and offered questions to us to help us be curious about each other's personal histories, our values, and the ways we might most like to be known by others in the class.

Until that point, for an entire academic year, I had basically only known my classmates by the name tags on their desks and how they responded to a professors' questions. But now, I found myself asking someone, who I had just met, how it came to be that she decided to pursue social work and what she thought she was caring about by choosing this field. I still remember the stories she told me that day. And when it was my turn to share, I noticed I had never been asked questions like this before. I had never reflected on how I might most like to be known by another person, and found myself sharing stories I didn't even know I had to tell about myself.

People who have been students of Steve's wouldn't be surprised to learn that we didn't get to talking much about Narrative Therapy that first class, or even the second. Because introducing each other to the rest of the class took the better part of three 3-hour sessions.

I came to realize later that this was Steve teaching at his best. These were not "icebreaker" exercises in service of the real learning to take place later. Steve taught by doing. He wanted to teach much more than another "modality" of therapy. He wanted to introduce people to a new way of seeing the world. He wanted to grow alternative ways of relating to each other that were healing and had the chance to address the harmful effects of injustice. I remember him saying to me once, "One thing I like about the narrative worldview is that we don't have to talk about it; we can just do it." And he lived it as a teacher in ways that were just remarkable to me.

Even when we finally did get to the syllabus, we found Steve using it to take stands against oppressive stories of learning. Assignments would come with explicit statements, like:

"What you genuinely think matters much more to me than what you think I think will be impressive."

Or a weekend intensive might start with: "Is it okay if, for the next several hours, we privilege my relationship with these ideas? Then we can have a chance to explore what you think about them, and we can discuss

whether you feel they they might suit you or not?"

I mean: who does that?

Steve took real risks to go against the norms of teaching. Time and time again, he went out on a limb to do things differently. And man, could he make it look easy. But I later learned that doing teaching this way was incredibly difficult for him for a long time. Before classes, he would be shaking with Nervousness. He could be caught by immense waves of Fear and Self-Doubt. He called trusted friends in the early hours of the morning, panicking about whether or not what he was doing was good or whether he could do it.

But standing up to oppressive learning cultures just mattered that much to him, enough to fight through the Fear and Self-doubt in order to do things his own way, ways that he hoped would help people know they mattered and their knowledge was important.

I would often ask him, "How do you do it? Who was your Steve?" He would smile and say, "I'm very, very stubborn." Then he would add, "I have far too much privilege to not doing anything about the ways people are being absolutely crushed by these oppressive learning expectations."

Steve taught like there is a lot at stake in any learning environment. Because there is. It matters if a teacher shows they're vulnerable. It matters if a teacher pauses to care about someone in the class who is hurting. It matters if a teacher shows you that they don't have it all figured out. It matters if a teacher shows a real desire to be accountable to their students.

A course with Steve would always end with a final assignment, usually something along the lines of: *"Please share with us something that has been meaningful to you about your experiences taking this course."* During these presentations, incredibly moving stories came forward that sometimes people had never shared before in their life, anywhere. There were often tears, swells of emotion, a feeling of connection and being seen in ways you could not have imagined before Steve's class.

Steve's classrooms became communities. And the most important lesson I believe he would want to impart was this:

Every person is unbelievably precious and utterly unique—and it is our urgent responsibility as human beings to do what it takes to help each other know this about ourselves.

And it brings me such incredible hope to pause and think of just how many of Steve's students have taken this to heart and are out there living the values that Steve held so dear. I know Steve would be so proud of what his teaching has made possible in so many lives. Thanks for everything, Steve.

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In Memoriam: My Farewell to Steve

GUADALUPE HERNANDEZ MORELOS, PhD

Editor's Note: This is one of two articles written by graduates of the Narrative Therapy Initiative's Training Program following the death of Steve Gaddis, in the spring of 2022.

A few years ago, Juan Gabriel, a very famous Mexican songwriter, died unexpectedly from a heart attack. Many Latin-Americans went into a state of shock and grief. It is fair to say that for many days, our stories of growing up, of love and separation could be heard in any conversation happening on social media, TV, and any corner where there was a Spanish speaking person involved.

Literally, our routine stopped the day we learned about his death, and I felt the world also stopped for a few days.

Juan Gabriel's songs have been with me in very difficult times. I cried then because of his departure, but I was and I am so grateful and happy for having a chance to know about him and benefit from his art. I can tell so many stories about how his songs lifted me up from very dark places, times when he showed me how to care for the simplicity of life, and the humility of any loving act.

My relationship with Steve Gaddis and Juan Gabriel's art have many things in common.

On January 6, 2022, my normal routine stopped, and I reached out to my beloved people in the Narrative Therapy Initiative family. I have found connection with them while sharing tears, laughs, fears, and so many stories. I shared with many my disbelief in my strength to go on without Steve. I struggled to believe in a world that I knew did not matter because he was no longer there to remind me of it. For many days I wondered why the world did not stop when Steve died, but then I remembered, listened, and read the stories…

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Let me tell you a little story about why my big blue eyed brother mattered in my life.

Steve and I met in a safety training at a family and children human service organization. We both shared our dislike for the whole concept of protecting ourselves against the people we tried to help, especially children. In one exercise, we were asked to hold each other, pretending one of us was a child out of control with anger. I quickly assumed this role since there was not much pretending; after all, I was so angry about being there in the first place. Steve said, "I won't do anything to you," and, protecting himself from the anger he probably saw in my eyes, we both laughed, talked, and ended the whole silly experience without laying a finger on each other.

A few days after I met him again at the program I was working at, and we were assigned to work together as co-therapists. I was jealous of him being a PhD student; going to graduate school was the only reason I had left Mexico 5 years before, but I got in some complicated detours of my plans. I was angry too about my job title "non-masters level clinician", when actually I was a psychologist. I was told I would be Steve's teacher or coach during this experience. I felt silly and resentful with the subtle ways I kept receiving messages that I was less, or that my value as a professional had little, if any value at all. I tried to prove myself, my language, and my knowledge to Steve. He was always humble, and so real. Once in a while he would say to us in the program, all overworked and underpaid, "Do not hate me. My wife is the one with the money." I began to like him because of his shameless sarcastic comments.

His irreverent attitude towards people with power and privilege surprised me many times, but I felt he was representing my experience. I wished to get to know him more.

Later, Steve was seeking advice about Will and Laurel, one toddler and the other just a baby, who were resisting Steve's and Ashley efforts to put them to sleep. Steve exclaimed, "They do not let us sleep! I am going nuts! What advice can you give me?"

"Try something else," I told him. He laughed with all his body and tiredness. Steve saw me as this skillful mother I had a very hard time believing existed. His regard and respect for me was unexpected and even uncomfortable.

Those times were before Steve had studied with the big narrative guys. He was already a loving, generous therapist. I regularly listened to him and my dear friend Phil Decter having discussions about Narrative Therapy, and I witnessed Steve's attitude towards the family we worked with. He talked to them with respect, and I saw his huge curiosity in action. One night, I remember I had to pull him out of the home of the family we were working with because we saw some police activity outside, and people were coming and going in the house. "We got to go, Steve!" Nana, the matriarch of the family, and I told him. Despite Nana's efforts at ordering one of her relatives to escort us out to our cars, he wanted to continue his conversation with Nana.

Many years after remembering this, he told me about this day. I made fun of his naïve attitude when he asked me, "Did you know that Nana walked with Martin Luther King in the famous march?" His eyes lighted up with admiration again.

I thought for myself, "Oh, I though your eyes were lighted up by the police car sirens of that night."

I perceived Steve as naïve in that moment; I was able to reframe naivete with the capacity to have a great place of curiosity to wonder about Nana and her stories.

About six years later, I saw him again in a workshop he gave at the Cambridge Family Institute called "Working with Boys". I came late and he stopped his class to welcome me in with open arms, with one of his big bear hugs. He invited me into the Salem Center to his office practice, telling me I was always welcome there, I did not go, life was still too complicated for me.

Boston College welcomed me with money and lots of appreciation for my life experience, the perfect combination I needed. Steve was already teaching an elective class on Narrative Therapy. I did not try to register; I figured the class was probably filled already. I had a difficult experience at BC where a former classmate would have been a teacher of mine. She mentioned to me that being in her class was a conflict of interest, and suggested that I drop out of her class. I was outraged and I felt so out of place. I told Steve, and he responded, "Bullshit, she was afraid she didn't have anything to teach you." It was so easy to be seen by Steve, and I am so grateful life kept inviting us both to more permanent reunions.

A few years after graduate school, my tolerance to injustices at my workplace was getting so thin. I called Steve, and he interrupted my tears that day: "Are you telling me that they are treating you like crap because you are a problem to them, just another angry Latina?" He did not let me answer, saying "I want you to come and join me in this group that I'm starting about social justice. I believe that we can help." He followed, "Would you like me to meet with your supervisors?"

I thought of him as condescending and naïve but also very endearing and protective. I remembered answering, "No thank you, big hermano, I will have to do without you."

Steve exclaimed, "I am pretty sure you got this. I just want you to remember you are not alone."

I worked with Steve, and I continued to see Steve's ways to connect with each person with wisdom, tenderness, love, and humor. His irreverent attitude had sharpened. I am pretty sure in those meetings we all did annoying things, like showing off our knowledge. I admired his patience, and his tears always surprised me. He told us his intentions were to be close to us and create intimacy. I particularly appreciated his very fresh and casual way to make sarcastic comments on what he heard. One of those daring moments was when one of the participants, a male, read his

letter to white male privilege, or male toxicity. Once he finished, Steve asked him, "Oh are you saying, please fuck off white male privilege?" I loved him so much for it. We all laughed so hard; imagine the effect for me, the only woman of color in those meetings.

I like to think that our sibling connection got strong because of our differences and despite his privileges.

One time he was challenged about not being antiracist enough. He told me something about the anger of the person who challenged him and then he quickly asked me, "How come you are not angry?" I responded, "I just feel that I understand both of you, but you two are not listening to each other." He was tormented by this misunderstanding. "I am totally okay with listening to the unintended effects of my actions, but I am not okay with anyone imposing their expectations on me," he said.

One day, Steve invited me to the chair of diversity of inclusion of NTI. We had a conversation about lack of diversity in race in the workshops and in NTI community. He surprised me when he said, "I did not start NTI as a social justice initiative for people of color. I don't think it is my place to position myself in that way, and no community of color has asked me to take the project. I created NTI to do something to hold the white mental health world accountable for acting as a system of social control that negatively affects many marginalized and disenfranchised communities."

I was speechless.

He was criticized by the use of his academic language in his presentations; though I appreciated this change. I often teased him, "Yes Dr. Gaddis", and then he would respond, "Okay, Dr, Morelos, now what will we do?" The way that Steve navigated the academic and professional worlds was tireless and brilliant.

During his time with cancer, I heard some of his challenges, the effects of his treatment, the uncertainty of the future, the pain of Ashley and his kids. I told him "Thank you for continuing to show up for your life despite the difficulties."

I have so many memories of Steve and the many dreams we started together: Our teaching or, better said, sharing of our knowledges and values, our love for the narrative worldview and our commitment to the narrative revolution. His influence is everywhere in my life, and his always loving ways help me grow my self-love.

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A Narrative Framework: An Interview with Steve Gaddis

JEREMIAH GIBSON, MMFT
Editorial Team – *New England Journal of Relational and Systemic Practice*

Editor's Note: This was an interview that I conducted with Steve Gaddis in 2019. The NEJRSP editorial team decided that, in honoring the life and influence of Steve Gaddis, it would be fitting to have his words and vision be the concluding article for this issue of the journal. You can find the video of the interview at the NEAFAST Youtube Channel: https://www.youtube.com/watch?v=iIUCtdGTWiQ.

Jeremiah Gibson: I'm so happy to be joined this afternoon by Steve Gaddis. Steve is the Director of the Narrative Therapy Initiative in Salem, and we wanted to take a few minutes today to talk about some upcoming trainings that are going on at NTI and to talk a little bit more about narrative therapy. So, Steve, thanks for joining me today.

Steve Gaddis: It's a pleasure, Jeremiah. Thank you for making this happen and keeping the family therapy world active and alive in Massachusetts. Family therapy was my first home professionally.

Jeremiah Gibson: Yeah, definitely. Mine too. And I'm curious, as family therapy was your first professional home, how did you kind of meander from family therapy specifically into narrative therapy.

Steve Gaddis: Well, there are so many places to start and so many stories to tell that's hard to select what to begin with, but I guess I would say that I met narrative therapy in my Masters in Marriage and Family Therapy at Colorado State University. I was a graduate student there and Toni Zimmerman was the Director at the time. And Toni was way ahead of her time in terms of infusing the program with social constructions…

Jeremiah Gibson: Toni is still ahead of her time.

Steve Gaddis: Yes, she is. I mean I have not been in touch with Toni for so long. So you Toni!

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Jeremiah Gibson: Yeah, she did a training for me when I did the AAMFT Supervision.

Steve Gaddis: Oh, fantastic! She's an amazing, intelligent, energetic person who I really feel grateful to have been at the head of the program at the time. She had brought a lot of feminist, multicultural, and social constructionist ideas into the program. And I was learning a lot. I had started in Psychology and was pretty unexcited by most of the ideas and ways of thinking about how to help that I was learning in Psychology. I had decided to become a therapist later in my early thirties. I'd had experiences throughout my adolescence in therapy because I'd been subject to abuse and violence as a boy and was experiencing the effects of that. People who were trying to help me—my mom, therapists—were all well-intended, caring, good people. But the therapy itself was not helpful for me and upon reflection, you know, I think had harmful effects. So when I decided to become a therapist, it was after I'd had some really nice experiences with a therapist in San Francisco when I was about thirty.

And so I had these juxtaposed experiences in therapy that inspired me to think about exploring the idea of becoming a therapist myself and seeing if I could be helpful. I wanted to explore what it meant to be helpful, what it meant to think about problems and how to be with people. So when I went into graduate school I was looking for something that could help me answer those questions in a way that felt good to me.

And I wasn't finding anything until there was a three-hour class that was dedicated to narrative therapy. Michael White and David Epstons book Narrative Means to Therapeutic Ends had just come out. And Toni said, "If you were going to read one thing in this particular approach, here's what I would suggest." That was, I think the first book I decided to actually read, and the first chapter of that book is about power and knowledge and story, and that just hooked me. I became really excited and interested in what that was and immersed myself fully in it. And it's been a love affair ever since. It's taken me around the world. It's gotten me to write. After my wife and kids it's my most precious relationship.

Jeremiah Gibson: When you studied narrative therapy, who and what were some of the profound experiences that you had in your training of narrative therapy?

Steve Gaddis: I had to kind of train myself because there wasn't much available to me except through what I was reading, and I started reading everything I could that Michael White had written and found that to be really helpful in getting me to think about how to try things in my practice. I learned through trial and error and making mistakes and reflecting. I quickly became known as the narrative guy because nobody around me knew much about narrative.

And it was kind of painful at times because I was kind of characterized pejoratively as too narrative. And I felt like that was a misunderstanding of what I experience as the sophistication and the rigor and the breadth of the assumptions and ideas that are the foundation of the narrative worldview.

So the first formal training I had: Michael White came to Albuquerque in 1996 and did what became kind of a famous workshop there. There were probably about 150 of us present. Through that conference, I decided to get a Doctorate at Syracuse, and one of my professors there was Ken Harvey, which many people will know. And Ken really was an amazing teacher for me. One of the things that I came to care a lot about through Ken's teaching was congruence: people striving to live the ideas they say they stand for.

And one of the things about Michael that I really experienced was that sense of congruence; that he was really embodying a lot of the values, the ethics, the practices that he was also teaching and kind of benefitting from in terms of people being interested in and stuff. So that was very heartening. And the first formal training I had whet my appetite for more.

Jeremiah Gibson: Right. Narrative Therapy isn't just applied Foucault. Narrative therapy is an embodiment of some of the values and some of the principles of Foucault, some of the post-structuralists, and some of the folks who evaluated that. And I'm curious which of those values came the most natural and were the most exciting for you as you began to practice narrative therapy?

Steve Gaddis: That's a great question, Jeremiah. Like most people I was introduced to power at a young age, so I had a pretty strong sense of forms of power that had to do with domination and physical strength and intimidation; the ability to influence through repression and holding people back through physical threats or violence.

But I think I also had knowledge about power in the form of meaning-making, and yet I didn't have a language for it; I didn't have a way of making sense out of it other than through a felt experience. And so when I was introduced to narrative, and Michael's introduction to Foucault and the idea that power operates in this normative judgment and discourse and meaning-making, that just got exciting because it helped me have a way of understanding ways of being influenced and constrained or even constituted. I felt like it made it possible for me to experience something different in relation to the problems in my own life.

One of things that was immediately exciting to me was that I felt like I was engaging with narrative ideas and practices and ethics, and I was discovering some help for my own struggles in my life. So I thought that might be a legitimate criteria to think about possibly bringing these things to other people to see if they found them helpful.

But I would say even more specifically, the notions of accountability was one; that kind of practice of accountability in relationships and being curious about the real effects, however unintended they might be in a relationship; the sense of who's at the center of the meaning-making at any time. Understanding what Michael White would describe as the de-centered and influential position that the narrative therapist takes up in their conversations. We're bringing skills

to be helpful, but the people we're talking with are at the center of the meaning-making and leading the conversation.

Jeremiah Gibson: The thing that I love about our field is that so many of the different therapy models that we have don't just transform us as therapists; they transform us as people. And in a bit we'll talk about some of the yearlong training modules that you guys have. But I'm curious: what are some values that you hope that participants of these programs also get to embody and experience as they go through these two programs?

Steve Gaddis: Yeah, again, I appreciate the question. Just to back up a second to something you said, I think, something very important for me to hold up is this idea that narrative therapy is more of a way of being in a worldview than a technique or a strategy. It's not something that I do when I'm with clients and then I don't do in the rest of my life. It informs all domains of my life from my relationship with Ashley, as a dad, as a teacher; hopefully it's shaping how I'm approaching this conversation with you. So for me, I have a hard time now separating conversations that are different in what gets called "therapy" or what gets called "training" or what gets called "life."

And so I hope to embody these in the trainings that we do and the teachers that are part of Narrative Therapy Initiative now do as well. And our hope is that we help people know about what's possible through the narrative worldview and practice primarily through experiential learning, through exploring how these ideas make it possible for them to develop richer stories about what they care about, what they stand for, their hopes and dreams, and through that, see how it helps change relationships with those problems.

And in that process, we think that people will get the best knowledge about whether this is a way of working that they like or they don't like. We really emphasize the experiential quite significantly. The personal, professional, and political really are part of the experience.

Jeremiah Gibson: What are some other aspects of the narrative worldview that you get excited to witness in your students and with your clients as you teach and as you practice narrative therapy?

Steve Gaddis: The most exciting thing for me is when I witness people experiencing themselves as the knowers of their own lives and relationships. When I witness them experiencing an ability to have the final say for themselves about what things mean and how to understand things. We just recently had an end-of-year ceremony for our certificate program, and the structure is the students present what had been most meaningful to them in the course. And these are some of the most moving days of my life. I get to witness, not them sort of explaining what narrative therapy is or teaching narrative therapy or anything like that, but showing how their ability to know what's precious to them, to have it be unique and specific to them is presented and honored and witnessed and celebrated. And so the thing that I love most is just helping each person experience

a kind of dignity that I think is at the center of the ethics and values in the narrative worldview.

Jeremiah Gibson: That's great. I wonder if I can ask a couple questions also about the programming for 2019-2020. You've alluded to the Narrative Certificate Program. And then there's another program that you guys are offering too that's called—remind me?

Steve Gaddis: It's the Apprenticeship Program.

Jeremiah Gibson: The Apprenticeship Program. I'm wondering if you could take a few minutes to describe those: the Certificate Program and the Apprenticeship Program.

Steve Gaddis: Yeah, I'd love to. You know, these are emerging programs. You know, we're a small nonprofit organization that started ten years ago and we've just been slowly growing, trying to do it at a sustainable rate, without any outside funding. Everything is tuition-funded at this point. But, we've tried to develop training opportunities where people can fit in at whatever level they're at and whatever interest level they have.

So right now, we offer a one-day kind of introduction to the worldview called "What is Narrative Therapy?". And we offer that a couple times a year as a way for people to get a taste of this without too much of a commitment. And then we have a two-day "Narrative Therapy and Practice" for people who want to follow up on the one-day, where they can learn more about some of the practices that have been developed within this worldview: externalizing, deconstructing, re-authoring.

And then if they still find themselves interested, then we have these two ten-month-long programs. And the primary difference between the two is just the level of commitment. The Apprenticeship Program is a peer-facilitated consultation exploration of the narrative worldview that meets once a month on a Friday for the whole day. And myself or another NTI faculty are there to help facilitate that. It's highly experiential, lots of practice of being introduced to some ideas and then putting them into practice and trying them out and that kind of thing.

The Certificate Program is more rigorous. It involved some readings, some writings, some practice intensives—so we meet a few times a year for two-day practice intensives where we dive into different practices quite deeply. There's a weekly online small-group meeting that happens on Tuesday nights so people can stay connected to the learning and their concerns. There's multiple faculty who teach in this course who students just adore. And so those are the primary differences between the two that I can think of.

Jeremiah Gibson: How might someone interested in learning more about narrative therapy be able to make an informed choice as to whether the Apprenticeship Program fits them better than the Certificate Program or vice versa?

Steve Gaddis: You can read some about it on the website—the differences. The website is www.narrativetherapyinitiative.org. We're developing an application kind of process so that people can discern whether it's a good fit for them. Those are some thoughts.

Jeremiah Gibson: What are some things that you would like participants of these programs to know or to come into the first day of these two programs with?

Steve Gaddis: For the two year-long courses, I think it's important that people have some exposure to the worldview and some of the practices. So at a minimum I would say at least the one-day "What is Narrative Therapy?" and the two-day "Narrative Therapy and Practice", or a course in graduate school that they might've had in narrative therapy. It doesn't have to be very extensive, just not completely brand new to the worldview.

Jeremiah Gibson: Gotcha. You mentioned in the Narrative Therapy Certificate Program that there is a project that students do—a way of incorporating the narrative worldview and narrative principles into a particular lens or pocket of practice. I'm curious to learn more about how that works and what's an idea or two that you've seen students that have been really valuable.

Steve Gaddis: Well that's a good question. The goal of all narrative therapy is what's called "rich story development." So that, you know, if we think about people living their lives through stories and internalizing narratives that are often supported by culturally-dominant discourses of gender, race, class, etc., then they've often internalized stories as truths that are not fitting best with what's important to them and yet have a lot of power.

So part of the Certificate Program project is for students to experience personally what it means to have their own stories about what they care about much more thickly developed and described as a result of participating in the course. The projects are them sharing with us a rich account of something that they hold precious. It's very unique to each student.

One of the practices in narrative therapy is what's called "outsider witnessing." So when these presentations are made, we follow them up with responses about how we were moved by them and where it took us and what we care about and an acknowledgment of that. It's very moving.

One example of a presentation that comes to mind was one of the women in the course was in her small group interviewed about what's meaningful to her, what's precious to her, and she talked about how she experienced problems as the metaphor of a fog that would creep over and have its affects on her life and try to convince her that there was something wrong with her. Many of us can relate to how problems try to influence our lives.

I live pretty near the ocean and she decided for her presentations she was going to take us all for a walk to the beach. And in the walk to the beach she was sharing with us what the significance of this event was—the significance to her of taking us to the beach and reclaiming her life from the fog that kind of had too many negative affects on her life and talked about how…I forget exactly the words that she used, but something about the importance of it being okay to not be perfect and not have to kind of succumb to the perfectionist discourse. And then she linked that to how that had her thinking about who and how she wanted to be as a therapist in her work, particularly around chronic illness, which is an area that she both has a lot of knowledge of personally and wants to do work in professionally. There are ten or twelve of those in two days. They're thirty minute presentations and they're just stunningly moving.

Jeremiah Gibson: Right. I imagine it's really cool as a Director to also be not just in the position of Director but also as a learner.

Steve Gaddis: Yeah, I mean that's another principle in the narrative worldview that I adore is that these are two-way relationships; they're not one-way relationships. So yes, I am certainly benefitting immensely—both from the learning and the ways it keeps me hopeful and heartened about the possibilities that this tradition of thinking can make.

One of the hopes I have for the Narrative Therapy Initiative is to be a vehicle to help grow and authenticate and legitimize these very nontraditional ideas about how to think about help, how to think about people, how to think about problems. And so as more and more people come through and become part of our community and then go out and grow these things, it's just incredibly satisfying and invigorating. And we have just an amazing community of people that I come to really think about family as much as anything else.

Jeremiah Gibson: Absolutely. What are some ways that you've observed students take the narrative worldview and apply it effectively and meaningfully in the ways that they practice therapy, be that with individuals, couples, or families?

Steve Gaddis: It's not easy because so many of them go into contexts where there's no immediate support or appreciation for these ways of working. It really takes a lot of perseverance and some subversiveness at times to change the culture or open up possibilities for something new. But I've seen everything from these heroic micro influences to students bringing me in as a consultant to their agency and training entire staffs. One of the recent graduates is bringing ideas about how to have conversations around racial identity from a narrative perspective into a school context where he works.

What I hope to create next is a program that follows the Certificate Program that I've called the Diploma Program, but we haven't really got it up and going yet. That will be where people who really have a good grasp of this narrative worldview—of which the Certificate

Program gives you a really solid foundation—can then take on a topic or a subject that they're passionate about and develop either a workshop or a paper or both.

Jeremiah Gibson: What feedback would you give to therapists who are new to the field to help them maintain a sense of perseverance?

Steve Gaddis: I get very concerned about how completing graduate school can introduce new practitioners to this idea that they should now understand themselves as fully equipped and prepared to know what to do. And that somehow they should adopt this identity as expert and professional and knower. And I think that can really be very oppressive and harmful and support burnout. And so what I would say is most important is to find your own relationship to ways of thinking about how to help, ways to think about problems. See if you can find a community to be a part of. If you need to, even though we don't make much money, try to find some way to get support for your ongoing skill development, your ongoing confidence, and feeling like you have a story about knowing what you want to do and how you want to be. And I think graduate programs and agencies often aren't able to provide that for you. So, I think that would be one thing. But I'd be curious about what you think about those, Jeremiah.

Jeremiah Gibson: Well, I'm really drawn to this idea of not knowing. Knowing has been a really important part of my story and a lot of the construction of my identity—as someone who grew up in gifted and talented programs in school, as a man, as a white-presenting person, as a Christian, as someone who grew up in a Christian context. I think that a lot of the work that I've done through a narrative worldview practice is becoming okay with the process of not knowing and experiencing kindness to myself, being gentle with myself when things don't come out the way that I want, or if I ask a question that doesn't make sense, being compassionate towards myself and practicing that and giving myself the permission to not know, which is really an equalizing principle from a relationship standpoint that allows me to join me with my clients, with my partner, with my friends on an equal playing field.

Steve Gaddis: Yeah, that's lovely. I think one of the most important practices in the narrative worldview is curiosity, right? And so I think, for me, rather than not knowing, I prefer to think about curiosity.

Jeremiah Gibson: How would you distinguish the difference between the two?

Steve Gaddis: Well, I don't think it's true that we don't know things. I think it's whether or not we're centering them or not. So if we're curious, we can be centering the knowing of another person.

I think we are learning things that we know about how we practice. Like, what are the skills that we're bringing? Why are we asking this question and not this question? There's knowing in that. So I don't want that to be disqualified or marginalized.

But I really appreciate what you're saying about the idea that not knowing what's meaningful to another person, not knowing what stories are influencing their lives. And I do think, like you, I had a relationship with knowing as kind of what was the measure of a successful person. It is always uncomfortable for me to take up this curious practice but it's an ethic that I am committed to. I see it as an act of love. I see it as an act of respect. And I don't know what more people want than to be met with that kind of interest in their lives and their thinking and their hopes.

And if we're providing that, that, to me, is such an honor. And so I guess back to what you were saying about the ideas that I might offer to younger practitioners who are newer in the field. I know a lot of them get very nervous about doing harm and they really care a lot about not wanting to make things worse for people. And one thing I would say is: If you stay genuinely curious, you're probably less at risk of doing any harm than interpreting, giving advice, giving solutions.

Jeremiah Gibson: Even if you push a client to an uncomfortable place.

Steve Gaddis: Say more. What do you mean by that?

Jeremiah Gibson: Well, I think that there's a difference between safety and comfort. I think for a lot of new therapists those two ideas get really blurred. That: "I don't want to ask a hard question because I don't want to make a person uncomfortable"—which really reflects on: "I don't want to make myself uncomfortable." "Oh my goodness, what am I going to do if this client across from me is super anxious." I think that what you're saying is that if you build a relationship around compassion, around curiosity, that gives you the space, that gives you permission to ask some of these tougher questions, but also to do so in a way that's warm, that's inviting of reflection, that's non-judgmental, non-shaming.

Steve Gaddis: Yeah, I don't think those things can be said enough. It's often taken for granted that practices of non-judgment are critically important to any effort to be helpful. I guess what you said made me think about the idea of asking tough questions. One of the things that helps me recognize is a skill that I've worked very, very hard on is staying really close to what the person's been saying, the word they're using, not introducing much new, but building on what's been said.

And I think one of the things that helps is not taking people kind of into spaces they're not prepared for. I don't find people often getting to places where they're uncomfortable about the territory we're talking about. They might not know exactly what the answer is yet for them or what their thinking is, and so there's certainly discomfort around that. But I appreciate you saying that because it helps me to recognize that in my own history or practice.

Jeremiah Gibson: Right. I think that therapy is about addressing and to some capacity overcoming the discomfort of our life. The discomfort from problematic stories, the discomfort

that comes from recognizing the amount of privilege in our stories, and being able to write alternative narratives for the ways that we tell our stories and the ways that our stories play out in the ways we live.

Steve Gaddis: Yeah. Narrative therapy is a social justice approach because there's so much about power. If the story that everybody internalizes is that we should desire comfort, then anytime we are entering a territory of discomfort, we're vulnerable to turn somebody else into a problem, we're vulnerable to kind of get aggressive, confrontational, and in the service of maintaining our rights—our privileged rights—to maintain comfort. So I see it as a really ethical commitment to be comfortable with discomfort as a commitment to social justice, as a commitment to doing power relations differently, doing white maleness differently.

I'm so grateful to the narrative worldview; after all, for many people I think, it's not like they haven't thought these ideas before. They just haven't had the kind of language that's helped them articulate it for themselves. So for me, that's what that worldview has done: it's given me a language for things I think I know but I didn't know how to articulate, I didn't know how to put into practice.

Jeremiah Gibson: Yeah, I like that. Harlene Anderson comes to mind in saying that language is really the only intervention that we have in therapy.

Steve Gaddis: Yeah, I would love a world where we become much more humble about ourselves as a species and recognize that all we ever are are meaning-makers. We've been tricked in western society for thousands of years that we are really truth-finders, not meaning-makers. And so I think we could do relationships and accountability and power a whole lot differently if we were to kind of move into more of a recognition of ourselves as meaning-makers.

Jeremiah Gibson: Yeah. And it sounds like these two programs that you're presenting in 2019, 2020—the Apprenticeship Program, the Certificate Program—are two ways that we can incorporate these principles both into our therapeutic practices and also into our lives and relationships.

Steve Gaddis: That's exactly my hope and my dream. I started this because when I got to New England–I came here because when I was finishing my Doctorate program at Syracuse in Marriage and Family Therapy–I was looking for an internship where I could kind of become part of a narrative community. And at the time there was a family therapy institute called the Family Therapy Institute of Cambridge. And there were a handful of people there who were doing narrative stuff. They were hosting Michael White when he came to the U.S. as one of the few spots he would teach in. And it was Kaethe Weingarten and SallyAnne Roth and Phil Decker and Xijuan Wu and Betsy Buckley.

And so, you know, there were a handful of people who were around here, and I started working at a big social service agency—The Home for Little Wanderers—doing home-based family therapy with Phil and Betsy and XiJuan. It was a lovely experience. But I was up on the North Shore and kind of out of that community a lot, so I started a place called the Salem Center up here in Salem. It was a general post-modern therapy training program with two dear colleagues. And I was doing a lot of narrative stuff and they were doing other collaborative language systems, other traditions within this post-modern, post-structuralist world.

And then, Michael died unexpectedly and tragically. And I think many of us who had the privilege to be his students—I was able to do a yearlong training program at the Dulwich Center in Australia—so many of us felt a huge hole from his loss, and I think many of us have tried to figure out what to do as a response to try to keep these ideas growing. And they're growing fast around the rest of the world, but it's hard to get them going here in the U.S. So that's when I decided to break away from the Salem Center and begin the Narrative Therapy Initiative. And here we are, you know, ten years later. Proud to be one of the members of NEAFAST.

Jeremiah Gibson: You used the word "subversive" earlier as a way of encouraging people to not get so stuck inside the box of the agency world. And it sounds like the development of NTI is another version of that too; another way of creating a more holistic, more humanistic way of doing therapy in a state, Massachusetts, that's very centered around first-order change, around the medical model, and the bureaucratic systems that reinforce that. So…so thank you.

Steve Gaddis: Oh, well, thank you. I mean, that's a gift to me. It's fun to have this description of NTI as a "subversive organization." But it really fits. You know, I think you can be kind and respectful and hold people, stories, traditions, and structures accountable in a way that makes change. I've experienced many legitimate ways of doing social justice work and I think there are many pathways for that. I prefer the subversive one.

Jeremiah Gibson: Yeah, definitely. Well, thank you so much for taking the time to do this interview.

Steve Gaddis: Thank you, Jeremiah. This was lovely to have this time with you. I look forward to our future growing relationship.