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Life Experience as a Catalyst for Therapeutic Change

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Life Experience as a Catalyst for Therapeutic Change

by

Emily K. Wrobel , B.A.

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work

St. Catherine University and the University of St. Thomas
St. Paul, Minnesota

in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

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I want to thank my parents for laying the foundation so I could compose a life with purpose and meaning. Your sacrifices have become my opportunities. Mom you have been a constant source of love and inspiration. I would not be who I am today with out you. Dad I believe you are always with me...

To the many friends and family members who have also supported me and given me hope and encouragement. I'm grateful for all of you.

To love is to recognize yourself in another.

-Eckhart Tolle

Abstract

The therapist's lived experiences of personal transformation can be reflected to clients in a variety of ways in a therapeutic relationship. This was an exploratory study with a qualitative research design aimed to examine the impact of transformative experiences of the therapist on the therapeutic relationship, as well as how use of self is defined and operationalized by the therapist in clinical practice. Participants were recruited through a nonprobability snowball sample. Data was gathered through six in-depth qualitative interviews of female participants from both urban and suburban settings, with an age range of 29 to 65 years old. Participants were employed in a variety of settings ranging from private practice to hospital social work. The data was analyzed and coded using thematic analysis. Findings suggest a much more complex subjective process of use of self, an introspective practice, with significant overlaps in ways the self is reflected in the world; based on the unique qualities of the participants and their willingness to engage in deep self-reflection as a practice in itself. This was seen as the primary component for participants when trying to engage effectively with a client in a meaningful way. Introspection provided clarity by helping participants sort out their feelings, reduce stress, and find meaning in their experiences. Not all personal transformations created a significant shift in what the participants did in their practice in terms of technique. The personal experiences of the participants created more self-awareness, purpose, meaning, and clarity of life, which was reflected in a deeper intention in their work with clients. Implications suggest more education and research is needed related to inter-subjective experience & transpersonal perspectives in social work practice.

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Introduction

Just as clients deal with a vast array of life experiences, opportunities, challenges, and barriers, naturally so do the social workers that assist these clients. Social workers face many setbacks and hardships that impact their physical and mental health. Whether prior to their professional work or during their time in the field, these difficulties have the potential to impact the social worker's practice both positively and negatively. This seems logical when reflecting on client experiences in practice and the theories and perspectives that support social work practice.

The ecosystems perspective acknowledges human beings are intricate creatures impacted by internal and external forces in our environments, a perspective unique and significant in social work practice. As humans, we are multifaceted and our behavior and interactions develop and adapt over time to fit the context of our environments. At the same time, this perspective acknowledges environments also adapt to the needs of people. The person in the environment is constantly evolving due to this interrelatedness with social and physical influences (Miley, O'Melia, & DuBois, 2011). More specifically, the social constructionist view focuses on how individuals make sense of experiences in their lives and how the cultural and social environment in which they live shapes their perceptions of reality (Forte, 2007).

These perspectives acknowledge that social and cultural forces impact and shape an individual's reality. Problems or pathology are not insular, but are linked to the larger environment or system and not the individual alone, which empowers the individual versus blaming them (Forte, 2007; Miley, O'Melia, & DuBois, 2011). If this

interconnectedness is inevitable, what happens when the social worker is the individual faced with significant problems or pathology? How do they cope, accept and/or recover and simultaneously engage professionally and effectively in clinical practice?

Social workers often enter the field due to a personal connection with the groups with which they work, personal or life changing experiences, or because they feel compelled to help others address problems and change their lives (National Association of Social Workers [NASW], 2011). Inevitably, social workers' personal experiences and hardships have shaped their own perceptions of reality and challenged them in their personal lives. Social workers bring their own feelings, experiences, knowledge, and empathy to their work with clients each day in hopes the client will find motivation for change, learn new insight into their behavior, gain access to resources and services, or find comfort and hope in traumatic or crisis situations. During these client interactions, if the social worker uses an approach that is genuine and empathic, they share a reflection of themselves (Arnd-Caddigan & Pozzuto, 2008; Dewane, 2006).

Understanding these experiences and the motivation and passion behind engaging in social work practice is important component, and requires a great deal of self-reflection in conjunction with social work education (Miley, O'Melia, & DuBois, 2011; NASW, 2011). More specifically, social workers' perceptions of what is therapeutic in practice is based not only on education and supervision, but on current life experiences that have shaped or transformed who they are and thus their framework for the work they engage in (Dewane, 2006; Kaiser, 1997). Illness, aging, new opportunities, traumatic experiences, and other challenges and consciousness raising experiences arise and impact social workers' lives and can often result in changes, accommodations, and heightened

use of self in the therapeutic relationship, that were not considered or understood before (Elliot, 2000).

The social work profession plays a critical role in directly assisting individuals and families. NASW (2011) cited the U.S. Department of Labor (2010-11), stating over 95% of social work practice in the U.S. is related to direct service with clients in a variety of settings and specialties. As the largest providers of mental health services in the country, social workers often focus on engaging, assessing, linking clients to resources and services, and helping clients cope with everyday challenges (NASW, 2014). These practices promote change in clients and contribute to the greater good of society, which further advance core social work values (NASW, 2011; Miley, O'Melia, & DuBois, 2011).

Each day, social workers make decisions on how to proceed in a way that is most beneficial and ethical to the clients they serve. Social workers have an obligation to continually engage in professional development throughout their careers (NASW, 2014). Social workers are taught to use self-reflection to be aware of areas of growth, judgments, values, and beliefs that impact their work with clients. This is especially important when the social worker is facing challenging work situations or personal problems or hardships that significantly impact their lives and have potential to impact their therapeutic relationships. When identifying implications for ethical practice to address compassion fatigue among social workers, Wharton (2008), cited past research, which indicated approximately 48% of social workers in the U.S. experience higher than normal levels of stress as a result of the work they do. This is consistent with other research, which indicates people in the helping professions are exposed to traumas and stressors that

create greater risk for the development of significant clinical problems for the professional. Wharton (2008) cited additional research findings, which include higher levels of distress, suicide rates, relational problems, and higher job turnover among social workers as a result of their work. According to the Code of Ethics for social work practice:

“Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others” (NASW, 2006, p. 23).

When reflecting on the distress present in the social work profession and the importance of engaging in self-reflection and self-care through personal therapy and supervision, one could easily claim use of self in social work includes both an ethical and therapeutic component. Without some sense of self, a social worker may not identify warning signs in their personal life, which could negatively impact their professional work. Reamer (2011) claims use of self is essential in managing ethical dilemmas in a skillful, effective manner. He contends social workers must have a clear understanding what use of self is in practice to assess challenging situations and ethical dilemmas appropriately. More specifically, assessing risk and managing situations with clients through clear understanding of social work ethical standards, use of consultation and

supervision, and knowing oneself enough where co-transference issues in client relationships can be identified and addressed appropriately.

This research study sought to explore how social workers' own life events, illnesses, or dilemmas have impacted, altered, and/or shaped their practice with clients. This study also sought to explore how these personal experiences have promoted the evolution of the social workers' use of self in the therapeutic relationship and in their clinical practice. Additional questions were related to how "use of self" is subjectively described and used by social workers in practice.

Literature Review

This literature review is divided into four sections that identify common themes in past research, which reflect the significance of the therapist's use of self as an instrument for therapeutic change. The sections include the human element, the therapeutic alliance, use of self, and the therapist's life experience. For the purpose of this study, the term "social worker" and "therapist," are used interchangeably to refer to all clinical professionals from a variety of disciplines that are licensed to conduct individual and group therapy with clients in a mental health setting.

The Human Element

Social workers are vulnerable to life's challenges just as any other human being and sometimes seeking out professional therapy services to process is necessary. Utilizing consultation, supervision, and receiving feedback from clients are important in professional development to maintain ethical standards and prevent the social worker

from compassion fatigue and burnout (Kaiser, 1997). In fact, according to many studies, social workers and psychologists have found their own personal therapy experiences to be helpful when coping with life stressors as a way to heal and remain grounded in their personal and professional lives (MacDevitt, 1987; Mackey & Mackey, 1993; Macran, Stiles, & Smith, 1999; Oteiza, 2010; Wiseman & Shefler, 2001). For example, according to research by Wiseman and Shefler (2001), therapists who were interviewed about their use of individual therapy readily identified therapy as a critical component to goal achievement related to gaining self-awareness and growing responsibly as a professional. In addition, supervision is a critical part of competent social work practice that requires accountability and engagement by the social worker. To be effective, it requires skill development, which includes “personal skills” or the social worker’s capacity to continually engage in increased self-reflection and personal advancement (Kaiser, 1997, p. 12).

Social workers have several options for support professionally and personally and are expected to engage in practices of self-care that promote wellness and personal growth. This is essential if the social worker plans to be authentic and empathic in practice, which is related to the therapist’s use of self (Arnd-Caddigan & Pozzuto, 2008). Seeking supervision and therapy are equally important tools for a social worker to utilize. These tools have the potential to provide healthy outlets to reflect and process personal experiences and responses to distress in the workplace. In addition, utilizing these tools has the potential to provide the therapist with a stronger sense of self, which can be reflected in practice. One could state that the social worker’s personal experiences in therapy might help them reflect on what is most effective for them in therapy. The

therapist's empathy and understanding might create a desire explicitly or implicitly to incorporate these ideas or practices into their own work with clients (Safran, 2010).

The Therapeutic Alliance

Research findings consistently show there is a strong connection between the therapist's use of self and the therapeutic alliance (Asay & Lambert, 1999; Dewane, 2006; Norcross, 2010). When discussing the therapeutic alliance, Summers and Barber's (2010) reflect on the definition of the therapeutic alliance, which is rooted in psychoanalytic theory. The authors stated, an effective therapeutic alliance is an agreement about shared tasks and goals between the therapist and client, which consists of three parts. This includes shared goals, acceptance of the tasks each is to perform, and the attachment bond. Shared goals refer to the therapist's ability to understand the client's goals and be willing to work with the client to make progress in these goal areas. If the therapist focuses on another goal area, the client will feel misunderstood or criticized when no progress is made. Acceptance of tasks each is to perform refers to the role each will take in the therapeutic relationship. The client is expected to show up for the appointment, engage openly and honestly, reflect, and listen to feedback. The therapist is expected to listen, acknowledge and address biases, develop an understanding of the client, and reflect this understanding effectively to the client to develop shared meaning (Summers and Barber, 2010, p. 74-75). In addition, Summers and Barber's (2010) state the therapist should provide all applicable resources to the client so insights and approaches for addressing issues can be explored and implemented. The bond or attachment is critical to creating an alliance with the client. The therapists' use of

empathy and authenticity are necessary so the client feels the therapist is interested in what they say and do and cares about their situation. The client will feel safe and feel they can trust the therapist if this emotional connection is present.

Summers and Barber (2010) identified the therapist will likely feel they are not helping the patient and/or feel they are not fully contributing when a goal is not aligned with the client's goals, when acceptance and clarification of the roles is absent or unclear, or when the attachment bond is absent or not aligned with the client's needs (Summers and Barber, 2010, p. 72). This highlights the importance of the therapist's role in understanding their position in the relationship, acceptance of the client's desired or perceived areas of focus, and the ability of the therapist to open the door for a deep connection. With this foundation, the therapist's use of self can be used as a catalyst for change when the need arises or when life events arise out of the therapist's control.

Safran (2010) proposes significant relational aspects that are not fully recognized in Summers and Barber's (2010) definition of the therapeutic alliance. Their psychoanalytic perspective of the alliance minimizes and discredits the significant impact of co-transference. Although co-transference is seen as unavoidable, its meaning is reduced for not being objective or clinical enough, for it is seen as a reflection of biases and inaccurate thinking. Safran suggests redefining the idea of the therapeutic alliance as an ongoing process of "intersubjective negotiation," which is both implicit and explicit in nature (2010, p. 1). This ongoing negotiation includes discussion about "tasks and goals, as well as their respective needs and differing perspectives on reality (including the question of what is taking place in the therapeutic relationship)" (Safran, 2010, p. 1). Finally, Safran (2010) argues the negotiation process is the critical part of the therapeutic

alliance because if there is a rupture in the relationship, the client and therapist will need to find common ground through the negotiation process. At the same time, the client is learning to negotiate their needs with the therapist, which helps establish a strong sense of self by pushing the client to engage in reflection and find common ground with the therapist. The therapeutic relationship creates an ever-evolving model for navigating life challenges and future relationships.

Consistent with Safran (2010), Arnd-Caddigan (2011) suggests expanding the definition of the concept of the therapeutic alliance with the term “Internalization,” which is rooted in attachment theory and focuses on the process of mentalization and mirroring in the therapeutic relationship (Arnd-Caddigan, 2011, p. 77). More specifically, it’s the

“Therapist’s ability to hold the client’s mind within his or her own. When s/he turns her thoughts to a specific client and therapy the therapist is able to reproduce in his or her mind the client’s rhythms, mannerisms, intonations, and recombined bits of past interactions with imagined interactions. Based on his or her understanding of the client, the therapist can mentalize the possible feelings, intentions, motivations and needs of the client” (Arnd-Caddigan, 2011, p. 77).

Arnd-Caddigan (2011) proposes a definition of intersubjective experience, highlighting the relational dynamics that unfold in the therapeutic relationship, which requires the therapist’s use of self. When reflecting on characteristics of the therapist, the author concludes “Rogerian facilitative conditions, or the therapist’s warmth, empathy, and genuineness as well as interpersonal activities, such as self-disclosure, intentions and response modes” are commonly seen in effective therapeutic relationships (Sexton & Whiston, 1994 as cited in Arnd-Caddigan, 2011).

Arnd-Caddigan's (2011) idea of use of self in building a strong therapeutic alliance is consistent with Norcross' (2010) reference to two studies of psychotherapists themselves who identified in their own personal therapy, the most important lessons they learned about the therapeutic alliance. One of the most frequent responses included the significance of use of empathy in the personal relationship (Norcross, 2010, p.116). Norcross (2010) identified empathy as an obvious component to the therapeutic relationship and positive outcomes because it facilitates understanding and opens the door to new pathways to correcting affect and emotional states. One could argue if the therapist emphasizes the use of empathy and mutual understanding as significant and effective in their own personal therapy, they will likely identify this as something important when engaging effectively with clients. In addition, Norcross (2010) identified the therapeutic relationship as the most important part of effective therapy because being effective with the client and meeting all the client's needs in a session, is a direct reflection of the established alliance. Research on what clients identify as important in therapy reflected similar components related to empathy and person centered approach such as listen actively to the client, acknowledge the client's experience, ask for real-time feedback regarding the therapy relationship, avoid negative comments and criticism, and ask the client what is most helpful in therapy (Norcross, 2010).

Cultural differences and similarities need to be considered when building a therapeutic alliance. Therapy is a relational process and acceptance and common meaning are important for both the therapist and client in building a connection. According to Potocky-Tripodi (2002), social work practice is influenced by multiple facets of culture that include the cultural perspectives and beliefs of the not only the

social worker, but that of the client, the agency that employs the social worker, and the larger societal culture. These factors need to be considered when building an alliance with a client. Self-awareness is required in competent practice because in order to understand race, ethnic, and cultural backgrounds of a client, the social worker must know their own worldview. Potocky-Tripodi (2002) identified additional steps require social workers to acknowledge personal biases, values, beliefs, and experiences of their own in order to lessen adverse responses and judgment, which can create barriers to building a connection with the client.

Findings by Safran (2010), Norcross (2010) and Arnd-Caddigan (2011) reflect the importance of the therapeutic relationship in positive therapy outcomes. The therapist's use of self in practice is unavoidable and without empathy, authenticity, and understanding, among other characteristics, the therapeutic relationship cannot fully develop or be effective. This is important when reflecting on the research findings of Asay and Lambert (1999), who identified the therapeutic relationship or alliance as a significant factor in what client's identify in effective therapy. Asay and Lambert's (1999) review of over 60 years of research on the effectiveness of therapy and the common factors in therapeutic outcomes, identified the therapeutic relationship as critical and accounting for 30% of the positive therapy outcomes. Forty percent of outcomes were related to external factors out of the therapist's control, 15% were accounted for due to expectancy effects and the other 15% for the technique used in therapy (Asay & Lambert, 1999, p. 11). Thus, the therapist's ability to use their personality, empathy, anxiety, and other relational skills to create a connection is key to building an alliance and establishing a strong start to the therapeutic process. The alliance is the foundation

that is necessary for change, progress, and/or healing to occur if it aligns with what the client desires through the therapeutic relationship (Asay and Lambert, 1999). The authors go on to identify the therapist's ability to make a connection with the client is more important than a conceptual framework or technique that is implemented in the therapy session.

Use of Self

As previously mentioned, it is commonly understood from research and experience that sharing characteristics and feelings of one's self in the therapeutic process is unavoidable and necessary in building an alliance with clients (Dewane, 2006). In therapy, when the social worker listens to what the client needs, and when self-reflection and awareness are practiced effectively, the use of self in the therapeutic process can advance treatment and positive outcomes for clients.

Dewane (2006) identifies the therapist is the most important tool in the therapeutic process. Her research was cited in several articles related to use of self in social work practice and field education. The author suggests that use of self can be applied in practice in five different ways: "Use of Personality", "Use of Belief System", "Use of Relational Dynamics", "Use of Anxiety", and "Use of Self Disclosure" (2006). The therapist's own personality traits, natural use of humor, views, and perceptions determine what his/her theoretical orientation will be, which reflects what they relate to and experience in the world and these choices play out in the therapeutic process. In addition, the therapist must identify their belief system, reflect on the belief system of their client, and identify how it enters into the therapeutic relationship so they are not pushing their beliefs or values on a client. Dewane (2006) recognized the relational

dynamic between the therapist and client as a requirement for therapeutic change to occur. This includes the therapist's use of empathy, vulnerability or "humanness" in relation to the client, and "reciprocal transferences," acknowledging both the therapist and client have transferences and counter-transferences (Dewane, 2006, p. 552). In addition, Dewane (2006) identified anxiety as a normal response by the therapist who wants to engage in good practice with the client but may have doubts about their ability or competence. Accepting anxiety and being vulnerable can provide a model for the client that has potential to enhance the therapeutic relationship. In addition, the client can internalize and translate that meaning into other relationships. The author identified self-disclosure as the most controversial and commonly discussed use of self in social work practice. When considering disclosing, she suggested asking the question, "Is this for the client's benefit or mine?" (Dewane, 2006, p. 557).

Walters (2008) referred to Dewane's (2006) five perspectives of use of self when reflecting on field placements in social work education, identifying authenticity and use of personality traits as important tools in therapeutic practice. Having knowledge of personality traits and exploring how they can be useful or limiting with clients is critical. Reflecting on reasons for being drawn to the profession of social work and the motivation behind entering the social work field is important in the process. In addition, engaging in individual and group work with clients may reveal how effective the social worker is in relationships based on their personality traits. Walters (2008) proposed engaging in these practices can enhance self-awareness and growth in the social work student and essentially prepare them for the relational dynamics they will face in therapy with clients.

The importance of use of self within the relational context of therapy is also reflected in the findings of Edwards & Bess (1998), who stated the social worker's conceptual framework and level of skill are not as important to clients as their ability to use their personality and honesty as a pathway for strengthening the alliance and finding shared meaning in experiences with the client. In addition, the authors identified personal therapy as a beneficial tool for the social workers' growth both personally and professionally. The practice of self-discovery by the therapist has the potential to be reflected in the therapy session with the client (Edwards & Bess, 1998).

Similarly, Arnd-Caddigan & Pozzuto (2008) challenge the traditional definition of use of self in social worker, which they define as, "a freestanding being that is self-contained - though at times in interaction with other such entities - and relatively stable or constant" (p. 235). Instead, they define "self" in a relational context which states, "self only exists in relation to another" (p. 236). Thinking of use of self in practice as engaging with a client versus doing something to a client is more realistic to what actually occurs in practice. The self that is used in practice is based on past interactions that ultimately impact the present interactions with a client. During these interactions, the therapist's self is "maintained," "re-created," and "modified" (Arnd-Caddigan & Pozzuto, 2008, p. 236). The authors acknowledged that research indicates many professionals tend to step away from technique and naturally focus on relational aspects with clients to maintain authenticity and meet the client where they're at. In general, if the professional is not being authentic, this impacts the positive effects of therapy.

The Therapist's Life Experience and Use of Self

As the review of past research supports, there is a connection between the

therapist's ability to be genuine and empathic with clients and the ability to build a strong alliance. The ability to be authentic and vulnerable with clients may be thought of as an inter-subjective experience because it has the potential to provide a framework for the client to find meaning in their own lives. Dewane (2006) cited Mezirow regarding authenticity, defining it as "a genuine, empathic approach" critical to the self-reflection social workers engage in and how their choices and awareness of self impact what they do. According to Mezirow, "authenticity" in relation to "perspectives transformation" is part of what allows for intentional change in a therapist and this authenticity in practice can facilitate or assist a recipient in this transformative parallel process by providing a perspective or track to follow (Dewane, 2006, p. 545). This authenticity by the therapist can be reflected in a variety of ways. The following stories are examples of how the therapist's life experiences forced "perspectives transformations" in order for the therapists to continue to relate with clients and find shared meaning in their clinical practice (Dewane, 2006, p. 545).

Neurological illness. According to Elliot (2000), "When language alone is not enough to move the therapeutic process forward, other working knowledge in the therapist's life can be brought to bear as a powerful evocative force for therapeutic change" (p. 321). Elliot identified that her own struggles with Parkinson's disease transformed her therapeutic work with her clients in therapy because it required her to make changes in her own life that consequently changed her therapeutic process. She was able to open up new doors as alternative options that could tap into affect and emotion that likely would not have been possible before. Elliot's struggles with her neurological illness, multiple surgeries, and chronic physical pain prompted her to find

alternative options to cope in her own life. She began engaging in art, music, poetry, singing, and meditation in her own life, which improved her ability to focus/concentrate, increased her energy, and decreased her physical pain. Elliot (2000), who grew up on a farm, identified this shift in energy and focus as “Mental Crop Rotation” stating, “rotating my energy and attention around the landscape of the mind and the universe of my interests seemed to conserve my resources and increase their productivity” (p. 323). Her engagement in expressive therapies helped her tap into her creativity and teach herself how to focus in different ways, which in turn, helped her apply this to other aspects of her life.

Through her own experience, Elliot realized that for some people, language is not always the best way to convey emotion. “In the microcosm of the therapy situation, affects and experiences are encouraged, contained, understood and resynthesized in novel and more livable ways” (p. 327). She applied her experiences and ideas to her work. Elliot identified alternative ways to access the self while being present in the moment by suggesting clients read various books including children’s books, engaging in sketching, creative writing, poetry, and listening to relaxing music with clients. Elliot emphasized the need to not push her hobbies or interests on clients stating, “In the therapist, the principle ingredients are authenticity, self-honesty, and accountability” (Elliot, 2000, p. 325).

Life threatening illness. Henry (2009) reflected on her own experience with life threatening illness and how it impacted her work with clients. She described aging as an important consideration when reflecting on clinical practice and emphasized the importance for therapists of confronting deep fears regarding sudden death or serious

illness. If the therapist denies their vulnerabilities as a human being, this will be reflected in the relationship with the client. From a relational psychology perspective, Henry emphasizes the inter-subjectivity within the therapeutic relationship and how healing occurs within this realm. Just as the health issues and limitations of the client impact the therapist, the health issues and limitations of the therapist impact the client. Without prior notice to her clients, Henry was diagnosed with stage three cancer and was absent from her practice for a month. While absent, Henry felt the discomfort in having to put herself before others. She was in crisis and wanted to isolate herself. Henry had not planned for a life changing event like this to occur and therefore, had to contact all of her patients herself and explain very candidly that she was very ill and would not know if and when she would need to be absent from work to address her condition. Fortunately, Henry was able and willing to continue working throughout her cancer treatment.

Henry quickly learned her vulnerability when working with clients promoted significant positive change in clients who had been struggling for years. For example, Henry identified a client who was frequently suicidal and when she disclosed her illness and admitted to being scared to die, this client immediately began focusing on Henry's feelings and needs. In addition, Henry was able to convey to this client she was utilizing the same skills and strategies they had worked on in their therapy sessions. As a result, the client began attending a support group for friends of people with cancer. When the client had asked Henry what she could do to help her, Henry asked that she give up her suicide plan. The clients realized that dying was no longer an option because she could see Henry was desperately trying to live. This experience allowed the client to get out of her head and focus on the external events around her. Henry could see all of the skills

she had taught the client coming to use in front of her. The client essentially used the therapist's illness as a "metaphor for finding meaning in her own life...vulnerability ignited a spark in her that she didn't even know that she had" (p. 296). Henry believed that abruptly ending the relationship and/or not disclosing her illness would have been an "empathic breach" that could have permanently damaged the therapeutic relationship (p. 296). Reflecting on the power of inter-subjectivity and being in the present moment, Henry (2009) stated:

"Our own process of aging and facing death deeply enhances the client's work. Bringing existential issues directly into the therapy deepens the therapeutic exchange and allows the therapist and patient to sit together in the knowledge that there will be inevitable loss" (Henry, 2009, p. 296).

Aging & Transformation. Buxton's (2009) husband came out as a gay man after twenty-five years of marriage, which shattered her assumptions and beliefs of gender and marriage. The belief system she grew up with that emphasized there was "one correct way to do or so anything" gradually shifted as she experienced the social and cultural barriers as a teacher and development coordinator in an urban multiethnic school district. She was forced to reexamine her belief system; the meaning of life as she knew it, and question the social and cultural beliefs and constructs that seemed to create barriers and pressure conformity among people. Through personal exploration and study of eastern religion and philosophy, Buxton started her personal transformation. She wrote a book and founded an organization specifically for straight spouses of gay or lesbian partners, providing presentations on the impact of a spouse coming out. Buxton began providing

peer support groups for straight spouses and families, which eventually led to counseling services. Buxton began bringing her transforming experiences in her life into her counseling, which was very helpful in promoting personal growth and creating a desire for transformation and change in clients.

When Buxton remarried and her husband became increasingly ill due to a neurological disorder, it was necessary for them to move into a retirement community. Buxton continued her transformation as she adjusted to being one of the youngest people in the community, facing her husband's decline in functioning and confronting her feelings in response to experiences of frequent loss around her due to illness and old age. Buxton was also surrounded by constant relationship building and a diverse group of people from varying cultures, beliefs, and lived experiences. These relationships were observable models of wisdom and acceptance of pain and suffering with equal moments of joy and curiosity for the unknown, which was amazing to Buxton. She was able to bring this acceptance, empathy, mutual respect, and shared experience to her counseling practice, which helped empower her clients and also fulfilled her desire to create shared meaning and help people. "I am learning to view their suffering, and my own, as part of the ongoing nature of life rather than a measure of whether we are good or bad. This helps me, and them, see that how one deals with the pain and grief is what matters most" (Buxton, 2009, p. 283).

Summary and Research Focus

There is extensive research on the significance of the therapeutic alliance and use of self in effective therapy outcomes (Asay & Lambert, 1999; Arnd-Caddigan, 2011; Norcross, 2010; Safran, 2010). The literature on use of self in therapy suggests the

therapist's use of self is complex and essential when building a therapeutic alliance (Arnd-Caddigan & Pozzuto, 2008; Dewane, 2006; Edwards & Bess, 1998). Relational dynamics are an unavoidable aspect of clinical work. The literature review supported the focus of this study by highlighting the therapist's use of self, specifically the transformative experiences of the therapist, in forming a deep and meaningful connection with the client, which is necessary for therapeutic change to occur.

Conceptual Framework

Existentialism and transpersonal theory have influenced culturally and spiritually competent social work practice. They integrate many insights from religious and spiritual traditions, questioning the exclusivity and ethnocentrism of major world religions. In addition, these perspectives see the unavoidable interconnection between individuals and their environments as an opportunity for personal transformation (Canda & Furman, 2010; Farber, 2010; Hutchinson, 2008). "Transpersonal theory is concerned with the study of the transpersonal and spiritual dimensions of human nature and existence. Etymologically, the term transpersonal means beyond or through (trans-) the personal, and is generally used in transpersonal literature to reflect concerns, motivations, experiences, developmental stages (cognitive, moral, emotional, interpersonal, etc.) modes of being, and other phenomena that include but transcend the sphere of the individual personality, self, or ego" (Ferrer, 2002, p. 5). More specifically, "Transpersonal experience may be defined as experiences in which the sense of identity or self extends beyond (trans) the individual or personal to encompass wider aspects of humankind, life, psyche, and cosmos" (Walsh & Vaughan, 1993, p. 3).

Existentialism and transpersonal theory are two major nonsectarian spiritual perspectives that stemmed from humanistic intellectual developments (Canda & Furman, 2010). More specifically, the humanistic perspective of psychology was created in response to mainstream psychology's focus on behaviorism and psychoanalysis, which was believed to limit human potential. Humanistic therapy is an umbrella term, which includes gestalt therapy, client-centered therapy, existential therapy and transpersonal theory, which focuses on human spirituality (Hutchinson, 2008). All of the therapies emphasize the importance of being in the present moment in order to make progress. The humanistic perspective focuses on the subjective and is rooted in empowerment and the innate value and dignity of human beings (Farber, 2010).

Existentialism and transpersonal theory believe being human requires responsibility for oneself and the choices made. "To be a free person means never allowing oneself to be trapped in a personal comfort zone or a viewpoint dictated by external rules and authorities" (Canda & Furman, 2010, p. 188). The transpersonal perspectives "draws attention to the neglected, misunderstood family of experiences; provide new understandings of ancient ideas, religious traditions, and contemplative practices; offer more generous views of human nature; and point to unsuspected human possibilities" (Walsh & Vaughan, 1993, p. 7).

Existentialism and transpersonal theory have common beliefs. However, each has contributed to social work practice in different ways. The following paragraphs attempt to differentiate the two perspectives and how they are incorporated into social work practice.

Existentialism

According to Canda & Furman (2010), existentialism has been incorporated into social work literature for over thirty years but its biggest contribution to social work has been through its practice wisdom. This practice wisdom has shaped the field of social work by promoting a therapeutic use of self in practice, emphasizing use of empathy, the lived experience, and acceptance and non-judgment in the therapeutic relationship. In addition, “The existential therapeutic approach is client-centered, experiential, rapid change focused, and sensitive to issues of values and philosophical or religious perspectives” (Canda & Furman, 2010, p. 189)

Existentialists focus on the present or the “immediate human experience” and when social norms and religious teachings create a barrier to the inevitable push for human growth and potential of the individual, it needs to be contested. When faced with unavoidable limitations such as systemic conditions or death, existential suffering occurs, which can lead to alienation. Existentialists believe feelings of remorse, humiliation, fear, and anxiety are natural consequences of feeling alienated (Canda & Furman, 2010; Elkins, 2009). Despite these limitations, an individual still has to continue to make choices and make meaning in life. They must learn to survive in the face of pressure to follow social norms and adjust when they make mistakes or confront limitations and barriers.

Social work implications include the requirement of the existential social worker to be well rounded, knowledgeable and comfortable with culturally and spiritually competent practice. Exploring the religious and spiritual perspectives of the client without explicitly doing so, by understanding their worldview, and being “alert and

responsive to themes of meaning, connectedness, responsibility, purpose, and transcendence” so the inter-subjective experience can be possible (Canda & Furman, 2010, p. 189).

The existential perspective is important when understanding the barriers and inevitable limitations, such as death or illness that both the therapist and client face as human beings. Despite these challenges, each person has the freedom of choice, which can lead to personal growth, self-discovery, and changes in perception or can result in suffering and/or illness. The existential perspective is aligned with the focus of this research, considering the transformative experiences of the therapist, and how this is reflected in their practice with clients, who also inevitably suffer.

Transpersonal Theory

Transpersonal theory is grounded in the idea that both peak inspirational experiences and events of suffering and/or confusion lead to altered states or heightened awareness of one’s self and their reality. According to transpersonal theory, situations of existential confusion occur when a person’s system of meaning is challenged by a situation and forces the person to be open to something different.. “Inspiration is experienced as an opening that occurs quite unexpectedly and spontaneously for some...along with such opening, a sense of awe, relief, freedom, and gratitude emerge” (Hart, Nelson, & Puhakka, 2000, p. 35-36). In contrast, someone may experience intense suffering that pushes the person beyond the limits of their self-identity, which can “fracture the person’s ordinary psychosocial status quo and open up new possibilities” (Canda & Furman, 2010, p. 194). In addition, people have the ability to have an

experience of great suffering, which leads to acceptance and experiences of inspiration and/or gratitude.

Transpersonal values have strong implications for social work practice, pushing to broaden theoretical frameworks of the “person in environment” by stating they not only influence one another but are inseparable. This perspective challenges developmental theories that set limitations on personal growth or potential. Transpersonal theory emphasizes human freedom and dignity and believes there are no absolutes. There is always a potential for growth and this is encouraged. Transpersonal social work is a mutual process because both the client and social worker grow through the therapeutic relationship (Canda & Furman, 2010, p. 194-195).

Therapists can become disheartened when clients identify barriers and social pressures as oppressive and alienating. Transpersonal theory is an empowering perspective that encourages change, self-determination, and personal growth throughout the lifespan, which is something social workers are taught to incorporate in their work with clients. Reflecting on cultural and spiritual considerations is important in social work practice and is emphasized in transpersonal theory. Often times, clients use their religious, spiritual, and/or cultural beliefs to cope with suffering. However, human beings can become disillusioned when their beliefs, values, and practices create further limitations or do not fit with their desires and needs. The therapist can use their own experiences of suffering and/or inspiration to aid the client in their experience and give them hope.

This study builds on the belief that the therapist’s transpersonal experiences and use of those experiences in creating shared meaning and connection with a client, is the

primary catalyst for instilling hope and promoting change. The interviews explored how therapists have experienced transformative change because of peak experiences or opening of consciousness related to inspiration, gratitude, trauma, illness, and loss; how each therapist challenged their human limitations and made a choice to engage in personal growth and healing, which included sharing their vulnerabilities and inspirational experiences with clients through their practice. The use of the therapists' personal stories of transformation, gives validity to the power of the therapist's use of self in practice.

Methods

Research Design

This was an exploratory study with a qualitative research design aimed to examine the impact of transformative experiences of the therapist on the therapeutic relationship, as well as how use of self is defined and operationalized by the therapist in clinical practice. Data was gathered through six in-depth qualitative interviews, which allowed the researcher to build upon in-depth understandings of intimate and challenging situations for the purpose and goal of understanding how the mental health professionals in the study changed or transformed their lives and integrated this experience into practice with clients (Gilgun & Sands, 2012).

Sample

The six participants were found through a nonprobability snowball sample, which was initiated by the researcher through email. The email provided a recruitment letter (Appendix A) introducing the study and inviting people to participate. The recruitment letter was emailed within the researcher's internship and professional work settings and

specifically requested friends and colleagues to refer others who had an interest and fit the subject criteria for this research. A snowball sample was chosen for this research because many mental health professionals who engage with clients in individual and group therapy services engage with each other due to previous jobs, support groups, professional memberships or affiliations, client referrals, networking and community meetings or events. Due to the personal nature of the research topic, it was anticipated referrals through professional friends and colleagues would provide a well-rounded group of potential participants with unique transformative experiences fitting for this study that might not have been available otherwise (Monette, Sullivan, & DeJong, 2011).

Participants

The population for this study focused on licensed mental health professionals who had practiced or were practicing at the time of this study with individuals and/or groups in a private practice, agency, clinic or other medical or public health settings where there was direct engagement with clients.

In addition, the following inclusions applied to participants at the time of the study:

- (a) Reported having experienced an altered state of consciousness or peak experiences that brought them gratitude or inspiration; traumatic events, physical or mental illness, loss or death, or other life changing experiences
- (b) The experience has caused them to alter their thinking; to engage in personal growth and self reflection to be content or find deeper meaning in their personal life
- (c) The experience has caused them to alter their work or practice in some way in

order to be effective in clinical practice with clients and maintain positive therapeutic outcomes

All participants were women from both urban and suburban settings. All identified as Caucasian/European American. One participant identified as being Czech and another identified as being Latina in addition to Caucasian/European American. Four participants identified as heterosexual and two identified as queer. Participants' ages ranged from 29 to 65 years old. Three of the six women were under the age of 33. Educational background ranged from a Bachelors degree to a Doctoral degree. These women had degrees in the following areas of study: Women's studies, Social Work, Counseling Psychology, Theology, and Transpersonal Psychology.

All participants had different occupational roles, which included direct contact with clients. Some participants identified engaging in multiple roles in their work, which included teaching of both students and clients, speaking at conferences and trainings, program management, and supervision of other staff. Occupational settings included Adult Rehabilitative Mental Health Services in clients' homes in the community, individual and family therapy in both a private practice setting and within a program setting, Oncology Social Work in a large hospital setting, which includes consultation, individual and group therapy; psychiatric rehabilitation services in a residential mental health treatment setting, and care coordination in an integrative clinic setting. All participants engage in some level of clinical practice (psychotherapy and/or assessment) in their work with recipients.

Despite the many differences among these women, common themes emerged in their narratives that reflected their personal experience(s) of transformation and self-awareness and how this has impacted their lives both personally and professionally, as well as their impact on use of self in their clinical practice. Participants identified a variety of experiences, which included physical illness, mental health disorders, and peak experiences or heightened states of awareness. These peak moments, also defined as heightened or altered states of consciousness, were related to cultural and environmental shifts, which led to experiences of intense feelings of gratitude and inspiration in their lives.

Protection of Participants

Approval by the Institutional Review Board at the University of St. Thomas was required prior to the start of this study. Additional oversight and approval was required from a research committee. All participants completed a consent form (Appendix B) before participating in the research. In addition, all participants were given the opportunity to ask questions about the research, including any potential risk, and confidentiality concerns prior to the interview process.

After completion of each interview process, this researcher ensured the confidentiality of participants' data by taking the following precautionary measures: data and identifying information on paper or on audio recording devices were placed in a secured space. Data and any identifying information, including email correspondence on this researcher's computer were kept and maintained in a password-protected document on her personal computer. The researcher transcribed the data with the help of a research

assistant. The research assistant was required to sign a confidentiality agreement (Appendix C) in order to protect the participants of the study. Participants were informed that all data would be destroyed on or no later than June 1st, 2014 after the completion of this study. No identifiable information was used in reporting the findings.

Confidentiality was assured by use of pseudonyms.

Data Collection Instrument

The researcher used semi-structured survey questions to provide a guiding framework or outline for the interviews. Chronological organization of questions helped the researcher emphasize developmental changes and/or the unique process of change for the participant both personally and professionally.

The interview questions (Appendix D) included five demographic questions and three main interview questions that attempted to gain detailed personal knowledge of the therapists' use of self in practice, their transformative experiences, and how the therapists incorporated, reflected, and/or acknowledged their lived experience in practice. More specifically, their thought process, motivations, and ideas around reflecting this experience in their work.

Data Analysis

This research study was based on a phenomenological framework, which focused on answering the foundational question "What is the meaning, structure, and essence of the lived experience of this phenomenon for this person or group of people?" (Patton, 2002, p. 104). The exploratory nature of this study reflects the life experiences or narratives of the participants who engaged in this research. This study focused on the

perceptions and meanings of personal experiences in retrospect, which makes it a good fit with the phenomenological perspective.

A small sample size allowed for lengthier more in-depth interviews to clearly disseminate the therapists' stories and process of growth and transformation personally and professionally. The goal was to include a group of licensed social workers and psychologists from a variety of multidisciplinary settings and diverse backgrounds. The six interviews were completed between February 18, 2014 and April 4, 2014. All interviews were conducted face to face. The interviews averaged approximately 1.5 hours in length. Interviews were audio recorded by the researcher. The researcher transcribed the interviews with the help of a research assistant. The data was analyzed to pull out unique themes and experiences from the six interviews that may inform future social work practice.

Findings

Overall, participants acknowledged the importance of being authentic and human with the clients they work with. Participants identified building and maintaining a meaningful connection was more important than anything else when working with a client. Environment and other external factors were considered to be critical factor in participants' own personal experiences and an important consideration when they work with clients. The therapists' personal stories reflect their life journeys and process of transformation. Pseudonyms were used for the personal stories and quotes.

Themes

The interview questions were designed to elicit themes related to use of self in practice, life experience and transformation, and how the clinician's experience is reflected in their clinical work. The data was transcribed and coded. Concepts that were mentioned by at least two of the participants were considered themes. Quotes that best reflected the themes have been included. Concepts that were unique and relevant to social work practice were also indicated in the findings.

The findings of this study are organized by the following categories: The Therapist's Lived Experience and Transformation, which reflects the experiences of three participants in detail. This section also includes a subsection titled Integration of Life Experience into Meaningful Practice, which highlights the main themes from all six interviews. These themes were reflected through quotations from the remaining three interviews that were not used as narratives. The final category is titled Use of Self in Practice.

The Therapist's Lived Experience and Transformation

"Inspiration involves being filled and being moved. Inspiration provides psychological and spiritual sustenance and often provides an education in values by reminding us of what is most important. The event does not take us away from the mundane but brings us most fully into the heart of it, begs for our full presence, and transforms it before our eyes" (Hart, 2000, p. 50).

To reflect the lived experience of the therapist, three detailed life stories, which include transformative experiences are included in these findings. These stories provide an accurate representation of a variety of transformative experiences that were the

intention of this study. The remaining stories will be reflected through quotes in the theme section. The stories are titled: Life Threatening Illness, which reflects Marie's experience facing life threatening illness and how her transformative experience has shaped her life, work, and ability to find gratitude. Person In Environment, shares the story of Heather's life experience and the impact external forces had on her life, including her ability to feel she had choice and control in her life. Unity of Mind and Body is the story of Sara and her experience of growing up in a dysfunctional environment. Sara shares her journey going from loss to a sense of hope where she writes a new narrative for her life, which leads to a deeper connection with her physical self through mindfulness practices. All of these journeys, whether they began from positive experiences or life challenges, ended with participants feeling gratitude and hope in their lives.

Life Threatening Illness. Marie had been working as an oncology social worker at a large teaching hospital for 14 years when she was diagnosed with breast cancer for the first time. Marie was 44 years old. Her mother had been diagnosed with breast cancer post-menopause. She had not considered the idea of possibly getting cancer that young. Marie was shocked by her diagnosis:

“The first time [diagnosed] I think was transformative because the first one was, wow, I’m mortal too. Although we all sort of know that, you don’t really know it. Until it hits you and it only comes directly to you.”

At the time of Marie's first breast cancer diagnosis, she had less knowledge and experience working with pathology reports and understanding the risk factors. She recalled being terrified by this. She was a single parent raising two daughter. Her oldest daughter was away at college and her 11 year-old daughter was at home. Marie recalled thinking about what was going to happen to her younger daughter if she did not recover:

"I think the biggest fear for anybody with a life-threatening diagnosis who has kids, it's oh my God. And particularly as a single parent. That was really really terrifying...everybody worries about their kids. I'd still worry if I got hit by a bus today but they're grown up. They'd be okay. But at that time, there was this little one who would not have been ok."

During Marie's first diagnosis with breast cancer, she made the decision to receive her oncology care where she worked. She had a lumpectomy with radiation treatment. Marie identified the experience was easier because she was working more with oncology staff versus more intense work with clients. After her treatment, she went into remission. Marie reflected on the impact this had on her life:

"I had been living with kind of a low-grade anxiety because with cancer you're never really cured. There is this sick joke in oncology circles that goes, the minute we cure somebody she's dropping dead of something else. You never know. So I had been living with that for twelve years so that didn't really change. And by the time of my second diagnosis, I had really gotten pretty smart about

breast cancer... I'm talking about drugs. Risk factors and pathology reports. So the science behind it. So the second time I looked at it, I knew this is really not so bad. Not good, obviously, but I knew that as breast cancers go, this is one that if I had to pick one, that would be one that I'd be willing to sign up for."

Marie's second diagnosis of breast cancer at age 56 posed different challenges in her work setting and personal life in comparison to her first cancer diagnosis. Marie's work had already been informed by her life experience. Many people she had worked with for years knew of her breast cancer history. Marie had written and spoken publicly about her life experience and the impact it's had in her life and work setting. Her personal life had more stability. Marie was married at the time of her second diagnosis and her children were grown, which made her second diagnosis emotionally easier on her. She was already established with an oncologist at the hospital and decided to do her treatment there as she had twelve years earlier.

"I knew I was going to be different, that it would sort of happen to me...because I was going to work. And you can't hide it. You look different when you go through cancer treatment. There is no pretending that it's not happening... I wore a wig sometimes. I wore hats and scarves more of the time. You loose your eyebrows, you loose your eyelashes, and you have a lot of treatments. And it's like it takes one to know one. I might have been able to fool you, but I couldn't another woman going through treatment. She'd be like I know that look. I sorta see it. But it was two things. It was one, thinking the only thing that people would

know if I got my treatment down the street, two blocks away, they wouldn't know anything but what my blood counts were. But big deal. They'd still know what I'm going through [the people she works with], chemotherapy for breast cancer and two, it was so much more convenient [at her work place] because these were my friends. Ultimately, these are people who I love and they love me. And I knew they would take really good care of me. I thought it would be a difficult decision, but it was an easy decision."

Marie reflected on the process that occurred when her oncology unit had to decide who would become her oncology nurse:

"The first time, I'm told, and I only heard about this two or three years later, the chemotherapy nurses, whom I worked with very closely, and I had known for a number of years. The first time they had a meeting after my diagnosis to say okay who can do this? Some one to become my chemotherapy nurse...and I think the impact on them... and a woman [name omitted] said, I can do it. Where some others said, no I just want to be her friend. So she's now been my cancer nurse for 27 some years. Because I continue to get treatment. I get two shots once a month and she still does that. She comes to my office and does it. I think, very honestly, I've been well... I mean I had to go through these treatments and I mean, God forbid that this cancer becomes invasive, metastatic some day, and then I'm going to die from it, that's going to be hard on everybody. But she [her

nurse] has been able and my doctors have played a role in getting me through this and keeping me well. And so far it's working."

Marie reflected on her cancer treatment experience with colleagues and the work environment:

"In terms of privacy it had to be worked out. I was getting chemotherapy and obviously we can't do that in my office. That's like much more paraphernalia. And we'd schedule it for the very end of the day, and there were some sort of private chemo rooms that we could use for chemotherapy. I never sat out there [waiting room] for treatment. And there were times when I had radiation, I also did it at the end of the day and I'd wait in the conference room and then they would call me when it was my turn and I would just go directly into where the machines were and I never sat in the waiting room or I might possibly be sitting next to women who were my patients. So people tried really hard and did a good job. And they helped me maintain that kind of privacy for me."

After her second diagnosis, Marie was still working with oncology patients in groups and met with patients and families. However, her experience was very different. Cancer treatments had become more advanced and rigorous since 1993. In addition, her body was not recovering as quickly from treatment due to being 12 years older.

Marie continued to work with her clients but in a more intentional way. Marie was intentional about talking openly in her groups about her experience of learning her

diagnosis to normalize the experiences of her clients. She talked openly about going bald to reduce the shame many clients experience around this. Marie provided a more personal perspective of the process and her experience of how that felt in order to bring comfort to her clients.

Marie identified situations that arose where clients in her work setting crossed boundaries they may not have known existed because of her disclosure about her experiences in groups:

“Women would say to me, what drugs did you take in chemotherapy and how big was your tumor? Or what’s your prognosis now? That kind of stuff. I mean I’m not going there! I need to maintain my boundaries. I’ve had chemotherapy so I’m bald again. It’s pretty hard to cover that up. And I was very open about my having it [breast cancer] for the second time and I talked about it partly because I was trying to take away the shame piece. But I wasn’t really going into details so that its sort of here’s the facts.”

The information around the personal details of Marie’s treatment was not an area she was comfortable sharing with clients. She quickly learned the importance of setting clear boundaries with clients in an intentional way. The setting and personal experience had blurred boundary lines. Boundaries that were clear to her were maybe not as clear to her clients and their families.

Marie’s husband also works at the same hospital and is a well-known medical oncologist, which added more complexity to the situation and her ability to maintain

privacy. Marie reflected on the challenges she faced when trying to maintain her privacy and identify the best treatment options available:

“My husband is a medical oncologist where I work...so because of that a lot of people know that [cancer history] about me too, although not everybody, but a lot of people do. And the fact that I worked there all these years, there’s this magical thinking piece of like, oh my God, if this happened to [name omitted], how are they going to keep her safe? It became a huge problem...and particularly when it was his area of expertise. If some other medical thing had happened, it might have been a little easier for him...So I had to have a mastectomy. But it was clear that I needed chemotherapy but since I had already had some, could I again? It was hard to figure outSo he’s [husband] calling all his friend’s that are cancer experts and I walked in the bedroom one night and it’s like four days after my surgery. Anyway, I heard him on the phone talking to somebody someplace about my progress and I about lost it. So that I think was hard for him. He’s not my doctor. Someone else is there.”

Marie reflected on situations her husband experienced due to the blurred boundaries in their work settings:

“He [husband] tells a story about the second time I was in chemo some man he’d never seen before came up to him in the cafeteria and said, Dr. [name omitted].... your wife, you should do this and this and this. It was terrible and he was like,

back off, get away. And you know the kind of standard things people will often say to their doctors about, what would you recommend for your wife, mother, or daughter? Lots of people instead would say to him, what did you recommend to your wife? And it puts him in a spot that he really doesn't like.'

When asked specifically if personal and professional experiences with cancer have altered her perception of how she sees her life, Marie reflected on her upbringing:

"I just kept going...and maybe this is going to sound conceited. I come from a long line of West Point graduates. It has been like the central theme in my family. My father, both of my grandfathers were generals. Everybody was a West Point graduate. I was kind of raised with that really militant ethic. Yes, a strong work ethic. You just keep going. Had I not been able to get out of bed one day to go to the office, than I wouldn't. But I guess I also really pushed myself, but not like I can't get out of bed. You know how you feel? It's the two ends of the flu. Not like you're in the bathroom throwing up. It's just like things aren't quite right. My stomach's not quite right. That's kind of how it was, and you can work through that."

Marie went on to share thoughts about gaining clarity and gratitude from her transformative experience:

"I think to some extent because I'd already been working in cancer for 14 years, when I had the first diagnosis. And it hadn't hit me quite as hard, of course, but I

was really aware that life is short, that you shouldn't wait to do things, that you think about your priorities with the people that you think are important. Because that's what I spend my days talking with other people about. Obviously, it's different when it's me. But those were the themes of my days. So it sort of felt like I already know this, it just brought it down more, down to a more cellular level. The second time I sure knew that. I didn't need a reminder."

When asked about her ability to work in such a challenging area of social work practice, Marie reflected on her personality and engagement in self-care:

"What kind of self-care do you do...that's always the social work question... The thing about oncology social work in general is that it's either a good fit or its no fit at all. I think of my experiences... Other people come and they do it for a couple of years and then they run screaming from it or they do it their whole lives. In terms of taking care of myself, because I've been doing this for 35 years, it's hard to know, I mean I have a wonderful life...I eat right and exercise. There are days that I get to the gym and my husband and I are just back from almost three weeks away on a trip. I get to do so many things. I get to see and spend time with my family; visit my family. I consider myself really lucky."

Marie's Practice Integration

When reflecting on knowing when to incorporate her life experiences into practice, Marie acknowledged the fact that many things were beyond her control and her

life experience was simply playing out in the moment, in front of her clients because there were certain things she had no choice but to disclose to clients, such as being bald due to her own cancer treatment. Marie discussed her use of self-disclosure in practice, as a way to move the relationship to a deeper level by normalizing with the client's experience:

"I do believe that when you think that if you are going to disclose something you have to think about why. And it's not because it makes me feel better. Because in some way it's helpful. So very often I say nothing. If it seems as though it would be really helpful, and it can vary from one end of the bell curve to the other. For example, there was a woman that I saw only one time. I got a page from the infusion nurse saying there is a woman here who is hysterical. She's had a mastectomy, her hair is about to fall out from chemotherapy, and she's just a mess. So I brought her back into my office and she was so distressed. She wondered how she would ever be able to go out in public again. She had a mastectomy...was there a medical reasons why she couldn't? But I said to her, 'Look at me. Do I have two breasts? Do I have two breasts that are natural breasts? Is one a prosthesis? Are they both prosthesis?' And she was staring and staring. And you can't tell. So I said, 'This one is real, this one is rubber.' And that really was the most helpful thing I could do for her that day."

Marie reflected on her client's response:

"She stopped crying and she said, really? And that really was a turning point. It didn't fix everything, obviously, but that made it possible to continue our

conversation and for her to begin to think, okay, I really can do this. There will be ways. My life will go on.”

Marie identified other ways her personal experience comes out in practice:

“When women here [At the hospital] have been in chemotherapy as part of their treatment, because not everybody does. Some won’t. But if it turns out that you do.....First, most people are more frightened by that than any other piece of cancer treatment. So you’re already very scared and then for most women it’s the hair loss, which they’re the most distressed about. So I get it, that health part. Because if you haven’t been through it, you step back and say, yeah, you’re going to lose it but there really are great wigs now, and that’s true. You can’t tell with some people’s wig. It used to be that you could always tell...and it will grow back, so it’s okay...but it’s really not okay.”

Marie admitted after being in oncology social work for 35 years, she has moments with clients where she does feel less empathic. She has become used to the experiences, has knowledge of the types of cancer, their treatments, and other factors, that cause her to minimize clients’ experiences at times:

“I hope I don’t show it [Lack of empathy] or say it. I swallow it and hope ...and I must be able to do it fairly effectively because the women often compliment my work. In the breast cancer world there’s something called DCIS [Ductal carcinoma in situ], which is precancer. And at some point the doctors have to figure out which of those will go on to become cancer and which are just going to

sit there in a precancer stage and will never cause any trouble. But they can't tell that yet. So any woman who is diagnosed with that, they read about the increasing rates of breast cancer, and pick up all these things. The MRIs have become so sensitive that they're picking up all these DCIS and they don't know the difference. So they told the patient we just can't tell if it's going to be future trouble or that it could sit there for the next 15 years and never do anything."

She went on to explain the traumatic experience women have in response to precancer diagnoses:

"So all studies have proven women with that [Precancer] are just as freaked out as women with a real and invasive breast cancer. They never get chemotherapy because it's not really cancer. But they do need surgery. So women are always very frightened. They find it very frightening, very upsetting. I have to swallow exactly what you're thinking, get a grip. This is not good! Nobody would choose this! But most of the time they can get a lumpectomy, which is pretty minimal standard and then some radiation. Not fun, but it doesn't hurt, and you don't lose your hair and then you're done but it's not easy."

Marie reflected on losing clients to cancer:

"That's the hardest part of the job. And that was hard before I dealt with cancer, for sure. Because of the sadness. It's harder since 1993 because it also is scary to me. Although, I must say I have pretty good denial because I've been able to keep doing it. But it's very, very sad. I mean you know it's coming. People don't drop dead of cancer. You see someone become increasingly ill and it's coming."

Marie described the process of preparing a client for death. She identified the most important question she asks clients is about what they fear:

“We talk about it [Dying] all the time. They talk about death almost every time we meet. And sometimes it’s about the loss. The saddest ones are moms with young children, of course. And they talk about that and people kind of open with oh I’m so scared. So then the most helpful strategy I know about is to really try to drill down to, what is it that you’re scared about? What is it about the fear of death? Are you worried about the process? Are you worried about the pain? Or worried about your family? Are you worried about being dead? Are you worried about the after life? Are you worried about being buried? What is it that your worried about?”

She describes normalizing the client’s experience and problem solving with the client.

The client often can come up with unique ways to address their fears and find comfort in their decisions:

“When we have these conversations, I keep checking in, are you okay with this conversation? Do we need to veer off and come back to this later? But people usually are relieved that there’s somebody who will enter into it. Because hardly anybody can...or will is more fair to say. And some of those things I can’t do anything about. I mean a lot of them [Fears] I can’t do anything about. There really are some things, you can’t fix it, but you can plan for it. If somebody says, ‘I’m so scared, I’m so afraid I’m going to be writhing around in death.’ See death is reassurance to me because pain control is good. It’s not 100% working, but it’s 99% good. The trade off being you might have to be willing to be asleep.

But if you're willing to be asleep you're pretty much guaranteed that you would be comfortable. So then that reduces that particular worry. The worry about leaving my children, I mean well clearly there's no way...you can't take that sadness away, but you can plan for it. I've planned with women who have been doing remarkable things, like gather together two or three of their closest friends to come over for an evening and they drink a lot of wine. And they talk about I'm going to die and I'm leaving the six or eight year old. And here's what I want you to promise for me. Like when she some day going shopping for a wedding dress, will you take her? And really concretize it that way and I can imagine that everybody is weeping, and its so painful, but it really is helpful. So acceptance...it is what it is, and being able to kind of take care of the kids. In a way that's going to be possible in the future. We talk about that all the time."

Marie shared her experience doing group work with cancer clients. She shared an example where the group took on a life of it's own and had a remarkable impact on the members of the group including herself:

"We have a weekly group that meets on Monday morning that's for women with advanced cancer. Mostly women with breast cancer but not entirely. What amazes me is how this group functions. The size varies, but at the moment there's about eight women. But it's everybody dealing with the same issues. Last Monday there was a conversation on whether it was better to be buried or cremated and there was a conversation about how they could help each other with this. And you know that group, probably a dozen years ago, there was a

young woman, 40ish. She grew up in Vermont, lived in Boston for a long time, and was fairly estranged from her family. She wanted to be placed in a living community in Boston. It happened on a day when she was so ill, and hospices were being very rigid about the history of the primary care giver in the home who would want to take responsibility. She was able to find somebody but then she didn't want them because she was close or comfortable with her kin. But she was talking about this in the group and somebody in the group said, you know, we could do that. And the group said, we can do that. And so the group, including me, I negotiated with the hospice and the hospital said ok, the group became her primary care givers, cancer patients. It [The process of dying] can be so lonely but there were at least one and usually two people there 24/7. Can you believe that these people, who knew they would go through this too, they signed up to be there and take care of her?"

Marie expressed curiosity about the possibility of her cancer returning and possibly dying from it. She wondered if members from her advanced cancer group would accept her. She wondered if she could open up to them:

"The unanswered question for me is in my work in my head. If the cancer comes back, and it's clear that it will kill me and I mean we [cancer survivors] walk that fine line anyway. I don't have an answer for that. But I wonder about...if I'd be comfortable letting my patients in and as part of the group...transition to letting me be a friend now, and I wonder if they would be comfortable letting me be part of the group."

Marie's story provided a narrative of her life journey as a social worker. The story reflected her experience with life threatening illness, which transformed many aspects of her life both personally and professionally. Her story is an example of the positive impact the human experience can have in oncology social work and within other types of clinical practice settings with clients.

Person In Environment. Heather's narrative reflects the impact environmental and external factors can have in our lives. When sharing her life experience, Heather reflected on external factors that she believes had a significantly negative impact on her mental health and her life in general for several years. She was able to see the dysfunction in her family and in her friendships, including the way she reflected herself to others through her attitude and behavior. Heather tried medication and went to therapy but continued to struggle to make sense of her life and her symptoms. She was unable to identify what she needed to do to start feeling better. Heather's realization that she had the ability to change things in her life was an empowering experience for her. She gained a sense of control, she was able to be her true self and engage fully in life.

"I think that for myself... my experience of going through therapy and how for myself, how that really didn't worked for me. And realizing that you really had to change...I mean I'd go and I'd talk and I was feeling bad. And it wasn't until I changed my life, changed things, and I really looked at...what is it, these outer forces? ...I was realizing how the external was affecting me. That it wasn't just let's talk about it and get it all out. I was being impacted by all these external things, and if I can do something about it, then I can change my life."

Heather reflected on the dysfunction within her family:

“My dad always said that I shouldn’t go into psychology because they’re [the psychologists] crazy [laughing]. However, if you’ve never been there, if you’ve never been like really low down. It’s hard to see why you would be there. What’s really going on when you’re that low...and my family is... they’re great and they’re part of the problem at the same time. A lot of my stresses come from [whispers] family. My mom is somebody who has been a support but at the same time she can be just always talking badly about people and that energy ...it gets hard. And my dad, growing up, was a compulsive liar, and he’s not anyone that I can rely on. My brother has a lot of anger issues and so I can’t go to him because they have become so personal to him. If I were to think, gosh, it really bothers me that dad did this... and he [brother] takes it really personally instead of seeing that’s my relationship with dad...Sometimes with my family I feel like sorta this sane person in all this crazy. They create all these expectations and the healthier I’ve gotten for myself I’ve kind of pushed away from them. It’s hard for me to deal with them. I’d rather go hang out with his [fiancé’s] family because it’s not as ...well, I can say this is how I’m feeling about this thing and it doesn’t become a big deal. We can have a conversation and not have it be turned into something else.”

Heather reflected on her life long experience with anxiety symptoms, which she identified often triggered depressive episodes. She felt out of control, which made her feel like she had no options or choices. Heather was able to acknowledge the fact she

had never learned how to cope with these symptoms and other stressors in her life in a healthy way:

“I had a lot of anxiety and it was causing me to get depressed... I think it [anxiety] was just something that I think I’ve always experienced... You know I scare really easily and I never really was taught how to deal with it. I’m going [to therapy] and talking about things...okay. Talking about what’s going on in my life. What does this mean, do you know?”

Heather’s experience with mental health symptoms and inability to find relief with medication and therapy, created a significant amount of distress for her. She struggled to understand why talking about her feelings was not helpful to her when it was so effective for others:

“It [the anxiety & depression] really clouded so much of my late teens to my mid-twenties. The anxiety, it really took over my life. When I was about 24-25 it was the hardest time for me because I just felt ...I really just didn’t have any outlets. I was going to school [undergrad], I was doing things and that was an outlet but it was like everything else was this feeling of loneliness; that things were never going to get better than they were now. And I was doing what I was supposed to do. I was taking this medication and going to therapy and it just wasn’t working.”

Heather went on to explain how her anxiety symptoms made her question herself and the intentions of others. During her worst period of anxiety and depression, she became indifferent to relationships and experiences around her because she was overwhelmed. When reflecting on this experience she said:

“I was getting to the point where I couldn’t go out with people. Like be around people because I was feeling like people didn’t want me around. I felt like...it was getting that bad that I was shutting myself off from people. Not having those relationships anymore. Just letting friends go. And how I allowed this one bad relationship to stay because it was easy. Easy just to have this person here because they would be there. So there was that and there were times when I had to call into work because I didn’t feel like I could emotionally go to work. I could do school because it was easy to do. That was more of a motivator to keep doing things than everything else. Because everything else looked like everything I didn’t want to be doing.”

It was environmental and cultural changes that facilitated a deep sense of awareness, of liberation, and of gratitude for Heather:

“Actually it started with me studying abroad in Mexico. And just getting away. I was so in the thick of it, you know, and I got away and I was able to see my life from the outside. I didn’t have to deal with all of it...I was totally aware of this as an experience that not everybody gets to have. This is a very rare experience. I wasn’t working my job. I didn’t have to live pay check to pay check. I didn’t have to deal with a particular person who was making me miserable. Well, it wasn’t only that person. But it was part of it. I was just able to step outside my life and get away from all of that and it was just kind of like having a breather from all of that, you know and I came back and I felt really changed.”

Heather identified her reasons for going to Mexico, relating it to common experiences she’s had with clients:

“I think partly the whole...everything sucks here and if I leave here I’m leaving everything behind. A lot of my clients are like I’m going to move to say Arizona. You hear people talk about that. People want to escape their problems. And I’m sure that in some ways it was that, but also I had actually always wanted to spend a significant amount of time in Mexico. It was something I’d always wanted to do. And so I found this and I figured I could do this. I can find a way to make this happen for myself... Let’s get out of here let’s get far away. It wasn’t hard to leave people, but I didn’t realize... for myself once I was there for a while. After I was there for a while I started to get homesick. And I guess in that way too, realizing what is important to you. What do I miss that I don’t have here? There is definitely a cultural difference between Minneapolis and Mexico. As far as where you’re going to go out on a Friday night and what you’re going to run into and all of those little things. And it started to be...oh I really like those things about Minneapolis.”

Heather reflected on her time in Mexico and how her perception of reality was altered by the change in her environment and possibly cultural differences, which helped to lift the pressure off of her that she was feeling. Heather specifically recalled the impact time had on her perception of things around her:

“It’s [Mexico] a much more laid back place. I think that I used to be like a very on-time person and now I’m not a very on-time person. [Laughter] And I realized that time is much more...well just an idea. It’s not so set in stone. I don’t care. I used to worry about those kind of things. It probably is a cultural component. This is kind like how people you know just let go a little bit... I actually like the

idea of not being so set to this schedule and having everything so ...this is how everything's going to work out. It's freeing in ways."

She went on to state:

"So now time is more conceptual. I'm grateful for the experience. Just the idea of being somewhere where ...the situation when I went there, I went through the program like at [Names omitted]. You go there and you stay at the school but then you also stay with a family in a rural area and you also stay with a family in the city. And then you also make some excursions out and about. It was really interesting to see, and being so white and really seeing white privilege being played out around you... And then too...how easy we have certain things.

Someone has to walk up a hill to get water and walk back down and they have to do it five times a day and all I have to do is turn on the faucet. Your way of what is important...So maybe that did change, maybe it helped the tunnel vision and I started to see what's really important here [Minnesota]."

Heather discussed her perception of time in her interactions with staff and with clients in practice:

"So then with clients, I like the idea...well, people ask me, well how long is this or that going to take? I say it's going to take as long as it takes and they're like what are you talking about? [Laugh] I feel bad though being a manager and being like, oh who cares if I'm five minutes late. I don't care, but at the same time...well, as a manager, that can become a slippery slope."

Heather realized she had a fear of not being in control of her life. She was able to identify that she could not control everything around her but she did have a choice in how she would cope and respond to it. This realization was transformative. It empowered Heather to intentionally direct her life the way she wanted to versus giving the power to others and simply going through it. Heather reflected on her experience when she returned from Mexico and her decision to end a dysfunctional friendship in her life:

“It was really different. It was like doing a crossword puzzle...my brain was just so unclouded. And I got back and it wasn't really like getting back was easy. Getting back was really stressful actually. Because I got back and I had to start school that week and I had to go back to work the next week and then my grandma died and I had to buy a car and I had to move and none of that stuff was easy. So when all of that stuff started to happen then I had taken a step back from my life. So instead of so much tunnel vision right at that moment. Realizing like, wait a second. This isn't how a friend acts when your grandma dies, you know...I needed to cut this relationship off and it definitely takes a while to cut a relationship off. I started going this way and she started going this way...It was really like I can see this friend at this moment for who they really are and how supportive they are. And that was like the death of the relationship. It took a while to fully cut that off. I just realized that I have a choice of the people that I want in my life.”

The depression and anxiety symptoms that she had been battling since her late teens were gently lifted and this transformed her life. She became open to the world

around her for the first time in years. Heather identified that when she gave herself to the world, she received much in return:

“You think it and that’s the kind of thing you’re putting out into the world. So that’s the person that you become.... so you kind of do it to yourself. That’s the energy you’re putting out and that’s what you’re going to get back. I was probably not the kind of person who...you know if you’re calling people up you should be, hey, let’s go out and do this thing and that’s not what my attitude was. It was [demonstrates a whiny, sad voice] are you doing something? So and re-finding myself, being back into myself, things have changed since then. One of the things that I’ve gotten back is having a life for myself. That negative self-talk sometimes is there, bad, and it’s like okay, quit it! But it’s there. What am I going to do to actually help it? Help myself versus getting walked on if I fall down, and all that thinking...and knowing that that’s not real. Whereas when I was younger the falling down was real because I didn’t have the coping skills to see past that.”

When asked how she has been able to maintain mental health stability since this transformative experience, Heather stated:

“I definitely still have it [the anxiety & depression] but I’ve learned ways for myself, oh things are starting to get this way for me, this is what I need to do then. To tell myself just to calm down. Perspective – for myself I was realizing that I was having all this...feelings so depressed because I feel like I have no control over anything that’s happening. And I started to realize that, for example, this job is making me miserable. That’s something I can change. It’s not going to change all the anxiety in the world that I have, and it’s not going to make me rich,

and it's not going to help me pay all my bills, but that's something I can change to make myself happy."

Heather learned about her mental health issues for the first time when in graduate school for social work. The psycho-education she received was validating and helped her normalize her own experience:

"When I got back from my trip I started attending grad school and I learned more about anxiety...before it was kind of like, here's some meds and you should probably go into therapy. Okay. I start on medications when I was in my senior year of high school. I had been on like a series of meds too. I started off on Paxil and then Prozac, and then I was on Lamictal and all this stuff was ...it just wasn't helping. And I'm not saying that it can't be helpful. I think if I did it differently now, I feel in some ways that it could be helpful, but I really do believe in this idea of helping people with what's going on in all the areas of their life and not just focusing on the inner."

Heather not only can make sense of her experiences with anxiety and depressive symptoms, she is now confident in her ability to counteract these symptoms when they arise. Through heightened self-awareness, Heather has been able to identify warning signs that symptoms could become unmanageable and she has developed coping strategies. She has increased healthy social supports, which has increased her sense of self-worth:

"First of all, I know what it is that's causing it, you know? That knowledge causes power...Oh its anxiety, this is what we can do for anxiety...and they never

told me that when I went to therapy. We would just talk... So for myself when I start to feel that way I can tell myself that's not true, and instead of isolating I purposely force myself out. I go out. It's like, what do I want to do tonight? I'm going to go with somebody. I'm going to call somebody and I'm going to force myself to get out because I need to counteract this."

Heather became emotional when reflecting on her ability to engage in self-care, which allowed her to become reconnected with her physical body. This nurturing of herself allowed her to open her eyes to the world again. This brought Heather immense gratitude for life, which simultaneously allowed her to experience deeper connections with others:

"I try to do yoga, go for walks. Right now it's driving me crazy because you can't get outside due to the weather. But I have the treadmill...at least my muscles feel like they're working. You know, they're working...I feel like it is awesome just having people in my life who are way more supportive. I feel so emotional...[she's crying]. It was at that end point, when I really started to get myself moved into a direction that I could really appreciate and love life. It was at that time that I met my now fiancé and so having someone really be there for you. It was a helpful reminder of oh you're a good person. You're a worthy person. It's really nice [crying]...When we get married, we'll have been together for six years"

She reflected on the Indian religious concept of Karma when explaining aspects of her transformative experience:

“Just being open to it. Open to the possibility of good things...it’s actually what the real meaning of Karma is. Most people think Karma means that if I do good in the world that good things will come back to me. But what Karma really means is that if I put this energy out into the world that I’m a good person, and that I’m worthy of love, and I’m worthy of good things, that what you actually get back in the world is that reflected to you.”

Heather explained that her ability to be open to the world has transformed her daily life in a variety of ways and she can see when it’s missing in other people’s lives. Her ability to be less constricted, less eager to control facets of her life, has transferred into other aspects of her life, specifically her upcoming wedding:

“There are all those things that we’re trying to do to put a wedding together. Which that in itself people are always like it’s so hard...dealing with all those people. I just find that even with all of my learning and all this, like my learning of all of the things we’ve been talking about right now, and how it helps me in my life in so many different ways. As far as this idea of letting go of control. The anxiety gets so bad if I try to control everything...just learning to let go of that control. And the idea of just being open to the world, I guess, has actually helped me a lot with this wedding planning process. It’s been a very different process for me from what people have told me it would be. I have not become like that person who is, oh why aren’t you doing this for me? [Whiny voice]. I’ve talked to friends who are getting married and they’re like, nobody’s supporting me blah blah blah. And I feel like my experience has not been that at all. People have been much more open and helping me and trying to do what they can, in ways that I would

have never even thought. People have said that they got really tired of planning their wedding, but maybe because I've been planning it so slowly... I'm not in a rush and I don't have certain princess expectations so it's like, oh, you want to do this? That's great! Because I just want to have a party...it's been a pretty positive experience so far."

Heather's Practice Integration:

Heather reflected on the impact her personal experience has had on her work with clients. Specifically, her ability to compare her own experience of suffering with that of the client's. She identified being more authentic in her work with clients. Heather's empathy is reflected in her ability to be realistic with clients and focusing on the idea of meeting the client where they are at.

"I don't know if I can pinpoint to an actual shift. I just feel that because of my experience. Having had that experience of being so low that when people are in that position and they're much lower than even I had personally experienced, I'm in a position of just being able to understand it. Being able to be there for them in that moment, versus having some expectation that I just have to have it together...being able to really see the humanity in people in that situation. And being able to see too when you think about people ...you're thinking about what their goal's going to be in the next six months and how small do you really need to have it, so you find what's really possible and achievable for them."

Heather reflected on her level of comfort when disclosing her mental health issues to clients and others:

“I think that sometimes our clients think that we have these perfect lives and that we never struggle. And without being like, oh, listen to my story... I try to work with people and sometimes say, I try to convey to them things aren't always the way they seem. Because sometimes people say, I have a mental illness. They own it. And they go out into the world and they're like, these people don't have mental illness. And I'd be like you'd be surprised who actually suffers with mental illness. I think the one thing for myself that I struggle with is actually owning that. Some people can really own that, but for myself.... I haven't owned that. I'm not... like saying that for myself.

She sees her own recovery as a lifelong journey:

“I hope it doesn't sound like some overnight kind of thing [her recovery] obviously it was a process, a journey ...just kind of for myself but I still feel like I'm very much a part of it...and every year becoming more and more myself. Understanding that journey a little bit more.”

Heather identified a hesitancy to own her experience with clients because she feels her mental health issues are small compared to her clients' mental health issues:

“When I think of it [mental illness], I think of somebody who has a severe and persistent mental illness and it's like you're connecting with humans but I'm having a harder time connecting with you on the fact that we both have this. Because it's much more for you than it is for me. It's not that I dealt with it then and now I'm better. That's not true because I can say that I still have those times where I ...so much change is happening and I'm realizing that I'm not taking good enough care of myself. I find myself for instance, changing jobs, and I'm in

a lot of change right now and I found myself having a really low day where I just sat in my bedroom and just having cried and I'm able now to say: Okay you've allowed yourself to do that and now let's do something about it. Well those are those moments when anxiety is taking over. And so that means that anxiety still really affects my life."

She went on to state:

"I haven't gotten as low, anywhere near as low as I was. I had a couple weeks a year and a half ago where I got really low down, but never like it was. I can see more clearly. And even in that experience where I had a couple of weeks, was another good learning experience for me. Okay, when that happens you cannot just allow yourself to succumb to it. So in the past you had these big changes that you made, well now we have to think about small changes. You know, those small day-to-day things that affect you. And I think at that moment was really when I really thought about control. How I was allowing control to really rule my life. When I had gotten into those two weeks a year and a half ago, it really changed my way of dealing with how I allow myself to kind of let go and just decide what I'm going to focus on and not allow things to consume me in that way. I mean it's still a process."

Heather went on to explain the thought process she goes through when doing case conceptualization of her clients:

"No, we're not going to do this whole thing in six months. We're going to teach them and we're going to move them one spot and that's it because that's going to be a lot. It's going to be slow and there are going to be lots of setbacks, but if we

really focus on...you know, supporting them. Like go to therapy, because I do believe that it can work for people. I don't NOT believe it... I just don't think that I had as much support, as I really needed. Also really working with them, seeing the choices that they have, and that there are things that can really help them. And understanding that for them, it really feels like there is nothing."

Heather reflected on the relational dynamics that occur with clients and how working with clients has actually taught her a great deal about herself. She identified the therapeutic relationship and change she sees in her clients is what keeps her motivated to stay on track with her own mental health. Heather expressed a sense of gratitude and feeling privileged by the opportunities she's been afforded so she can engage in meaningful social work practice:

"I feel like I learn a lot from my clients about myself. And I feel that the work I do I learn a lot about myself through it. I feel like every client I meet and they tell their story and probably for some of them I never even had any experience like they had. You hear their story and you're there...no matter how bad of things they may have done. They could have killed somebody. You're still able to see the human being in front of you and there's this person there and they are deserving of compassion and good things in their lives. Regardless of whatever it is that happened to them. And I think that the work I do actually just gives me a lot of joy and it just makes me betterto meet these people and hear their stories...you want to go home and cry sometimes but at the same time it's so

awesome to see what they're able to do for themselves and see how variable they grow. And that relationship that you have with them..."

Heather identified her experiences has allowed her to slow down, be more present, and increase flexibility in her work. Heather believes her level of self-care; her own coping strategies and enjoyable activities in her own life are essentially protective factors in her own recovery. These practices allow her to continue the work that she finds joy in:

"I'm really blessed to have the job that I have, to be able to do that. [Tearful] I do get a lot of joy out of what I do. At first it was really stressful and I realized that for myself, I have to separate it when I come home. I have to realize that once I'm home that's going to end and I have to stop thinking about whatever happened in the day. And so enjoying what I do it helps to be like, okay I have to do this and I'm not going to get caught up in it. Because so I can actually come back the next day and be part of it."

Heather continued talking about this idea of having self-awareness, actively and intentionally shifting stressful energy into something tangible, and coming up with ways to problem solve it so she feels a sense of self-control. This has allowed her to find enjoyment in her life outside of work:

"So it's the same basic thing. If I go to the gym after work my mind clears. I don't even remember what I was stressing about at work. And it might also be the fact that I'm planning this wedding. I have things that are going on in my own, personal life and my work is not my personal life. I have friends. Things that I'm passionate about that are outside of that. If I get home and I give in to that, that's

gone and tomorrow's a new day. I don't ever want to let it overtake me. I know that when I first started my work, I was working at a group home and that was easy to separate. But when I started doing Independent Living Services, it was a lot harder to separate. Because I would come home...and when I was in grad school that was easy because I had this thing that I had to do. But then grad school ended and I'm going to start doing this full time and I'd get home and I'd have all these things I have to do, and blah, blah, blah. Oh my gosh, oh my gosh, oh my gosh. Alright I have to let it go. I'm going to write a list for myself of these are the things to remember tomorrow and that made it easy. And then I started doing it and integrating this, pretty soon I didn't even have to write a list. And it can be something so silly, like oh, I'm so excited about my Netflix queue. I have my own things to be passionate about so it's [work] not there."

She incorporates her knowledge and transformative experiences into her practice with the clients she serves in ARMHS:

"I can see that for some people that [therapy] works. I don't not believe in it, but for me doing this ARMHS work is the idea that your impacting people I feel very much within this social work model, much more is going on than just what's going on right here right? It's like all our environments and how this affects your mental health and everything...and I feel like I really experienced that and when I was able to, I made a change in my life and those things really did get better for me."

Heather shared examples of her own coping skills reflected into practice:

“So because this helped me maybe it would be helpful to them [clients]. Lets make a list...such as you need to do these things and you’re anxious about it and how can we set this up so you can get these things done? So it doesn’t feel like this humongous thing is over you...or I know that if I take care of myself and I actually care about what it is, if I have meaningful activities in my life, that makes me feel better. So let’s help this person find meaningful activities for themselves. Because that’s what I’m saying. It’s making me feel good. Coming home and I have meaningful things. So lets find things for that person to look forward to.”

Heather shared another example related to having choices:

“It’s looking at the whole picture. One of the things that people...because people are in different stages of change...and one thing is reminding people that they have choices. Sure there’s people who are on Social Security and they’re going to be poor and there’s nothing I can do about that. That’s the way it is. But if they’re not, we have choices of how we’re going to deal with the day to day. Are we going to keep people in our lives that are making us miserable and asking us for money we don’t have and making our relationship based on that? Or are we going to choose people who are going to be respectful of what we can give?”

Heather’s story reflected the changes she made in her relationships and the impact experiencing other cultures can have on how we perceive our lives. This includes our culture, communities, and family dynamics. Over time, Heather was able to recognize the impact these external factors were having in her life. Heather made significant positive changes that have impacted her life both personally and professionally.

Unity of Mind and Body. This is Sara's story about her transformative experiences and how they have impacted her life both personally and professionally. When Sara was asked about her life experience and personal transformation, she reported growing up in a very dysfunctional family. Both of her parents had addiction issues and untreated mental health issues were prevalent throughout her family. Her father had a serious cocaine problem and he would leave for long periods of time. Sara was left not knowing if her father was dead or alive. Sara's parents divorced when she was 11 years old and her mother developed a serious drinking problem. At this same time, Sara lost an uncle to suicide. One year later, at age 12, Sara lost another uncle to suicide.

"I was a young kid and I always didn't have the most supportive home environment. So I spent a lot of time independently trying to wrap my head around that experience. I think it really impacted how I think about, I guess people's willingness or ability to seek help. Also knowing that there's so much we don't know about people. There is so much that I don't know about the clients I serve right now. All I can do is really, and I think this does come back to use of self. Like be a relationship that hopefully is healing for people and can elicit some change like those situations just made me realize that, a lot of time you can't change those things, but what I can do is be consistent in providing a relationship to people. And I carry that over into my work with clients. So that was a really big thing for me. And even though it happened when I was a lot younger, I think about those situations a lot. I think it really informs my work with clients."

This dysfunction created constant instability in her life. External factors in her life were never safe, her environment could not be trusted, and she carried over this

anxious state into adolescence and later into her adult life. However, Sara always questioned the messages her family gave her about mental health issues. She felt strongly that one's ability to choose to seek help and make changes could create a very different outcome.

“My mom divorced my dad because of his struggles [with cocaine addiction]. My dad was just a total mess...my mom was really struggling with drinking at that point. I was 11, 12, 13, 14 and coming into my own stuff. It was a lot of chaos. I just had a sense very early on that it doesn't have to be this way. I actually got involved with a self-help group in high school. Kind of like an al-anon type thing. That was my first experience with a support groups and that was really motivating for me. But I always just knew, boy I can't wait to go to therapy when I go to college. I just had this sense....in my family mental health is just not talked about. I come from a working class family and like, pull yourself up by your bootstraps, if you're depressed you want attention, don't be sad, crying doesn't help anybody and so those were a lot of the messages I got. I was always skeptical of that.”

Sara identified participation in a support group in high school and visits with her aunt in New York City exposed her to healthy relationships and another way of life. By her late teens, she began reconnecting with her father:

“I had one aunt who had kind of escaped the family dynamic and she was in recovery and so this was a big thing in my adolescence as well. She lived in New York City and I always knew I wanted to move to New York City as well. I would spend time with her once a year or so. She would listen to all this shit and also

share with me her perspective on the family and that was super healing for me...and she was and is into new age spirituality stuff and so she exposed me to different ways of doing things and different ways of thinking about things. So that was an important relationship. And my dad for all of his messiness he was like a very emotionally available person. And as I got a little bit older and he got a little bit better he was a support for me. He was the one person in my family that you could have emotions with and it wouldn't be a problem. So that was helpful too but it took a long time to get there. It was probably close to my late teenage years."

Sara's ability to find meaningful support and connections on the Internet was a liberating experience for her. She blogged about her life experience and received a significant and positive response from others who were going through similar struggles. Sara also engaged in bibliotherapy, which helped her cope and provided insight into her experiences. She believes being immersed in these practices played a huge role in her ability to survive her youth.

"I was a big nerd when I was a kid and I used the Internet a lot and for better or worse, I had a support group on the Internet and it was helpful for me to have that. I also did a lot of blogging back in the day when I was a young teenager. Used this thing called Live Journal. Looking back I wouldn't do that, I would never encourage a kid that age because I think they would open themselves up to a lot of negative things on the internet. I journaled a lot online and had a big support group through that experience... It was amazing. I felt like fucking crazy. I felt crazy when I was younger. That's like an alcoholic family system. It just

makes you feel like you are the “nuts one.” So being able to have a support group where folks were like, nope! You’re not nuts, it just happens. Also, because I used the Internet a lot I would do bibliotherapy, yes that’s what it would be called. I just did a lot of reading and that was so helpful for me...it carried me through until I was able to leave home and it made that experience bearable so I didn’t have any major negative repercussions. I didn’t end up having struggles with chemical dependency or stuff like that. I think it was a huge protective factor.”

She reflected on establishing boundaries in her professional life and how this led to her creating more personal boundaries. This shift has made her less willing to be vulnerable in her relationships both personally and professionally:

“When I was younger I was super open and I’ve gone further. I’ve been through my own therapy. My work life, I’ve just gotten less and less open about myself. Which I think is partially to do with working in the field. Having so many professional boundaries. I think it has caused me to have more personal boundaries as well. And this was when I was a young teenager when I was doing this [self-disclosure] – 14 to 16. But I had nowhere else to put that energy. And so I was just like ahhhh, listen everybody. And it was helpful and I still actually have friendships with some of the people I’ve met through that [online support group]. And my very best friend, who still lives in New York, I met her through that. And now we did a total role reversal with our friendship and now she shares a lot with me and I struggle to be vulnerable in that relationship. It’s interesting how that worked out.”

When asked how her blogging experience impacted her ability to see things differently or think differently about her life, Sara identified finding a healthy balance has been challenging at times. She tries to remember that she has choice and has the ability to change her circumstances:

“In terms of trying things that were not what I was seeing and weren’t like my family life. I think that I still struggle with this sometimes. I just have to remind myself that I don’t have to have that life and there is other ways to live. I actually have good relations with many of my family members but I still don’t want to have the life they have. Having these experiences helps me to realize that I don’t have to live that, I can have something different; I can have a happy life. Sometimes I struggle with that a little bit though. I’m not like falling into the traps that they have. They have a lot of negativity. There’s just not a lot of belief that things can get better in my family. So that’s probably one of the biggest things I’ve taking away from some of this stuff is that you can always change what you’re doing and I never have to be stuck in a rut and I never have been, I’ve been really lucky for that. If something’s not working I change it. Having some of these experiences when I was younger showed me that I have that capacity to make different choices.”

Sara reflected on her experiences with mental health issues and how her experience growing up has impacted her mental health today:

“When I was younger, I used to think at times that I was maybe borderline. But I think it was more like I did not have positive relationships around me. So when I was a teenager and my hormones were raging, anytime that there was turbulence

in a relationship, I would flip-out and have so much difficulty regulating my emotions. Fortunately, I grew out of that but I had a lot of depression, definitely periods of depression. Then when I was 22, and it mostly happened when I was a teenage so it felt like congruent, but that actually was the most difficult mental health thing I experienced. Because it felt like, okay, I'm an adult now, I'm feeling better in a lot of ways because I had worked on the depression stuff, but I had panic attacks. I haven't had one in quite a long time, but I still have anxiety and that's just something I live with most of the time. I have lots of coping strategies for it, but it's kind of always an undercurrent. Like the threat of it. I'm just an anxious person. It's generalized. I think a lot of it is how my body got wired through all that. When I was younger, I really do believe that those kind of experiences change our bodies and I think that a lot of that is why I have so much anxiety now. It's better than it has been in the past."

Sara shared ways she has learned to cope with mental health symptoms:

"I haven't had one [Panic attack] in 8 years or something, which is awesome...I haven't had one since I was 23 or so. So that's good. It was very difficult to learn to deal with that, but I figured it out. I've been in therapy on and off really for 10 years and honestly, I'm so sick of being in therapy. I've been thinking about this lately. I'm just tired of going... just so tired of it. At the same time and I don't want to give that resource up because I do think it helps me be balanced. Its just part of my self-care routine. It doesn't mean that I'm not sick of it. I went to college and immediately went into therapy and it was super helpful and I've been on anti-depressants on and off since that time. Right now I do take anti-

depressants to help with that and I don't really struggle with depression, although this winter has been very trying. It's been terrible... The anxiety comes first and I tend to get really depressed about being anxious. I start to feel like, oh my God, when am I not going to feel anxious. So the depression is not like the primary thing that I struggle with. So therapy has been a primary thing."

Sara identified using several coping strategies to cope with symptoms. She engages in regular self-reflection, which allows her to have the awareness necessary to identify what's working and what's not in terms of her self-care:

"I do a lot of self-care. I've done different things over the years. Like in the past I've done yoga, I've taken a mindfulness based stress reduction course in the past. I would try to do some mindfulness stuff, try to be mindful of deep breathing, and sometimes I'm more intentional about those things than others. I love to read, reading is my ultimate escape. I read trashy crime novels, young adult [laughter]. Fantasy novels, I just love them and they're super helpful for me. And I exercise. I try to be mindful. Lately I've been doing the self-care pretty hard because this winter has been difficult for me. And right now I'm taking vitamin D supplements, so that's been helping a little bit too. I try to work on building social supports. Social supports have always been a difficult area for me. It's not easy for me to have intimate friendships with folks. It just doesn't come naturally to me. So I'm continually working on cultivating that, having a healthy social life."

Sara shared her fear of being vulnerable or feeling incompetent in her clinical practice, which becomes a barrier to building deeper connections with clients:

“I think that part of it is that I got sick of telling my story. Another part of it is that I’m less comfortable being vulnerable. Being in this field, I feel far less comfortable being vulnerable. Like I feel worried about what people will think about me being a therapist. And if I share that, I think that’s been a big thing. I think that I am now more concerned about how people perceive me because of that. I think it’s more comfortable to hear other people’s stories. I think I’ve started to realize that. And I spent so much of my late teens and early twenties sharing and processing and whatever. As we know, I’ve gotten into my late twenties and I feel exhausted. And it’s like the same way I got sick of me in therapy. It was like, oh God, I’m so sick of talking about this topic. Yes, this topic of me. Clearly I know that it’s really important and I’ve recognized that. The guardedness I have is not healthy and not helpful to me and I’ve got to get somewhere back in the middle. I started way over here and I’m now over here and I have to find a middle ground. So that’s something that I’m working on a lot right now.”

Sara believes identifying as a professional and still being able to be real with clients about life experience can have a positive impact on the therapeutic relationship and facilitating change. However, she is more hesitant to engage this way:

“My use of self includes very particular parts of myself. The parts that I’m super comfortable with. And it’s like the same me that I would be like if I went out to a gathering or something. And I am more reluctant to connect around the other things. I had a client a few weeks ago ask me, how can you help me, do you know what it’s like? The response is, well tell me more about how that information,

and how it would be helpful to you. And then I shared, what I can tell you is that I've had my own healing process, so I can relate in that way. But I'm kind of wary of that. And this is a client I'm wary of anyway. So I don't know if I would be any different with anyone else. In the past, I think in my internship, I think with a couple clients I did say, something specific, like I can tell you that I know what it's like to be in that chair. For some reason I've really backed away from being that direct. As I grew further into my career, I do think there are barriers. I think there are moments when it could be beneficial to a client. And I think maybe I'm not quite sure I know when those moments are or I second-guess myself about when those moments are. I don't know, I don't feel as comfortable doing that as maybe I did when I first started, which is kind of funny. I just wanted to try things more. Now, especially that I'm licensed I feel like I should be this big professional, I've been a supervisor in the past, and I think those things got in my head a little bit and can sometimes make me question myself more than I need to."

Sara reflected on the idea that she is always bringing aspects of herself to her work environment and to her practice with clients. Her experiences of meaning making and the process of co-transference that takes place, is not always obvious to her in the moment with clients:

"I guess I had it [knowledge of self, of transference] in school. Intellectually at least I had it. And part of the reason is that my first experience in this field was with psychoanalytic theory and psychodynamic theory. I was always really interested in counter transference and transference and so I came to school

intellectually thinking about those things and being really interested in that. In the actual work, it's hard to tell sometimes exactly when that's happening, but I always try to keep it in the back of my mind. And it's something that I came into grad school and then into my internship expecting that I'm going to be bringing stuff, people at work, and they're going to be bringing stuff, So I always think that's something I brought with me. And mostly I have my own therapy experiences too of knowing that I have my transference with my therapists and all that stuff."

Sara supported the idea that simply meeting consistently with clients, maintaining a positive environment, and building a connection, is more important than what she says or what skills she teaches a client. Sara went on to explain what this may look like in actual practice:

"I think that when I leave a session with a client, I might think, oh my God, I say this and what are they going to think about that? It doesn't happen that often, but sometimes I question myself. I think, in reality, most of the time the client is focusing more on their experience. What they're thinking about, what they're going through, not necessarily, than the things I say. I think that's why just building that relationship or rapport is more powerful than the specifics things we say or the skills we teach. I think it's more about how they experience that relationship. I just don't think clients pay super close attention to the things I'm saying. Sometimes they do, depending on the person. But a lot of times I do feel like that's true with clients. I'll touch a client in some way that I've be seeing five days a week for the last ninety days. And during those meetings I don't actually

necessarily feel like they're hearing the information or that it's useful to them. But when they leave I can see a shift in their recovery. I don't know that it's because their relationship with me but I think it's just more than specifically what we're talking about in session and again, the skills we're teaching and things like that. I mean take the whole environment. When we make it a positive environment. As a whole, I think that is really therapeutic for people."

Transformation through Mindfulness-based Stress Reduction Practice

Sara reflected on the impact mindfulness based stress reduction practice has had in her life. She identified it as a transformative experience in terms of her own ability to cope with her mental health symptoms. She uses these experiences when working with clients by engaging them in some of the practices she learned:

"I try to teach folks about mindfulness because that was actually a transformative stress reduction experience for me...I've just always been so wound up...just like an anxious person. I'm a tense, un-relaxed person. I kind of always knew that. My therapist suggested that I do this course and it was just eight weeks, once a week, three hours at a time. It was intensive meditation, mindfulness techniques and that was really transformative for me. It was the first time that I was like, oh, coping skills!...and they can work. I didn't really know before then and this was probably only four years ago. It was right before I started my clinical internship. It was the summer before that. I had always been like, coping skills eh-h-h. I just needed to talk. Talk therapy is what's helpful and the psychodynamics is helpful and the heady stuff is helpful, and so this was the first

time that I realized that there are strategizes that I can use to actually help with this...and it required me being intentional so that was really big for me.”

Sara began tapping into her emotional intelligence. She had focused on intellectualizing her mental health for many years. For the first time, Sara felt empowered to connect with her emotional self:

“It was once a week for eight weeks and it was like, oh my God, I can sit with my emotions and nothing terrible is going to happen. And it was the first time that I’d really found a constructive way to sit with my emotions. After 16, 17, I kind of shut off emotionally, and I got really intellectualized. I was like, cool, now I know how not to rock the boat. I know how to keep things going well at home. I just need to not be feeling things. So that was kind of the first time in my adult life where I was like, okay. You can feel things and just sit with it and observe it and not get all ruffled up about it, it’s just there and that concept was so new to me.”

Mindfulness stress reduction practice allowed Sara to be able to get reconnected to her body after years of trying to control her emotions:

“I was so detached from my emotions for several years at that point. It was just really helpful and with the anxiety and panic attacks I had already done some of the breathing stuff before that experience to help with the panic attacks. But this kind of helped me figure out ways to go through my life in a much more relaxed fashion. And it really did tone me down a bit. So it was really good in that way.”

Sara talked about the nurturing experience she endured when attending the classes. Sara experienced validation about her mental health and life experience, which increased her confidence of working in the mental health field:

“There were a bunch of people in the class and so every week we’d be a different technique to use. And we would have home assignments to do. So some of the things were, we started off with simple things, like mindful breathing. Then we did guided meditation. Meditation on our own, like body scans, mindful eating, mindful walking, so we focused on each of those things. And then we would do home assignments, like exploring our barriers, exploring things that came up for use when we were doing these assignments or activities (42:40.8). But a lot of it was focused on the actual practice of doing these different techniques. We did yoga and Qigong, things like that too. It was cool. It was really nice. We had one of those teachers who was like super soothing, hippy dippy, I just loved her. She read all the best poems. I was very nurtured by her. Her presence was very motherly. And then also in that class there were several other mental health professionals who were there partially to help their work with their clients and also for themselves for their own stress anxiety. So that was also super validating for me. I was like, okay, other people are working on stuff too. I don’t have to be perfect to be in this field. Because right before I started my internship I was really nervous about that. I was like, oh shit. I don’t know if I can do this. What if I just have too much of my own stuff to help folks. And that quickly went away and I do see it as an asset now.”

After her mindfulness course ended, Sara continued to engage in yoga practice as a way to stay connected to her body and emotional states. This allowed her to reflect on the impact her environment has played in her life and how this has impacted the anxiety she experiences:

“It [yoga studio] just is a very peaceful space and so for like several months I went to yoga all the time to try to get that motherly, peaceful feeling back. Those yoga teachers are so calm and chill. And that was a new experience for me to be around that. And also I had just moved to Minneapolis the year before that and I had lived in New York City before and I just think that the energy of New York City was frenetic for me. It did not help my anxiety any and so being here, just being in the environment of Minneapolis was so much calmer and so all those things together, it was very helpful for me. I realized too that my environment played a part in that. I knew that my home environment played a part in that, but I didn’t really think about how a city, the neighborhood that you live in, those things do play a part in the stress you experience. I really empathize with my clients who are living in places that are loud, or disruptive or not safe. In a sense I’ve been there.”

When reflecting on her current mindfulness practice, Sara identified a desire to repeat the mindfulness stress reduction course to restore her mindfulness practice:

“I don’t do it [mindfulness practice] as much as I want to. I always try to incorporate deep breathing. Taking times out of the day where I do that and occasionally if I’m getting really stressed out I’ll spend time doing body scans. I have some recordings that I do. I’ve actually been thinking about possibility doing that course again, or something similar to it...so I don’t really want to spend the money on it but there’s something so nice about just kind of being taken care of in that way. I felt very taken care of in that course. So I’ve been thinking about possibly doing it again just to kind of recommit to those things. Because it

is hard. It's hard like it's hard for clients to do those skills. Life gets in their way and gets going and they [skills] go by the wayside."

Sara reflected on the connection between her own meditation practice and intentional work with clients. She believes being intentionally present can help her create deeper connections with her clients:

"In general I want to get a little better at using silence and not rush. Depending on the client, sometimes I can feel a little rushed to get things done and to do some of the skills teaching and I think I can miss the mark on relationship building. Because of that, I want to intentionally work on slowing things down. Just using silence because that is something I really struggle to do with clients."

Conclusion

These life experiences encompass the idea that engaging in the process of introspection through education, self-care/practice, and life experience indeed can serve as a force or catalyst for change in the therapist. Findings suggest there is an interconnected process that occurs in these experiences, which translates into practice. For example, the self of the therapist is mirrored in the therapeutic relationship both explicitly and implicitly through authentic and empathic practice. Through these transactions, the self looks for familiarity, meaning in the other person, and this co-transference creates an attachment, a therapeutic alliance.

Transformation Themes and Practice Integration

Participants were asked to share their personal narratives that altered or transformed how they experience the world and how this has impacted their work with

clients. Several patterns emerged in the interviews, which led to four common themes: Anxiety and Depression, External Forces, which included both positive and negative forces; Connecting and Reconnecting with the Physical Body; and Education and Supervision.

Integration of transformative experience into practice appeared to be reflected by participants through a person-centered therapeutic approach with clients that focused on the relationship versus therapeutic techniques. Participants felt gratitude for their work with clients and felt they were able to be more authentic and relational in sessions, which significantly increased positive connections in their therapeutic relationships with clients. Participants were more empathic to external factors in their clients' lives and the need to focus on small steps toward goal achievement, including engaging in self-care and coping strategies when life challenges increased. Participants often utilized their own personal practice in sessions with clients when they felt it could be beneficial.

The connection between Anxiety and Depression. Five participants identified having problems with depression, anxiety, or both. Most commonly, participants identified anxiety was their primary mental health issues. When anxiety was unmanageable, this led to depressive episodes. Subthemes of anxiety were perceptions of not having control or choices in life. Five participants identified anxiety was often related to constricted thinking or inability to see the big picture of what was playing out in their lives. The perceptions that they had no choices and/or had no control of their lives did not shift until the participants were faced with changes in their support systems, environments, or health and wellbeing. These shifts allowed the participants to see their

perceptions of reality in alternative ways, which created possibilities and new experiences.

Lisa reflected on her depression, somaticized pain, and how going through her own process was a humbling experience for her. She knew what to do when her ex-partner was experiencing somaticized pain in relation to the loss of her mother. When this happened to her, she realized how challenging it truly is when facing depression:

“There were days when I couldn’t get out of bed and there were many days when if it hadn’t been for work I wouldn’t have gotten out of bed. I never missed work but there were Saturdays and Sundays though that I was just under the covers and it was so interesting too....I felt so humbled that there were so many things that I was saying that she [ex-partner] said after her mom passed away.....so she would say things like, oh, my chest is so tight, I can’t breath, I can’t breath. So what I would do as her partner, I’d roll over and I would rub her chest and I would sing, old black water keep on rolling, and I’d get a wet wash cloth for her and I would just rub her chest until it wasn’t tight any more. So as I’m sitting under the covers and my chest is just hurting and my body hurt for no reason, and the pain wouldn’t go away, and I was praying for it to go away. I would just cry profusely. As a practitioner I knew what I needed to do. I knew that I needed to breath, but I was like fuck breathing. I knew that I needed to go outside, fuck outside. I don’t fucking care about outside. So I was really experiencing depression and somaticized pain.”

Katie recounted her experience in her early twenties when she learned her father had an affair. This led to strained relationships with her father and the instability of her

mother, which ultimately began to consume her life. When additional stressors were added in her life over the years, her anxiety began increasing, which led to a depressive episode that lasted several years. She shared how this has created more intentional presence and empathy in her work with clients, which has helped her manage her transference and use it to benefit the therapeutic relationship:

“My mother was screaming that the breakup had been a betrayal. He [her father] had an affair. Also my dad’s girlfriend was only five years older than me. So my sister and I also felt betrayed by him and what happened. That relationship became challenging and awkward for quite some time. So there are a couple pieces of that that impact my work. First of all when I get clients that are just going through a divorce, two things can happen. One is that I can have a lot of empathy and understand of what that involves. Sometimes I have to really be careful of my own transference because it’s caused so much trauma in my family for so many years and I have to be so patient with it and wanting it to be over. If someone is being too much like my parents, like when I was an intern I had a woman who was too much like my mom and her reaction. I was like I don’t think I can do this...because I’m not patient, I’m feeling impatient and I had to talk to my supervisor and say it. I was able to work with her but I really had to be attentive too. So it can go either way. It can either cause an, I don’t think I can be there for this person because there is too much of my own stuff that’s coming up or it can help me be very compassionate and to understand some of the loss and dynamics that come with that.”

External Forces. Five participants identified external forces as playing a role in their transformative experiences. External factors included both positive and negative impacts on the participants. Negative impacts included dysfunctional family, friendships, or intimate relationships. This included one participant's experience with overlapping boundaries in the workplace, which led to a dysfunctional work environment.

Positive external forces were directly related to environmental changes that the participant's experienced in their transformative experiences. Environmental changes included studying abroad, shifts in work settings/roles, participation in a mindfulness stress reduction course, and moving to a new space. These positive environmental shifts altered perceptions of reality for participants, which created a sense of clarity in their lives. This led to feelings of inspiration, gratitude, and grounding with themselves and others.

Five participants identified experiencing multiple stressors in their environments around or during their time of transformation. These experiences were identified as losses or life crisis, which included death, life threatening illness, relationship changes/endings such as family separation, perceptions of a loss of a dream or loss related to how they perceived people in their lives.

Jane talked about her experience traveling abroad and how this environmental change created a heightened or altered state of awareness. This experience was intensely emotional, providing her with a sense of awareness about the interconnection between people in her life and filled her with a sense of gratitude for the opportunities she was given:

“So I went to art school and in that process I had the opportunity to go to Belize with my art instructor. She took a group there to study Mayan history and Mayan art and so I went down there. I was supposed to be there for six days and I was like no, I’m not going home. I was living in Chicago at the time. One of her friends had a place there so I got to stay for an extra month and work at the restaurant and hang out in Belize, which was great when you’re 20 years old. So here I am a 20-year old waitress from Chicago, art student, and hanging out in the rain forest.”

Jane went on to share her transformative experience:

“I kind of wandered off and I had this opportunity to stay there and living in the rain forest for a summer basically. So I went for a walk and so, there’s this hill – mountain type thing – and it was just trees as far as I could see, and then you could just hear the birds, and the monkeys, and these massive flowers, and these butterflies as big as my head. I actually collapsed onto to the ground. I was crying and crying and I felt like the greatest experience of gratitude I’ve ever experienced. It was like my whole heart just shattered open...and in that moment, standing there in the rain forest by myself, I felt more connected to everyone in my life that mattered to me than I ever did before. Like my parents who came to the United States from the Czech Republic with my brothers and all this web of connections of like all the things that happened and all the circumstances that happened that allowed me to be there in that place to witness this beauty and this sound...and to have that opportunity as this 20 year old. You know, a struggling art student from Chicago and I just couldn’t grasp the gratitude that I felt for my

family, for my friends that were supportive, and I couldn't get over it. It was so big and I was just so aware of those relationships the value, and the gratitude for it. I was crying so hard, but it wasn't sad, I was glad and that stayed with me for a long time. I was like, wow, what is this? And I don't think I even had a name for it. It was this big thing and I just felt different."

Jane identified experiencing significant life stressors after having her transformative experience of gratitude and interconnectedness. She longed to have this experience again and felt multiple events around her caused her to experience another intense transformative experience but very different from the one in Belize:

"I finished art school and came up here to Minnesota and worked in publishing, sort of doing production, for a magazine and it was okay. But nothing was ever all that fulfilling. I had a relationship with this man...this attorney guy, but we had nothing in common, but there he was and he was in my life and I thought this is this wonderful thing until it wasn't and then it ended very abruptly and very peculiarly. Just nothing made sense, and at the same time that he left, my father became really ill and for my parents there was a whole thing that happened with their business in Illinois. It was like all these areas of my life were falling apart and I had this other intense experience again it felt like I shattered, but in a very different way. I'm just sitting at home and just sobbing and having this....feeling more disconnected than I've ever felt from everyone and more isolated. So I had this contrast of these two experiences that were both like full body sobbing, releasing, but one was so deeply connected even while I was alone, and this other one was, I don't even know what it was, but it was heavy. There was this

heaviness to it. I think after that I thought, I have to go back to school. So I went back into Marriage and Family Therapy because nothing was feeling connected. I kind of had played around with going back to school but now I needed to go back and finish what I started, you know, however many years ago and so I did. I wanted to get in right away, so I got a January start and got a degree in Marriage and Family Therapy. While I was doing that I found the Institute of Transpersonal Psychology and wanted to go there very deeply for my doctorate . So I went there with the intention of studying gratitude, because I wanted to know more about that experience. That's what I felt when I felt so connected in Belize."

Lisa reflected on the impact her ex-partner had on her life. She identified the dysfunction in their relationship made it difficult to focus on her own life, needs, and the ability to be present in her professional life. She identified her work life has greatly improved:

"Clients haven't noticed a change but in a way they have, because they're scheduling more with me and my supervisor and I often talk about this. I've seen it and he noted that I just seem much more confident, even when I was with [her ex-partner], how much more confident I am now. I think there are different reasons for that. You know, her [ex-partner] and I were a little enmeshed as a couple. That sometimes happens. And she sometimes did take up a lot of my time for different reasons. She had anxiety and an anxious person, being a caregiver I tried to be there for her. She'd call me during the day and so my time was less devoted to the patients...and I don't know, I should have been more focused at work with work instead of more personal life stuff. Now I have that opportunity to

do that and really focused on my professional career. So yes, I think there's definitely a difference and if someone were to ask my patients...they're so wrapped up in their own pain right now because they are that very homeless, transients, population so I think if anyone were to ask them, they'd probably say that they notice a difference, but I don't know if they'd think enough to say it themselves.....if that makes sense."

Katie reflected on the multiple stressors that occurred within her family. These traumatic experiences impacted her life in many ways and has informed her practice with clients:

"In my early twenties, just after I finished college actually, my father had an affair and left my mother. In fact I was in Spain and got called home early to deal with that. And that was very, very challenging for me ..my family was in general disintegrating. But it was also super challenging because my mom really ventured into a period of really serious depression. She's always had maybe what we call dysthymia and anxiety. My dad also has plenty of anxiety. So there's always been a little bit of that but not enough to really affect and in the way that she attempted, it was sort of half-hearted, but she ended up in the hospital with a suicide attempt. After that I had my first year of teaching. That was pretty traumatic and challenging because at one point I had her on the phone in the morning, saying, I want to take these pills and I was supposed to be at work in 20 minutes. And it's my first year of teaching and it's before the time of cell phones where I only had the one phone and I had to call school and say I'm going to be late. That's a very particular traumatic piece that I have. I said, oh my God what do I do? And she was in St. Cloud and I was in St. Paul. So I'm trying to figure

out how I respond at that point. She didn't take the pills that day, but a couple of days later. So I just tried to be there, be emotionally present for her."

Katie shared a story about relating to a teen that had been caring for a depressed parent. This experience was something she has dealt with for many years with her own mother and she had a breakthrough moment when she realized the teen was very angry, just as she had felt toward her own mother:

"I found this particular experience of mine helpful when I happened to be working with a young woman, a teen. She was acting out tremendously. It was going to get them kicked out of the shelter, basically. But somehow it finally clicked for me and I was able to say, you're angry, you're really angry, and a big piece of that is because your mom is so depressed. And you try, and you try, and you try to cheer her up and it's not working. I think something clicked and she turned away from me and she started crying. I hit the right spot. Because I was able to finally piece together what I was seeing happening in her. I thought if I as a 20 and 30-year old got to a point where after so many years of trying to help I was so angry and frustrated with my mom, how's a teen supposed to deal with that? A young child? And I see that a lot with my clients. So my hope in working with them is that I can help them get better enough that their kids have more hope. And we do offer home visits so their kids know that somebody is helping mom or dad, whatever the case may be. I work more with women, but some men. And occasionally I might become involved with the family, with the child. I have a couple of kids that I've been working with where that's the case, they're really taking care of a very depressed parent. And especially as they hit the teen years

where they get a little more rebellious. They try as young kids and then now they're like, I want to have fun, I want to have a life and that anger comes out or they escape with drugs, running off with friends, engage in cutting behavior. So with that particular piece of my experience it's been helpful in understanding and addressing maybe some of this with the kids, or even the other spouse as I'm trying to work with them, trying to relate."

Connecting and Reconnecting with the Physical Body. Five participants identified being connected or reconnecting with their bodies in different ways throughout their experiences. Participants identified reconnecting through physical exercise, yoga, mindfulness meditation practice such as imagery and breathing exercise. Two participants identified connecting with their bodies in terms of acceptance of their physical pain. One experience was related to physical illness and treatment while the other was somatic pain from depression and muscle tension from anxiety symptoms.

Jane shared her experience of feeling gratitude while starting her doctoral program. She reflected on her experience at a yoga treatment center in the mountains in California:

"So I went there and with this intention of trying to figure out okay I'm going to do this PhD and I'm going to look at gratitude. But there was always that big self-doubt about well what am I doing? What am I doing in a doctorate program? You know, who am I to be ...I don't know what it was. I just think it's always a little lingering. I'm not sure where that comes from. I think it comes ...I think it's some of the figuring skating background I think of being pushed and never being quite enough. But I got there and that doubt was there and we're sort

of sitting in this room and it's 108 degrees. No air conditioning and there were 22 of us. Oh, it was so hot. We were asked to share our experience. How did we even get there? I don't even really know exactly... I went from having this really weird breakup, my dad being sick, to going to school, being told by a teacher that I needed a PhD, that I should do it because of whatever...and so I saw an ad for that school. It was the only one I applied to. It's the only one that felt right, so there I was. It just felt so arbitrary, but it also felt really certain. I started being very confused and having this very confused experience just that first day. And at the end of that week, again having that same experience of gratitude that I had in Belize...so there is something to this gratitude. In short, there's this experience of feeling grateful and connected and wanting to find a way to, in contrast to that great suffering that I had the other time to find the tools to get back to that feeling of connection. And wanting to help people find that on their own. So that's sort of where I come back to the body piece. They were both such physical experiences. The suffering, sorrow, loneliness here (holding chest). It hurts. It hurts. And it's heavy but then the gratitude is here too, but it has a very different feeling. It's expansive and there's warmth to it. So knowing that there's something here...and that this connection and isolation can be experienced here so how do we recognize the suffering in a sense but cultivate this? So that's been my experiences and this is a focus in my work with clients."

Lisa identified her own experience has informed her practice with clients and has normalized the experiences of clients she has worked with around somaticized pain, chemical dependency, and suicidal ideation:

“I never did take medications. My dad asked me once and I said, I think right now it’s very situational. But if it gets beyond six months, then yes, I’ll look at it. There was this awesome moment where I was, I just don’t fucking care how long this takes. I’m depressed, I’m going to face it head on. I don’t know what this means, what this is going to do, and there would be little glimpses of days where I would look around my place and say, I really like my apartment. Then the next day I would be depressed under my covers, just crying and bawling, and hurting in the chest, the tightness. I just couldn’t get rid of it. But, what I’ve come to realize too, and I think what separates me from my patients some times is that I had this little ball of light. I knew the day before I enjoyed my apartment, and so I knew in a few days I might enjoy it again...or I know that I have family out there waiting for me, that loves me and supports me. I’ve had this hope, this kind of light at the end of the tunnel. So even on days when I was like, [name omitted], you love your apartment, just look around. I’d be like, fuck you....I fucking hate just everything. But I think I could say this because I knew I had this. I knew it would come back at some point, some day and our patients don’t have that all the time or they never had it. They don’t know how to have it or they don’t know how to re-harness it or they don’t have the faith that it will be back again. So that’s where I got very humbled with what my partner went through in losing her mom. I got very humbled for my patients and I got very humbled for somaticized pain, for depression. I think especially in a clinical setting where you’re with medical doctors and they kind of look at well its somaticized pain. There’s nothing medically wrong with you. There’s nothing we can do. You just need to see a

therapist until you feel better. It sounds easy enough, but when you're in it it's so surreal and I'm so thankful to have gone through it. But I can't imagine going through a year, two years, 10 years, or 15 years. Some of these people have had it for 30 years. It gave me an even better appreciation for chemical dependency. I was fortunate enough that drinking was actually the last thing I wanted to do during this. But I can see why someone would want to drink to drown that. So it's kind of an interesting aspect. It gave me a better appreciation for suicide. I never once in my life even came close to even thinking about wanting to not be here but I see why someone would want to. If I had to go through those six months for a year, two years, or for 10 years, I can appreciate why someone would not want to live anymore."

Supervision and Education. All participants identified a connection between their educational background, experiences in supervision, or other learning opportunities and how they were able to make sense of their experience. They attributed their ability to learn through these experiences was based on their knowledge of illness, psycho-education, work experience/training, and learning and reflecting in clinical supervision.

Lisa reflected further on how her own experience has informed her practice with clients in terms of understanding the life experience of the client and suicidal ideation. She identified supervision as a critical component to processing feeling about suicide including her own experiences with depression. Lisa challenged her colleagues to look differently at suicidal ideation when working with clients:

"The practitioner that was me seven to ten months ago...if you were to ask me if suicide was selfish, I would be like yeah, it's selfish but as a practitioner today,

absolutely not. I think it's more about moral judgment and I brought this up in supervision. I had a patient recently who deals with suicidal ideation all the time. Suicidal ideation, all kinds of behaviors. I did a suicide risk assessment, the doctor had me come in, wanted me to check her main signs, go over her main signs for the past ten years. But it was interesting. She said to me, I know a lot of people think suicide is selfish. What I said and what I should have said are different things. There was a little bit of counter transference from my point. But what I said to her was, I don't think suicide is selfish. What I was trying to relay to her was that I pass no judgments. What I should have said was, I'm not here to make judgments. I brought this up in clinical supervision to my clinical supervisor and another therapist and they were like, oh, yeah, it's absolutely selfish and that really bugged me. I pondered it for the next two weeks until I had supervision again and I decided it's kind of a moral judgment and I challenged them. I said, [name omitted] you saw me this past six months. How did we work through this? Have you ever been to that point? and he said no. I said, then you don't know and you know what, I don't even know because I didn't get to the point of even anywhere near contemplating this [suicide]. I don't even know, but I have a different appreciation for it. It's logical at that moment in their pain because when you've gone to so many therapists and so many doctors, and through so many medications, and none of this is helping, and you're still where your at, what else is there? If you have no one else in your life to support you, and in your eyes they don't give a shit if you're gone and what else is there? Why? Where is this? So as therapists we need to help them either re-find this or

create this because they never really had this with a life full of trauma. They never learned to have this. I had this and mine is like this big. (arms outstretched) I had an amazing life. So when I was depressed it was this big. So if no one had this, when they're depressed, it's got to be like...that big (small circle with hands). So for me that is, as a practitioner I really learned to look at suicide differently."

Lisa reflected on her experience with a client and how her life experience helped her engage in indirect disclosure that was beneficial to her client. She identified use of supervision and being intentionally present, helped her identify her counter-transference and use it effectively in practice:

"So I'm here with this patient and I had this kind of quirky reality moment at the science museum and she's was kind of having the same thing and so I reflected back to her and I said, something like when we're so in our grief and depression it's always comforting in a sense that we're okay with it. It becomes our new normal and people around us leave us alone and the reality kind of stops...and time stops. So when we take those moments to dip into reality; whether it's going to the science museum or whatever, you get this prickly feeling and you get nauseous and life doesn't feel right. You don't like it and you almost want to revert back to that [the depressed self], because that makes more sense because that person isn't all the way gone. They're still kind of there with you and that depression because you're remembering them. If you get into reality, not only is it real, and they're gone but they're also not coming back. When I reflected that to her, she said, absolutely. So then I said, so what we need to figure out is how

we help you in that reality. What's going to help you step into that reality and stay in that reality for a little bit? So it's interesting to me...I never did disclose anything to her that day. It would have been inappropriate. That would have been more for my sake. It didn't occur to me at that time, but now that we're talking about self-disclosure. I didn't disclose anything, but I certainly had counter-transference to what she was saying. But it's interesting, counter-transference, because it almost therapeutically helped her because without telling her that I know what you're talking about, because I've been through this, my reflective statement showed that. I don't know that even the great, powerful [her supervisor's name] could have done that. So I kind of take a pride in that and told him that. We talked about that and he agreed that yes, there's some counter-transference there and it was therapeutically beneficial. So there's that balance of not self-disclosing, but using my personal experience to be able to reflect back to the best ability that I could what she was going through and how to move forward."

Jane reflected on the impact her experience with her educational cohort and supervisors have had on her life and clinical practice. It has allowed her to cultivate an intentional presence in sessions, which has also been impacted by her own personal practices for the past fifteen years. These skills have provided her with a foundation of knowledge and experience necessary to building healthy connections with clients:

"It was this group, this cohort. We were together all day, every day. It was very deeply intense seminars and we're getting to know each other, and we're working together, and talking; exploring our research topics. I was talking about

gratitude and when I left there I felt again really deeply connected. That actually became the start of being connected in a different way. I'm still really close to a lot of the people in that cohort. They're all over the globe but they're great. One of my classmates and I have actually been studying gratitude ever since. So I've been doing a lot of research on that. But it becomes sort of a passion when studying gratitude and exploring that, working that, cultivating that. I found that that's one of the cornerstones that help keep relationships together. When gratitude is present it actually increases trust, it releases oxytocin in the brain. There's all kinds of stuff. So I've had these transformative experiences, but they're all spread out and I think the accumulation of some that really sort of emerged into the way I practice the way I do... over that time I think that some of those skills have evolved and working with others, with supervisors along the way has cultivated that."

This section shared the common themes of participant's experiences and also identified multiple ways participants integrated their life experiences and transformation into their clinical practice. Findings suggest that not all participants' clinical practice was significantly altered by life transformation. However, introspective practice was significantly altered because participants' internal processes of growth and transformation were beginning to play out in their lives, which ultimately was reflected in their clinical work.

Use of Self in Practice

Use of Self in Practice breaks down specific themes from the study that reflected the subjective definition participants used when defining this concept in their work. Use

of self within the context of practice with clients was expected in this research. It is a common term discussed in most psychology and social work curriculum. Opinions of use of self in practice can vary widely and can be dependent on the agency culture where one works, the philosophical approach in which one works, the environment where services actually take place, life experiences, and the cultures of the clients or practitioners, among other factors.

Participants identified a variety of variables that have impacted their perceptions of what use of self is for them and the work they do. As expected, many participants identified aspects of use of self commonly taught in social work educational settings. However, findings reflected a much deeper perspective of use of self as simply being authentic and human with clients. The ability to reflect this in practice was linked to the therapist's ability to engage in their own introspective practice.

The findings suggest a much more complex subjective process of use of self with significant overlaps in ways the self is reflected in the world; based on the unique qualities of the participants and their willingness to engage in deep self-reflection as a practice in itself. It became apparent that not all personal transformations created a significant shift in what the participants did in their practice in terms of technique. It was more apparent that the personal experiences of the participants created more self-awareness, purpose, meaning, and clarity of life, which was reflected in a deeper intention in their work with clients.

Participants felt a shift in their practice with clients but were unsure if the clients were completely conscious of these changes or shifts in their experiences with the participants. Unless the situation was very obvious, as in the case of the participant who

lost her hair due to breast cancer treatment, this awareness by the clients was not always clear to the participants. In other cases, participants' life experiences informed their decision to enter into a helping profession versus altering their current practice.

Introspection. The central theme throughout this research study was the process of Introspection, in other words, the therapist's ability to have self-awareness and engage in self-examination. Introspection is impacted by the therapist's life experience, intentional practices, and supervision, education, and/or training. Subthemes of life experience include heightened states of consciousness that lead to inspiration, gratitude, and personal growth and heightened states of consciousness related to illness, loss, injury, trauma or other negative experiences. The subthemes for intentional practice include self-care and coping strategies. This Introspection in the therapist's life is then mirrored into practice, through a lens of ethical standards, their culture and environment. This is reflected to the client through authenticity and self-disclosure. Subthemes of authenticity included personality, intentional presence [this includes co-transference], and humanness. Subthemes of self-disclosure included normalizing, inter-subjective experience, and rapport building [strengthening the therapeutic bond].

This idea of Introspection was seen as a necessary component for participants when trying to engage effectively with a client in a meaningful way. When reflecting further, participants noted the importance of becoming comfortable with processing experiences with others, whether in supervision, consultations groups, or with co-workers. This practice, provided clarity by helping them sort out feelings and/or transference issues, reduce stress, and find meaning in their experiences. This processing of experiences transferred over to their work with clients.

Authenticity. For all participants, the ability to be authentic and express this to the client was seen as significant in terms of creating an honest and open relationship. Authenticity was reflected through participants' use of personality, their ability to be intentional and present with clients, and their ability to be human and reflect this to the clients. From an ethical perspective, the willingness of the therapist to acknowledge their level of comfort with the client, the ability to help the client with their presenting concerns/needs, and the ability to be realistic and trustworthy were seen as critical in establishing rapport and building a strong alliance.

The Human Element. The most common term participants referred to when discussing authenticity was the concept of being human or humanness with the clients they work with. All participants identified life experience as a way to experience empathy when working with their clients, which is a reflection of the human element they bring to their practice. Participants frequently mentioned the idea of being human as a way to normalize the clients' experiences. This was touched on in various ways when participants identified ways to build rapport and make connections with clients.

Heather reflected on this human element when working with clients:

“I think that as I learn more and more about the client, I learn more about how much of myself I can bring into that relationship, so that the person sees that you're another human being. One human being to another human being; trying to really be there for them in that moment.”

When creating connections with clients, Sara stated:

“I believe that the relationship is one of the biggest agents of change in the treatment process. And so using myself to build rapport. Letting people know that I’m human is super important to me. And of course maintaining boundaries while I do that, but just being really authentic with folks. And not being a blank slate is important. So I like to let clients get to know me a little bit, I like to let them in a little bit as they’re letting me in as well.”

Marie identified the importance of being genuine and human with her clients, putting transference issues aside, and focusing on the present. She reflected the importance of conveying this when she is teaching others how to work with people who have life threatening illnesses in a clinical setting:

“The thing about working with people who have a life-threatening illness whether it’s somebody who with any luck and the right treatment will go on and be fine, or whether it’s somebody who is not going to be fine, no matter what the treatment is, much of the stuff that I was taught in social work school is irrelevant and doesn’t matter. We’re there in the room and what matters most important is being there as a human being. I mean before I came up here [to Minnesota] yesterday afternoon, I spent three hours teaching at a workshop on working with people who have serious illness and end of life issues. And there’s three main points: one is to get over yourselves because this isn’t about you. It’s happening to the other person. The second being that [the life-threatening illness] really is what’s happening right now. There are people whom I have talked with weekly for two or three years and I know almost nothing about their childhood, and I’ve not asked the kind of questions that would be there in a more traditional mental

health setting because it's always just about right now. How we get through. The third thing being any time there's a question about do I make a really thoughtful clinical response to whatever problem that's in front of me, I say make the right human response...do I make the right human response because that's what matters."

Intentional Presence. Several participants expressed the need to have an intentional presence in their work with clients, as this provides a foundation for intersubjective experience and building rapport. Participants identified a variety of ways they practice this. For example, use of imagery, breathing techniques, planning sessions in intentional ways to elicit changes physically or cognitively, how they dress when working with clients, and maintaining ritual practices between client sessions were examples of the ways these participants fostered the ability to maintain presence and intention with their clients.

Jane described her personal process or ritual she goes through to maintain authenticity and presence with clients:

"I know if I'm distracted and then I'm not there and I have no presence, there's no self with me showing up. I'm somewhere else. Like making a grocery list or thinking about something else...but I have a tea thing. So one of the things is walking in a session, and using that as grounding. So then I go through all the senses and the sensory experience of that sort of grounding the spaces and set an intention for the session. So that when I walk in the door with that client...that walk is a place that is kind of grounding and connects, so I'm here with this person now, or this couple."

Heather reflected on her intentional use of fashion when trying to connect with a client and mirror a healthy relationship:

“I work with people who have so little ...they’re really trying to understand themselves. Sometimes, where they are developmentally they don’t really have a firm grasp of who they are. And so one of my clients... she doesn’t know how to trust herself. She really wants to be fashionable and everything like that but she does it in a way where she is vulnerable to others. And the way she talks about fashion... When we first met, she said nobody around here is in fashion... So I think how can I help her be her true unique self in a healthy way without asking her to change? So I think about when I’m going to see her next. What am I going to wear when I see her that day? How do we dress appropriately yet fashionably?”

Katie identified her intentional openness to different cultures and experiences, which she reflects to her clients in practice in order to make connections:

“When working with refugees we often do home visits...and they almost always serve food. I will try anything and that’s a part of my use of self. My coworkers are going... I couldn’t do that. So that’s a part of who I am. I am curious. I am open. I do believe strongly in affirming people’s cultures. And my clients usually pick that up. So they’ll say, you’ll try anything. It could be a new seasoning or you can see I’m wearing this top. Some of my clients love it when I wear clothes that are from their culture. So that’s part of who I am, and my comfort in doing that, is another way that I use my self and show my appreciation for their culture,

show my openness to it...I have a variety of cultural clothing, based on the groups that I've worked with over the years."

All participants identified the importance of maintaining their own intentional practices to be able to carry over this intention in practice with clients. For example, some participants identified presence as more than use of language and nonverbal communication, but the ability to be mindful and recognize the energy they bring to a client in an interaction. These intentional practice allowed participants to intentionally be present with client, and when necessary the ability to catch themselves in the moments they were not present so they could change it. For example, Jane identified her ability to be present with clients is related to intentional practice and use of supervision:

"Part of this process [of being present] is a daily meditation practice that I do; part of that's yoga, part of that's sitting practice. So it kind of goes back and forth. And I've been doing that for 15 years...something like that. So over that time I think that some of those skills have evolved into awareness of transference and working with supervisors along the way in terms of intentionally cultivating that. And it is practice. But it's powerful."

Lisa explained her practice of being present with clients:

"You take a deep breath, I kind of give myself time to breath, just kind of center myself. I don't know it sounds really weird, there's this movie Air Bender that I watched one time and so sometimes I can see the energy off of them and you can almost feel it and I wouldn't have believed it if I hadn't seen it so many times that I just like mentally picture just grabbing it and holding it so I don't take it in with

me. But yes, before I go into the room it involves just breathing, and I'm doing a quick check in, and before I go into the room you'll see me just kind of like, ok. Alright you are going to leave everything, whether it's my ex in the back of my head driving me nuts with something, my dog, the house bills, like this person has it way worse than I do in this moment and I can't bring this energy for them and so I need to leave all this shit out here that doesn't matter right now and bring the best part of me that I can to this person, because that's what I'm here for and that's what they're expecting. Kind of like breath, check myself, and be humble, humility is a huge thing for me."

Transference Stemming from Intentional Presence. Stemming from the idea of authenticity and presence came the idea of transference. All participants felt acknowledgement of transference requires some level of introspection, which includes authenticity and presence. Some participants were able to specifically identify what scenarios, people, or experiences would cause transference or sensitivities with a client(s). If this awareness about certain situations was not already established, participants reflected on the thoughts that came to their minds, the energy or physical experiences they had in the situation, and/or their ability to focus and be in the moment with the client. When these experiences occurred, participants stated they had to engage in some level of introspective practice to determine where these reactions were coming from.

Lisa considered presence as most important in terms of authenticity and the management of transference in practice:

“I think there’s a lot of different levels with that [use of self in practice]. I would say the biggest one that I really learned is presence. How to bring a presence in my interaction with a client. It’s so easy to just be unfocused especially in a clinic setting...you have different consults going on, you’ve got phone calls, you’ve got different things and so being able to just take a second and center yourself because you know when you walk in that door that person’s going to have their own energy going on. Whether it’s because they’re bipolar or schizophrenic, or they’re have auditory hallucinations, they’re anxious or depressed, they have, you know, so many things going on and so if I come in with my own energy of crap that I just did, that’s not going to help us and we’re just going to go in circles and it’s just going to be cyclical. So I think the first and foremost one is presence.”

Jane reflected on her personal use of mindfulness-based practices. This has taught her the ability to be present and authentic while also reflecting on transference, which is a natural part of therapeutic relationships:

“There’s really a paying attention to that happens.... Ok There’s been a lot of times of just checking in with myself, anyway, so I’ve gotten pretty good at telling....okay is this just my anxiety or is it something else, like I’m reading theirs? So to able to tell that if I’m feeling anxious, I need to check in with me...what’s that about? Is there something that I was worried about before this client? Or what’s going on? But if there’s just a general anxiety, I might just name it and say, it feels like there’s a lot of tension in the room, right now or, it seems like there’s a lot of anxiety in the room, right? I’m wondering if that’s your experience or what’s happening for you. And then they’ll respond, yes, no, or

elaborate on that. And I just kind of pay attention to kind of that dynamic of what's happening. So in any relationship there's always going to be energy or some kind of exchange that's happening in this space of the relationship. Because there's the person, the person and the space between. So you have to watch all three. And if it's a couple, then you've got this person, this person, this space, this space, you've got all kinds of things going on and sometimes I find myself very exhausted. So it's a much harder process."

Katie reflected on her life experience and how introspective practice allows her to recognize her transference with clients in practice:

"Based on my experience, what I do bring, in terms of some of my clients, it might be that drive towards... earning love, or feeling insecure about other's perceptions. You know... I do, I can bring some of those issues...my sensitivity that my clients can understand. I also, of course, bring understanding with people who, say, have family rifts. Like, oh, they're not talking to their parents, why? Oh, there's reasons, you know I can bring some understanding saying...don't be so quick to judge what might be a very complex situation. And you know, I can say I do better with clients, because my dad left my mom and betrayed her in that way with an affair, I tend to be more sympathetic with clients when the other one has left. In fact I doubt that I've ever had a client where they're the 'leaver.' But it would be an interesting challenge. And there are reasons though that people do and I shouldn't even say that. I've worked with women who've been abused who leave. So I bring that personal experience into therapy, but maybe more subtle than others."

Use of Personality in Authentic Practice. Personality stemmed from authenticity in practice. Personality was expressed in a variety of ways throughout the interviews. Some participants identified their unique qualities that come out when working with clients, their use of humor; the impact of their values and/or beliefs on their work, and their openness or curiosity to the experience of others who are similar and/or different. The use of personality was frequently related to making connections with clients and building relationships.

Heather reflected on the difference between the professional self and the true self when being genuine with clients:

“I think that it’s a certain authenticity that you have when you’re with people. And not just trying to be my professional self, being my true self enables you to get close to your client and have them trust you and have them feel like you really empathize with what they’re going through. And so I think that as I learn more and more about the client, I learn more about how much of myself I can bring into that relationship.”

Heather went on to explain the unique ways authenticity comes out when she is working in the clients’ homes and the opportunity she has to mirror a healthy relationship:

“Because I feel like in the work that I’ve done. Because I started out working at group homes, then in ILS, and now in ARMHS, you’re working with people in their homes. You’re so much in their lives. And it’s people who are many times isolated, what not, and so how you’re being teaches them how to have relationships with other people. So when you’re authentic, you’re teaching them how to be authentic.”

Jane identified using a mindfulness-based approach to work with clients in an authentic way that pulls in personality, the environment, and other factors that might be happening in the moment:

“For me, I definitely think that use of self is very critical and really, to me, that requires more of an authenticity and presence. So being really in tune to what’s happening in the room. I’m really being fully conscious of that for me in the session, so I can be. I want to be out of my own way and be really present with the client. I definitely work from very much a mindfulness-based perspective. And so to do that with clients, as well as always bringing attention to what’s happening in the moment with them, and with the space and the room itself. Humor would be a part of that if that comes up, if things are funny. So we laugh. It always keeps the focus really present and authentic.”

Sara reflected on her use of humor when connecting with clients:

“I let them in, let them know that they matter to me. Humor is a big piece of it for me. Just allowing myself to use the humor that I would typically use in my life, like the humor I use outside of work is no different than the humor I use in work. And the jokes I laugh at with clients are the same ones that I can laugh at with my friend. Just being natural and organic that way. Not being super uptight because I’m at work.”

Heather identified various ways she reflects her personality in her changing work environment:

“Talking about doing ARMHS work or ILS work and where you’re going into someone else’s environment, it’s very different. It’s a different experience all

together... I guess in some ways, I like that people still really get a good sense of who I am because I have tattoos, I have such markings, and also people get in my car. They're getting into some personal space of mine. You're in that setting for like two hours with somebody, that's a long time. If you're with somebody for four hours you're going to have moments where you say, I'm sorry it's been a long day. You know those little things, those personality things where if you're only with someone for an hour they don't come out. But when you're with somebody for a long time, your true self has a chance to come out."

Katie talked about conveying personality and intention in various ways to people of different cultures and worldviews:

"It's primarily about what am I going to bring that's really going to help me establish that therapy relationship? So again, with refugee clients I need to be able to establish, as soon as possible, a sense of warmth, a sense of I can be trusted, that I can be helpful to them in some way. Because again therapy is kind of a foreign concept. And the concept they do have of it is, it means I'm crazy. So certainly in terms of my use of self, in establishing that relationship a lot does come out through personality. My ability to portray warmth, my friendliness. Certainly also my love of different cultures. What I've chosen to learn about that, what I can bring from that. In terms of conveying that to a client. And a lot of that will include non-verbals as well as what questions I might ask."

Katie went on to share her level of comfort with different spiritual beliefs and practices, which she is willing to incorporate into her practice with clients:

“So I don’t work for a faith based organization but I know that faith is a part of their [the clients’] traditions. So with that, a couple of years ago when it came to holy week, and we had another group, we used the holy week readings, the stories, coming up to Easter. We had a little prayer service with their memories and their losses and their sufferings. And then the promise of resurrection. They [the clients] bring a lot of trauma and so depending on the women’s group, their faith, it’s a part of their experience. And they were all Christians so we could draw on that and we did. So it depends on the client and what they bring. So that part of who I am certainly plays into what I might bring or just my comfort level in responding to clients. Almost all of my friends, clients, my Latina clients, all of them will...you know, when I say what helps you when you’re feeling depressed? They’ll say reading the bible. Praying. If I do some kind of imagery or sematic experiencing [therapeutic technique], which I’ve been trained in, religious images will come. I’m very comfortable with those areas and what they are. So certainly when you tackle the use of self, that would be another area that comes into play.”

Marie identified a more simplistic way to look at personality and interactions with clients:

“There’s a simplistic way to look at it [personality] too. In any kind of human interaction, you like some people more than you like other people, just from the basic chemistry that happens or doesn’t. It feels good between us and it might not. You could be talking to somebody for ten minutes and it would be feeling a little awkward and not so sure as to how this is going. And I think that is

absolutely central to the core to an effective mutually gratifying therapeutic relationship. We [oncology staff] tell people this who we're maybe trying to help find a therapist in the community for... We go through the questions to ask and to be thinking about and you have to look for it. We say you have to like them. If you don't just like them it's the wrong place and the wrong person. So it depends on your personality and it matters enormously. Because none of us in an ongoing relationship can pretend to be somebody we're not. There's the professional stuff you know and then it's just who we are."

Marie went on to explain the connections that can be made even when clinician's think they may not be a good fit with a specific client. Her story highlights the importance of becoming comfortable with transference and other judgments; being open to new experiences:

"I know there's certain kinds of patients that I'm probably not going to as easily engage with or relate to, fortunately there are other people in my group who are pretty different from me and so it's more likely that they will have better matches and then there are surprises. I have a client that I've worked with for years. There are certain people, personalities that I don't usually make great connections with. I can do the work, but it's usually not the same and she is so attached to me. And I've never understood quite how and why things happen. But she's a certain personality type. The first time I met her I felt like, oh this is going to be harder work, and it's not going to be an easy match with me. But I was wrong."

Self-Disclosure and The Therapeutic Alliance. There was overlap between authenticity and self-disclosure in facilitating a strong bond in the therapeutic relationship. It makes sense that authenticity would be connected to use of self-disclosure. Two patterns presented under the context of self-disclosure in practice. Normalizing and inter-subjectivity were at the heart of self-disclosure as a means to build rapport and strengthen the therapeutic bond.

Heather discussed normalizing the client's experience based on her own life experience. These two quotes reflect ways she uses indirect or low self-disclosure with clients:

“Depending on where the person is too, as far as how open they are to being able to talk about things. I might say I know for myself, and I know it’s something that a lot of people struggle with, is the idea of trying to control everything around them. A lot of people with anxiety, they want to control what’s going on. Because that’s – I don’t know how to explain it – because if I can control everything that’s happening to me, then nothing will happen to me that I don’t know is going to happen to me. And I feel like for myself, I’m really learning about how I try to control everything. And my own need to let go.” “It’s like I can see that same struggle and so it’s kind of like, all right, when people are talking about their own struggles, I can be like, I know where you’re coming from. Because I can understand that. Different people are going to be open to different things, as far as the idea of that anxiety, of control. And being able to talk to them in a real way like, well you know we can’t control these things and it really sucks...or in those instances playing the devils advocate...”

Sara talked about engaging in comfortable topics that allow for low self-disclosure with clients:

“I share certain things with clients. There are a lot of questions I’m really comfortable responding to. Low self-disclosure items that I’m comfortable with. I have one client right now, she’s made a bunch of remarks about how it seems that I’d be cool to hang out with outside of work. So I have to be really clear with boundaries with her, but she just loves chatting. She really wanted me to watch these two movies and so I finally watched one and talked to her about it. And it’s the little things like that. Just kind of being human with the clients. We can watch the same movie and talk about it. We don’t have to talk about mental health all the time. We can talk about these other things as well. I talk about my pets all the time. In groups we typically start with a question of the day. It’s again like a little low self-disclosure question. And I always share in that and that’s part of the process. And those are some ways that I do that [self-disclose].”

Lisa reflected on her sexual orientation, being authentic, and self-disclosure with clients:

“I have to admit I don't self disclose too often these days. I think I used to do it a little more in the earlier years, in my undergrad and grad and the internships. But being GLBT I'm really aware of that. I suppose too...you know for a lot of people maybe you're out with a client, so do you have kids? Do you have a boyfriend? That sort of thing. If someone asks, it's so hard and for me it's also a bad feeling, you know, when someone's asking you something. I think a lot of supervisors will say, ask them why are they curious about that or whatever. And sometimes it's that and sometimes I feel like there is a time and place for some

self-disclosure or if it's going to help them further in what they need to do. You know, if they said something to you. I think that's the big thing for me, is it for my benefit or for theirs? And if it's for their benefit, absolutely. But it also being and understanding of how much to disclose and knowing so that this conversation isn't going to flip to me, disclose and still stay on you and what does that mean to you?... It's pretty powerful when it's right...do you know what I mean? It all comes down to timing, that feeling, and just being aware of the reasons that you're doing it."

Heather reflected on her life experience with mental health issues and her use of self-disclosure stated:

"I think that it's helpful to have that [life] experience when working with people, even though it's not like to the severity of the people that I'm working with, but you can at least be able to understand those things. To have this true empathy, almost sympathy. Because if you go in there and expect people to just have it all together. To say, I'm going to tell you what to do and you're going to do it and everything is going to be fine. This is going to last a month and you're going to be taking a shower and everything's going to be great...it's not real. When I think about sharing my experience, I think how will that help them normalize? And also I feel that people (clients) kind of want something to kind of cling on to. And so I don't go out and try to pretend to be this perfect person, because I'm not... I was in therapy for my own depression that was caused by my anxiety. But I don't feel like that in it self is healthy to tell people about. Because I feel like that's too

much disclosure...because it's just too much... we want to be able to deal with our own stuff. And that's why I can be there and help them..."

Katie mentioned bringing life experience to her work and use of self-disclosure:

"I bring of course, by own life experience. Which will come up at times in conversations with clients, so I'm certainly not one of these people that say a therapist is a blank slate. I don't really ascribe to that model because a lot of times clients will ask things. I don't usually offer a lot of information, but they'll often ask, do you have kids? So I will say no, I'm a sister. And if they don't know what that means, I tell them or they may know... or so one of my clients I discovered was Catholic. OK. Well then I said, me too. I'm a sister. So it will come up when it's appropriate with the clients. If I think for some reason it will help them feel safer. It may come up. I will tell them... We're not a religious organization, so I don't necessarily introduce myself that way. Because for some people it means something, for some people it doesn't. So it may involve figuring out some common connections or interests, or whatever. I find in terms of my use of self, offering anything from my life or my personality or my skill set that I bring to bear, that can be helpful in facilitating that relationship or the therapy process with a client."

Jane reflected on her ability to trust her thoughts, physical responses, and feelings when working with clients and disclose those feelings as they come up in sessions to create awareness and safety for the client:

"I think being nonjudgmental is a big piece when I'm working with people, particularly with anxiety and depression, and trauma, there's so much self-

judgment and so much self-deprecation that goes on in those thought processes. So much particularly with trauma, mistrust of the body and the body cues that are really part of the process. One, helping them connect those pieces and letting go of the judgment, but also modeling that that can be done and that that can be safe. So if I'm able to say, well as you're talking, I'm noticing this coming up for me I'm wondering if that's your experience. It's just more like, I notice that I'm feeling tense. It feels like it's a really intense story in your experience, I can almost feel it. What's that like for you? And then they can name that. What are you noticing in your body? So they can start to draw that connection without making it right or wrong or good or bad."

Finally, some participants reflected on the impact their agencies, supervisors, and work environments have on their experiences with clients and the level of self-disclosure they engage in. There were two interesting aspects reflected in the findings that are noted here: "passing" in a therapeutic setting and perceived barriers. This reflects the idea that there are some shared identities/experiences that a therapist can choose to disclose, and there are others that they don't have any choice about.

Two different participants reflected on their different experiences with self-disclosure and their ability to "pass" in the therapeutic setting:

Lisa identified a personal experience that impacted her view of self-disclosure in terms of her sexual orientation and the potential impact on the clients she serves:

"To be quite honest, it's [limited self-disclosure] something that was engrained in me when I worked at a homeless shelter at age 21 and 22 and my supervisor at the time she maybe had her bachelors in social work, but some resident asked me

if I was gay or something like that and it didn't even occur to me not to disclose, I was so open and just ...the supervisor pulled me aside and told me that she didn't realize I was gay and that she didn't think it was appropriate that I had told residents that. And so I guess it just freaked me out from that point on in a professional sense of letting clients know. And even to this day I work with a lot of GLBT, a lot of transgender too, a little more transgender than I would have expected to work with. And I don't think I've had anyone at my clinic ask me if I was gay, but to be quite honest, I think I would go with my gut feeling and if that's alright, yeah, I identify as GLBT. Because I've certainly had some clients who might benefit from that...I had a gentleman who was struggling with whether he was gay or not and he was an alcoholic, he was giving men blow jobs in the park just when he was drunk, and he didn't understand what it means and he kept coming back to me and we've all seen it... I think he could probably tell...I mean I look like a lesbian some days, most days and I think he just kind of picked up on that vibe and so he never asked me, but if he did I think I would have said, yes, I identify as GLBT. I mean I think I'm more confident in my professional career and when you are kind of the peon on the totem pole of an organization and the boss tells you that's not okay, but if my boss said that to me today, I think I'd have some choice words for her. And I'd let her know that actually no, you get to trust me as a professional and I'm going to be honest and open just as if my coworker was asked are you straight? And she says, I am straight. So it doesn't have to be a big deal.”

Marie reflected on her experience of having breast cancer and how this was playing out in the present moment when working with clients. She had no decision whether to self-disclose the fact she had cancer:

“It’s usually not a conscious decision and certainly when I was going through treatment it’s pretty obvious and it felt like everybody knew. It was the most awkward when I had a new patient whom I had not met, who probably didn’t know that I was in the middle of chemotherapy. So I went to the waiting room to introduce myself to this person, and they’d take one look at me and go, oh my God. Like holy shit! Here I am and here’s this person who is supposed to be helping me and look at the scarf on her head. What’s going on? And so, the decision was really made for me at that point. Like now, nobody would know. Lots of people already know. If they don’t know, probably more than half the time I never say anything about it because it doesn’t come up.”

In this case, Sara saw a barrier between her ability to disclose and be authentic with clients in the recovery environment she works in. Sara was able to identify that her work environments have played a significant role in how she perceives her ability to connect with clients and engage in low disclosure to build a therapeutic relationships:

“The other interesting thing is that we have a peer support specialist now, and in all the places that I worked that had a peer support specialist they’ve been like, the style has been, you’re a peer support specialist so you share this while the rest of us don’t. It’s like this assumption that I think a lot of people do challenge but, nonetheless, it’s there. The people who aren’t peer support specialists don’t somehow have this information, don’t have this experience [mental illness],

which is so not true. I know tons of people have this experience. But there's still this thing, well you've been trained differently, so this is not your job to share that. Yes that's true. Our job is not to be a peer, and our personal experience can still be helpful, but sometimes I feel like there's this dichotomy that's not real."

Sara shared ways she tries to overcome this perceived barrier through indirect disclosures with clients:

"This reminds me of ways in which I do kind of communicate my experience to clients in a non-direct way. I recently had a client who was struggling with anxiety and I used the term "we." When we struggle with anxiety or worry, than blah, blah, blah happens. And there are some tiny ways in which ... I think it's just a way of joining with someone too, it's not like putting it all on them. It is one way that I try to do that to let people know that they're not alone in this process."

The therapists' personal stories reflect their life journeys and process of transformation. The therapist's use of self is based on their life experiences and is reflected in a variety of ways in their personal and professional life. Through introspective practice, the integration of life experience into clinical practice can be meaningful. Being authentic and normalizing the experience of the client can promote therapeutic change. These themes overlapped in various ways. The themes represented the complexity of the human relationship and the inter-subjective experiences that are created in clinical practice.

Discussion

Use of Self as an Introspective Practice in Social Work

Findings support research related to the connection between the therapist's use of self and building a strong therapeutic relationship. Use of self was seen as a more introspective practice among participants, which was consistent with research indicating an attachment is created between the therapist and client in order to find inter-subjective meaning. The authenticity and normalizing by the therapist can facilitate rapport building and shared meaning, leading to a deeper connection with clients. This can facilitate therapeutic changes in various aspects of the client's life.

Introspection or self-examination was at the center of what participants did in their personal lives, supervision/training, and personal practice/self-care. This was directly mirrored into practice whether explicitly or implicitly through the participants' authenticity, which included humanness, personality, and intentional presence; and self-disclosure, which included the participants' willingness to normalize and engage in meaning making with the client. When this occurred, self-disclosure was strongly connected to building a strong therapeutic bond.

Self-Disclosure: "Passing" in the Therapeutic Relationship

In the findings, self-disclosure was seen on a spectrum primarily as normalizing behaviors, finding common meaning, and low disclosure experiences. More direct disclosure was used only when the participant felt it was absolutely necessary, and could possibly have a significant positive impact on the client's experience. In those cases, more direct disclosure was very positive because it normalized the experience of the client and helped them move forward in their recovery.

A unique experience that arose in the findings included the idea of “passing” in the therapeutic relationship. Participants identified they had moments in practice they could choose to disclose information, they could not choose to disclose information because of external factors within their agencies, or they had no choice in disclosing information, which was evident in Marie’s case when she lost all of her hair due to cancer treatment.

The experience of Lisa disclosing she was queer and subsequently feeling she did not have an option to do so in future work, is important. She had to take a pass on this experience, despite the fact it would have likely been beneficial to clients. It was unique because it highlighted the importance of supervision and the supervisor’s own awareness of their transference issues. These educational moments can significantly impact and shape future social work practice for students or social workers just starting in the field. In addition, I believe this emphasizes the importance of reflecting on agency and program policy decisions and how this impacts the rights and human dignity of not only clients, but the social worker. It reflects the importance of being intentional in education, supervision, and in practice, as all areas will be impacted in various ways by those decisions. If the queer social worker is unable to be equally authentic in practice as the straight social worker, then one has to question if something is missing in our education, supervision, and ethical decision-making processes.

Implications

Social Work Practice and Education

One could make the case the transpersonal perspective highlights the theoretical perspectives and practices most emphasized and taught in social work. It may be useful

to emphasize the connection between this perspective and introspective practice in social work education and training. According to Walsh and Vaughan (1993), the transpersonal perspective is a complementary perspective because it acknowledges and integrates multiple views and perceptions of human experiences. “The rehabilitation and appreciation of transpersonal experiences has enormous cross-cultural significance. It allows us to better appreciate many other cultures as well as their philosophies, religions, and art, and to integrate much historical and cross-cultural data” (p. 8). This parallels the significance put on cultural competence in social work practice. Understanding the worldview of the people being served and being open to perspectives, beliefs, and perceptions beyond our own understanding; that challenge the social worker’s reality and sense of self.

The life experiences shared in this study have the potential to bring a new dimension to clinical practice. One could make the case that these experiences [with clients] are in fact not clinical at all but are simply human. This is an important point to make when teaching social work student. The social constructs we have created in our world create complexity in something as simple as human interaction. These barriers to the human element can reflect new meaning when there is awareness and acknowledgement of the hold they have on the social worker. Education and technique are critical in good clinical practice and provide a foundation for the social worker. However, the social worker is the most important tool in that relationship.

Introspection is at the heart of forming inter-subjective meaning, thus creating human connection. Possibly the most valuable practice in social work is one’s ability to engage in reflective practice, supervision, and self-care to hone this skill. So how do we

teach this? The concepts of ethics in practice and making a clear connection to being authentic and intentional in practice need to be brought together when teaching clinical social work practice. Emphasis should focus on the importance of supervision, consultation groups, and other trainings/educational opportunities when making decisions in practice. Ethical decision-making should clearly reflect a connection to introspective practices in social work education.

Future Research

More research is needed related to inter-subjective experience & transpersonal perspectives in social work practice, including their connection to meaning making, the therapeutic alliance, cultural competency in social work practice and positive therapeutic outcomes. There was significant overlap or mirroring in themes suggesting a interconnectedness between clinical work and the therapist's life experience, education, and personal practices. Further research with more participants could yield deeper understanding and clarification of this interconnectedness that was present in the findings of this study.

In addition, creating inclusions related to specific life experiences of the therapist may provide different set of findings. For example, studying therapists who specifically experienced a life threatening illness and how this impacted their work or inclusions related to a specific area or setting in social work such as spirituality. This may yield different results that may be useful for future social work curriculum and educational practices.

Strengths and Limitations

Limitations in this research included the small sample for data collection. The small nonrandomized sample of participants may not accurately represent the larger population of therapists with transformative experience. In addition, the use of a snowball sampling includes the potential to miss participants who may be new to the field, live in remote areas, or for other reasons are less connected socially. This includes participants who maybe did not identify their experience as transformative based on the inclusion, but possibly had a transformative experience that impacted their clinical practice.

The researcher created the interview questions for this research, which is not a standardized tool of measurement, lacking reliability and validity as a result (Monette, Sullivan, & DeJong, 2011). However, the semi-structured interview questions allowed the researcher to probe for deeper meaning and understanding throughout the interviews. Although participants were eager to reflect on their life experiences and their clinical work, there was a level of hesitancy when discussing experiences that may lead to an impression the participant was weak or incompetent for clinical work.

This research was exploratory in nature, which allowed the researcher to have the ability to gain in depth information from participants, which was a major strength of this study. The narrative experience, or life experience of the therapist is a powerful tool to gain insight and understanding of the social worker in practice. Participants were appreciative of the opportunity to share their experiences and felt the interconnection between their life experience and practice was not acknowledged enough in social work education and their work settings. They felt empowered by their experiences and felt

their life experiences provided deeper meaning in their relationships both personally and professionally. They were more competent clinically but also in culturally sensitive practice and appeared to be more aware of their openness to the experiences of their clients.

In conclusion, the therapist's lived experiences of personal transformation can be reflected to clients in a variety of ways in a therapeutic relationship. Findings were consistent with previous research related to use of self, life experience, and the impact on meaning making to build a strong therapeutic alliance. Findings suggest a much more complex subjective process of use of self, an introspective practice, with significant overlaps in ways the self is reflected in the world; based on the unique qualities of the participants and their willingness to engage in deep self-reflection as a practice in itself.

It became apparent that not all personal transformations created a significant shift in what the participants did in their practice in terms of technique. The personal experiences of the participants created more self-awareness, purpose, meaning, and clarity of life, which was reflected in a deeper intention in their work with clients. More education and research is needed related to inter-subjective experience & transpersonal perspectives to cultivate this introspection in social work practice.

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Appendix A **Recruitment Letter**

My name is Emily Bailey. I am a graduate student at the School of Social Work at St. Catherine University and the University of St. Thomas. I am conducting an exploratory study, which is focused on the mental health professional's use of self (personality, self-disclosure, beliefs, values, etc.) in the therapeutic relationship. This study aims to examine the impact of transformative personal experiences of the mental health professional on the therapeutic relationship, as well as how use of self is defined and operationalized by the therapist in clinical practice. A primary goal of this study is to explore the therapist's experiences and use of those experiences in creating shared meaning and connection with a client, which the literature supports, is a primary catalyst for instilling hope and promoting change.

I invite you to participate in this research if you are a licensed mental health professional who did practice or is currently practicing individual and/or group therapy in a private practice, agency, clinic or other medical or public health settings where there is direct engagement with clients. In addition, you must meet the following inclusions to participate:

- (a) Report having experienced traumatic events, physical or mental illness, loss or death, or other life changing opportunities
- (b) The experience has caused you to alter your thinking; to engage in personal growth and self reflection to be content or find deeper meaning in your personal life
- (c) The experience has caused you to alter your work or practice in some way in order to be effective in clinical practice with clients and maintain positive therapeutic outcomes

If you agree to be in this study, I will ask you to meet with me for an interview. If this were not possible, a phone interview or videoconference would be an alternative option. I would ask you to engage in subsequent phone contact or emailing as needed to schedule an individual interview including answering basic demographic information by phone prior to meeting for the interview if you are comfortable doing this. If not, these questions can be saved for the day of the interview. Interviews will be audio recorded and will take approximately 1 to 1.5 hours and will take place in a private and mutually convenient location. More specifically, a private location would not include coffee shops or other public locations where people could potentially identify you or hear private information. If you would like to provide additional information past 1.5 hours, I will be happy to accommodate this by extending our interview or by scheduling additional interview time on a future date.

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. The types of records I will create include the following: hand written notes, audio recordings, transcripts, a master list with contact information, and computer records. This information would be reviewed in detail with you before the interview and you would have an opportunity to ask any questions before starting.

If someone you know meets the criteria for this research study and you believe they might be interested in participating, please forward this email to them. If you are interested and meet the criteria please contact me directly at 651-366-7926 or by email at bail3489@stthomas.edu. Thank you for your interest. I look forward to speaking with you!

Appendix B**CONSENT FORM
UNIVERSITY OF ST. THOMAS****Life Experience as a Catalyst for Therapeutic Change
[549944-1]**

I am conducting an exploratory study, which is focused on the mental health professional's use of self (personality, self-disclosure, beliefs, values, etc.) in the therapeutic relationship. I am specifically looking at the therapist's personal transformative life experiences and how these experiences have impacted their work with clients. I invite you to participate in this research. You were selected as a possible participant because a professional colleague or friend referred you to me for this research study. In addition, you are a licensed mental health professional who did practice or is currently practicing individual and/or group therapy in a private practice, agency, clinic or other medical or public health settings where there is direct engagement with clients. In addition, you meet the following inclusions:

- (a) Report having experienced traumatic events, physical or mental illness, loss or death, or other life changing opportunities
- (b) The experience has caused you to alter your thinking; to engage in personal growth and self reflection to be content or find deeper meaning in your personal life
- (c) The experience has caused you to alter your work or practice in some way in order to be effective in clinical practice with clients and maintain positive therapeutic outcomes

Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Emily K. Bailey, a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas and supervised by research chair Katharine Hill, Ph.D., MSW, MPP, LISW from the School of Social Work at the University of St. Thomas.

Background Information:

This qualitative research study aims to examine the impact of transformative personal experiences of the mental health professional on the therapeutic relationship, as well as how use of self is defined and operationalized by the therapist in clinical practice. A primary goal of this study is to explore the therapist's experiences and use of those experiences in creating shared meaning and connection with a client, which the literature supports, is a primary catalyst for instilling hope and promoting change

Procedures:

If you agree to be in this study, I will ask you to do the following things: Engage in subsequent phone contact or emailing as needed to schedule an individual interview including answering basic demographic information by phone prior to meeting for the

interview if you are comfortable doing this. If not, these questions can be saved for the day of the interview. Interviews will be audio recorded and will take approximately 1 to 1.5 hours and will take place in a private and mutually convenient location. More specifically, a private location would not include coffee shops or other public locations where people could potentially identify you or hear private information. If you would like to provide additional information past 1.5 hours, I will be happy to accommodate this by extending our interview or by scheduling additional interview time on a future date.

Risks and Benefits of Being in the Study:

The study has minimal to moderate risk due to potentially sensitive subject matter that may come up during the interview related to past loss, illness, or traumatic experience. Due to the potentially sensitive nature of the study, you may skip any questions you do not wish to answer or you may choose to answer only a part of a question. In addition, you may stop the interview at any time. The interview will focus on your life experience(s) that have transformed you personally, your use of self in clinical practice, and changes in clinical practice due to these life experiences. I will take steps to secure confidential information and destroy the recording of our interview to ensure confidentiality. Furthermore, I will not disclose identifying information during my reliability check or written findings.

There are no direct benefits to participating in this study.

Confidentiality:

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. The types of records I will create include the following: hand written notes, audio recordings, transcripts, a master list with contact information, and computer records.

When you have completed the interview process, I will ensure the confidentiality of your data by taking the following precautionary measures: data and any identifying information on paper or on recording devices will be placed in a locked drawer including a flash drive when it is not being used. Data and any identifying information, including email correspondence on my computer will be kept and maintained in a password-protected document on my personal computer.

As noted, an audio recording device will be used during the interviews. I will be responsible for transcribing all audio recordings. If an individual is hired to assist in transcribing the data, I will require the person to sign a confidentiality agreement in order to protect all participants of the study. Professional colleagues participating in the double coding process during the data analysis will be required to sign a confidentiality agreement to ensure your information and identity are protected. All data will be destroyed on or no later than June 1st, 2014 after completion of this study.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. As mentioned, you may skip any questions you do not wish to answer or you may choose to answer only a part of a

question. You may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you will not be used in my research. Please just let me know by April 1, 2014.

Contacts and Questions

My name is Emily K. Bailey. You may ask any questions you have now. If you have questions later, you may contact me at (651) 366-7926 or by email at bail3489@stthomas.edu. You can also contact research chair Katharine Hill, Ph.D., MSW, MPP, LISW at (651) 962-5809 or by email at kmhill1@stthomas.edu. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I am at least 18 years of age. I consent to participate in the study and to be audio recorded.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix C

TRANSCRIBER CONFIDENTIALITY AGREEMENT

Please read this form and ask any questions you may have before agreeing to participate in the study.

Please keep a copy of this form for your records.

Project Name	Life Experience as a Catalyst for Therapeutic Change	IRB Tracking Number	549944-1
Agreement			
I agree to transcribe data for this study.			
I agree that I will:			
1	Keep all research information shared with me confidential by not discussing or sharing the information in any form or format (e.g. disks, tapes, transcripts) with anyone other than the researcher who is the primary investigator of this study.		
2	Keep all research information in any form or format (e.g., disks, tapes, transcripts) secure while in my possession. This includes: <ul style="list-style-type: none"> • using closed headphones when transcribing audio taped interviews • keeping all transcript documents and digitized interviews in computer password-protected files • closing any transcription programs and documents when temporarily away from the computer • keeping any printed transcripts in a secure location such as a locked file cabinet • permanently deleting any e-mail communication containing the data 		
3	Give all research information in any form or format (e.g., disks, tapes, transcripts) to the primary investigator when I have completed the research tasks.		
4	Erase or destroy all research information in any form or format that is not returnable to the primary investigator (e.g., information stored on my computer hard drive) upon completion of the research tasks.		
Statement of Consent		By checking the electronic signature box, I am stating that I understand what is being asked of me and I agree to the terms listed above.	

*Electronic signatures certify that::

The signatory agrees that he or she is aware of the polities on research involving participants of the University of St. Thomas and will safeguard the rights, dignity and privacy of all participants.

- The information provided in this form is true and accurate.
- The principal investigator will seek and obtain prior approval from the UST IRB office for any substantive modification in the proposal, including but not limited to changes in cooperating investigators/agencies as well as changes in procedures.
- Unexpected or otherwise significant adverse events in the course of this study which may affect the risks and benefits to participation will be reported in writing to the UST IRB office and to the subjects.
- The research will not be initiated and subjects cannot be recruited until final approval is granted.

Appendix D

Semi-structured Interview Questions

Hi my name is Emily Bailey and I am a graduate student at St. Catherine University/University of St. Thomas in the clinical social work program. I'm completing my final research project, which is focused on the mental health professional's use of self in the therapeutic relationship. Specifically, the therapist's personal transformative life experiences and how these experiences have impacted their work with clients. I'm trying to understand how the therapist defines their use of self in practice and how they operationalize this or put it into action in their work with clients based on their transformative experience. I'm really interested in what you have to say about this topic and your own experiences.

Demographics:

(These questions may be asked by phone prior to the interview if the participant is willing)

1. What is your age?
2. What is your sexual orientation? Gender Identification?
3. What is your race and ethnic background?
4. What is your educational background?
5. How do you define your occupation and work setting?

Personal Experience(s) and Practice:

1. How do you define use of self in terms of your practice with clients?
2. Tell me about your personal life changing and/or transformative experience(s) in detail.
3. When did you know it was an appropriate moment to incorporate your experience into practice?