

COMING TOGETHER—DESPITE FEAR, TRAUMA—TO REDUCE RESTRAINT AND SECLUSION

Recent dialogues increase understanding around mental health issues

“I don’t even know how many times I’ve been in restraints,” says Nicki Glasser. “I couldn’t talk about it for years, even in therapy. It’s really severe trauma.”

Actually, it’s re-traumatization. Like Glasser, many people come to inpatient psychiatric hospitals with a history of significant violent trauma. For them, being physically restrained against their will—or even witnessing others being restrained—triggers a flood of memories; sometimes people are further harmed, instead of helped.

“That’s why, for me, even after all these years, it’s still so hard to talk about,” says Glasser, Policy Coordinator for the Transformation Center, a nonprofit organization of people with mental health conditions who advocate for change in the mental health system.

Staff, too, experience significant trauma in administering and witnessing restraints (using a mechanical device to tie someone down) and seclusions (placing someone in isolation), says Ken Thompson, M.D., Medical Director for the Center for Mental Health Services, one of three branches of the U.S. Substance Abuse and Mental Health Services Administration (SAMSHA).

Thompson recalls his experience thirty years ago when he worked at an inpatient facility in Massachusetts: “There was a sense of accomplishment in being able to restrain someone without physically injuring anyone. But that sense was heightened by the fear that something could go wrong. It’s an intense circumstance with intense emotions.”

In the late 1990s, a federal investigation and Congressional hearings concluded that “restrained and secluded customers were traumatized and harmed and that many died as a result of these often violent procedures.” (*Psychiatric Services*, February 2008 Vol. 59, No. 2 p. 194) In response, in 2003 SAMSHA created “A National Call to Action: Eliminating the Use of Seclusion and Restraint.”

As early as 2000, the Massachusetts Department of Mental Health (DMH) began to address restraint prevention. In both 2004 and 2007, SAMSHA announced the availability of eight three-year state infrastructure grants to increase the use of alternatives to seclusion and restraint. The DMH requested funding and received one of the grants in 2004.

In accordance with a stated goal to include input from patients, families, staff, and advocates (Commonwealth of Massachusetts Department of Mental Health Seclusion and Restraint Philosophy Statement, September 18, 2007), DMH subcontracted a portion of the grant to the Transformation Center. In its statement, DMH outlined three goals: preventing the need for restraint and seclusion,

“WHAT SURPRISED ME WAS HOW MUCH YOU COULD TRANSFORM A RELATIONSHIP DURING A THREE-HOUR CONVERSATION.”

NICKI GLASSER, POLICY COORDINATOR, TRANSFORMATION CENTER

using early interventions that reduce the need for restraint and seclusion, and preventing negative consequences when restraint or seclusion cannot be avoided.

Although there was a shared desire to talk about this deeply complex and highly emotional issue between people with mental health conditions and their advocates, and senior clinical and administrative staff at DMH, ultimately the Transformation Center recommended that PCP facilitate dialogues with the two groups. Last summer, during those dialogues, Glasser was one of nearly fourteen participants who did talk about their personal experiences.

PCP's charge was challenging: To help both mental health advocates and clinical staff share about these emotionally charged experiences and form the relationships needed to work together to reduce the use of restraint and seclusion.

"The chief concern was to avoid a situation where memories might be triggered and people feel emotions associated with the original trauma. We had to work to prevent harmful emotional experiences," says PCP Vice President Bob Stains, who, along with Program Director Dave Joseph, facilitated the dialogues.

CREATING CULTURAL CHANGE

Thompson describes the institutional challenge around reducing the use of restraint and seclusion and how it is complicated by the fact that these are long-standing practices designed to keep people in hospitals and inpatient facilities from hurting themselves or others:

"Restraint and seclusion are part of the culture of these institutions and until now there have been minimal efforts to change that. So the barrier is that this is a huge cultural change. That's fueled by the fact that staff feel unsafe if they don't have these particular tools.

In order to do that, Stains and Joseph turned to a standard practice at the Public Conversations Project: in-depth preparation. They held several meetings with each group separately, at which they helped participants identify their fears about and their hopes for the dialogues.

"I hoped that we would be heard as human beings about our real experiences in life. Our community is so disenfranchised, discriminated against, oppressed, looked at as less than human or not the same. Something different needed to happen so that we could experience understanding and connection," says Glasser.

A core piece of the Public Conversations Project's practice is thinking about how language impacts people, and the differences between what a speaker intends and how it impacts the listener, says Joseph: "We worked closely with participants to help them be aware of those differences and to 'mind the gap' by making very careful choices about their language." As part of the preparation, participants used role plays to see if their words elicited caring and concern or disconnection.

After significant preparation in the groups' separate meetings, Stains and Joseph were able to bring everyone together for a series of dialogues. In the end, both DMH staff and advocates had the opportunity to tell their stories, and listen to one another in a new way.

"THERE WAS A REMARKABLE CHANGE IN THE WAY WE WERE ABLE TO COMMUNICATE WITH ONE ANOTHER FOLLOWING THE FACILITATED CONVERSATIONS. WE WERE EACH ABLE TO SEE EACH OTHER AS REAL PEOPLE AND EQUAL PARTNERS."

BILL SCOTT, MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH PROJECT DIRECTOR FOR THE ALTERNATIVES TO RESTRAINT AND SECLUSION GRANT.

During a restraint, each person is assigned a limb and your job is to immobilize that one limb. And to avoid being bitten. That's straight out fear. Staff don't want to harm patients in any way. They go into this work to help people. But fear is a very powerful emotion and eliminating or controlling fear is very difficult."

"The flip side is that patients have said that being restrained or secluded, or even witnessing these things, is one of the reasons they don't want to go to a psychiatric hospital," Thompson explains.

Much was at stake in these dialogues; there would be conversations about intense emotional experiences with numerous complicating factors, not least that the two disparate groups had never before discussed this issue from a personal perspective.

"They were entering uncharted territory," says Stains. "Participants were concerned about not being fully seen, understood, accepted, or heard. So our work was to create a space where people could let go of these fears enough to participate."

"There was a remarkable change in the way we were able to communicate with one another following the facilitated conversations," says Bill Scott, Massachusetts Department of Mental Health Project Director for the Alternatives to Restraint and Seclusion Grant.

"Sometimes, when we were in meetings together, we felt misunderstood or, worse yet, judged even though we were all clearly committed to restraint elimination. Trying to find a safe, shared language was complicated by a long history of institutional practices that were not in keeping with the

new desire to be inclusive and collaborative. The dialogues helped to shift our language and understanding of one another. We were each able to see the other as real people and equal partners."

This shift was directly related to the pre-dialogue preparation, says Stains: "In situations like these, people often have a sense of what they want to say, but less a sense of how best to say it. The separate gatherings gave people a chance to work on speaking in ways that were more likely to be heard by people on the other side. So they entered the dialogues feeling much more prepared."

"There was a different level of honesty," says Glasser. "It felt very free of the normal sort of oppression and 'us-them' dynamics that usually drape over these meetings.

What surprised me was how much you could transform a relationship during a three-hour conversation. It opened the door to real talk about real issues." ■

Bringing PCP practices to healthcare arena



Vice President Bob Stains talks about the Public Conversations Project's recent decision to focus on the area of healthcare and why the organization's practices are applicable to this field.

WHAT SPARKED THE PUBLIC CONVERSATION PROJECT'S INTEREST IN THE FIELD OF HEALTHCARE? For many years, we've been aware of the needs within the healthcare system because so many of us came from that field. Senior Associate Dick Chasin has

been on the faculty of Harvard Medical School and has practiced psychiatry for many years and Program Director Dave Joseph directed outpatient programs at several community mental health centers. I have a background working in mental health clinics and as a hospital training director.

The issues we regularly address show up in all kinds of settings, including healthcare. For instance, the issue of gender and how men and women relate to each other exists in the general workplace, but it's a particular issue in healthcare settings where there's often a big power disparity between men and women. From several projects, we've seen that we can apply how we think and work to healthcare settings.

WHY NOW? PCP is intentionally planning for the future and looking into arenas to move into. Healthcare has clear needs, and we have the background to make a significant contribution.

CAN YOU SHARE BRIEFLY ABOUT THE WORK PCP HAS DONE IN THIS FIELD? In the mid-90s, Senior Associate Sallyann Roth facilitated dialogues at a community mental health center where the staff was divided over the issue of homosexuality and religion.

We also collaborated on a doctoral dissertation project that brought chronically ill patients into dialogue with doctors and nurses in a major Boston area hospital, and we've helped feuding agencies to collaborate on patient care.

More recently, we gave a workshop at the annual conference of the National Patient Safety Foundation. The workshop focused on how our approach to questions can help medical teams avoid mistakes.

And this spring we worked with the Massachusetts General Hospital's (MGH) Center for Integration of Medicine and Innovative Technology (CIMIT)—a collaborative enterprise between MGH,

Harvard, MIT, and other groups. Together with CIMIT, the Kingbridge Center, and the Masie Center we designed a conference about cross-disciplinary collaboration. The fifty participants—from different disciplines, perspectives, and institutions—served as a laboratory, mapping out barriers to collaboration and pinpointing successes and success indicators.

WHAT'S UNIQUE ABOUT THE HEALTHCARE ARENA COMPARED TO OTHER FIELDS? The consequences of healthcare professionals' actions are more immediate and have more positive/negative consequences in the short term, literally life and death for patients in their care. That really has an impact on how people work. In certain medical settings, there's more pressure to make quick decisions, and the consequences of bad decisions are magnified. Traditions of hierarchy and power in the medical world can interfere with clear communication.

But, I'm also struck by the similarities with other settings that are coping with differences—and we at PCP know how to help with dynamics of differences regardless of where they are found.

WHAT HAVE YOU LEARNED ABOUT THIS FIELD'S OPPORTUNITIES AND CHALLENGES? Whenever people are committed to a common goal, there is a great opportunity for our work. So in healthcare, it's all about taking care of patients. People are willing to sacrifice some of their comfort by engaging in constructive conversations for the benefit of realizing the larger goal.

It's an opportunity to make a difference: At the National Patient Safety Foundation conference when we asked people to look at a case study, sixty engaged professionals immediately came up with ways that our style of questioning could have been used to prevent some medical problems.

But, of course, there are challenges. There are many specialized contexts that we are not familiar with. And, there are high-pressure environments that require rapid decision-making to which our methodologies might not be as adaptable.

How well a healthcare team functions has to do with how free people feel to speak. A team member with really great ideas or vital information about patient safety who is perceived as an outlier will eventually stop giving input. That's a major challenge that most healthcare systems are trying to address and ameliorate.

WHAT DOES PCP OFFER THAT MEETS THE HEALTHCARE ARENA'S SPECIFIC NEEDS? We're really good at teaching about questions, the process of inquiry, and how to use that process in a way that will help individuals and groups move toward a particular purpose.

“HOW WELL A HEALTHCARE TEAM FUNCTIONS HAS TO DO WITH HOW FREE PEOPLE FEEL TO SPEAK.”

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From the President

Over the last year, the Public Conversations Project has been working in the health care arena (see Q&A on page 3). Coincidentally, in May, I discovered that I needed a hip replacement.

As a patient, I was able to fully experience how many of PCP's practices are relevant to delivering good care. From my first contact with the surgeon who operated on my hip to a physical therapy appointment yesterday, I have been impressed by the level of communication my family and I received from all the parties... the surgeon, his staff, the hospital, and the physical therapists I've seen since being discharged. They all have communicated with us, and with one another.

This type of communication is one of the essential differences between optimal outcomes and serious errors that affect patients, doctors, and hospital staff.

A number of organizations are paying serious attention to avoiding medical errors. When Vice President Bob Stains ran a workshop for the National Patient Safety Foundation in May, he shared a story about when medical communications gone awry affected his own family.

Disconnects between the medical staff and Bob's family during the final days of his stepmother's life angered some family members, who concluded that the medical staff was incompetent or uncaring. "Not true!" stated Bob. Simple inquiries—by family members and by medical staff—changed the way the process was managed and experienced. Bob's advice to members of the National Patient Safety Foundation: Ask questions. Be present.

After undergoing the procedure in June, I am delighted by my growing mobility and take joy in walking without pain. I am also very conscious (and grateful) that I experienced America's health care system functioning at its very best. Shortly after my operation, local newspapers reported that at another hospital in Boston, a patient underwent a similar procedure, which was done ON THE WRONG SIDE!

I am thrilled that the Public Conversations Project is contributing to the issue of patient safety and improving communications, both among medical personnel and between staff, patients, and family members. At one time or another, we will most likely all be vulnerable patients. We all stand to benefit from this valuable work.

Cherry Muse

Cherry Muse



From the Board Chair

This summer I became obsessed with bridges—not the intangible ones that PCP has become adept at building across ideological divides—but the tangible kind that you walk and drive across.

First, I learned that Boston's very own 101-year-old Longfellow Bridge across the Charles River has major structural deficiencies. Then I learned that it is one of two dozen bridges in Massachusetts that are similar in design to the Minneapolis bridge that collapsed in 2007. Then I learned that one quarter of all bridges in this country—that is 152,000 bridges—have been classified as functionally obsolete or structurally deficient.

It is reassuring to know where the problem bridges are and that transportation authorities from coast to coast are monitoring them to ensure that Minneapolis-type collapses remain rare. If we had comparable information about the condition of the intangible bridges linking and holding our regions, institutions, and groupings together, we could direct what Robert Putnam (author of the best-selling book *Bowling Alone: The Collapse and Revival of American*

Community) has called our "bridging social capital" to bolster the broken or vulnerable links in our civic infrastructure.

What we can do now to safeguard our intangible bridges is urge our Presidential candidates to resist their more cynical advisors and follow what Lincoln would call their "better angels" by limiting their use of inflammatory and demonizing language through the end of this election cycle.

I hope that our next President will take early steps to build broad and solid bridges to those who voted for his opponents and to those who chose not to vote. An initiative to enlist campaign activists in both parties as bridging social capitalists could be an important step towards generating the solidarity and collective resolve that will be required to transform the campaign pledges into wise public policies starting January 21, 2009.

With anticipation,

Laura Chasin

Laura Chasin

Using PCP dialogue in Liberia

Could you eschew violence if you were coerced into becoming a rebel soldier and were taught to commit atrocities at the age of eight?



If you were a citizen who had witnessed brutal executions during the civil war, could you welcome these former soldiers into your community?

These questions are at the heart of the first major project of Mediators Beyond Borders (MBB), a nonprofit formed in 2006 to help communities build their capacity for preventing, resolving, and healing from conflict.

The First and Second Liberian Civil Wars were murderous conflicts, fought from 1980 through 2005, leaving Liberia socially, politically, and economically devastated. This year, after more than a year of preparation, MBB is implementing a multifaceted plan to help one hundred former child soldiers (now 18- to 40-year-old men with families of their own) living in a Ghanaian refugee camp rejoin four Liberian communities.

The organization chose to focus on reconciling former child soldiers with their communities because, says Ginny Morrison, MBB Project Leader and Public Conversations Project training alum, “many experts believe the stability of [former soldiers] is a key to peace in a region or nation. The likelihood of these men returning to violence poses a serious risk to regions previously at war.”

Public Conversations Project Program Director Dave Joseph joins Morrison as a member of the fifteen-person all-volunteer team traveling to Africa during the five- to ten-year project. The long-term nature of MBB’s work reflects its commitment to establishing systems that serve communities, instead of one-time interventions.

A conflict resolution practitioner with her own business, Morrison embraces MBB’s principles, which are similar to PCP’s: “We work alongside people who live there; it’s not about importing our values and practices. It’s about supplementing theirs.”

In accordance with that philosophy, MBB works with local partners to provide former soldiers with vocational training, psychological support, and mentoring. Yet, what makes MBB’s work unique from other integration programs is their focus on preparing the community.

“We work for months ahead of time to surface the community’s concerns, to work through their worries and their legitimate, angry reactions and to prepare them. They have to think about how they

would like to rebuild the community and include the former soldiers and their families,” explains Morrison, who draws on her PCP training by using an adapted dialogue format during the preparation and post-integration events.

The real objective, Morrison says, is enhancing the possibility that former child soldiers and community members can coexist: “Since the war, people have had to rebuild their entire society, and part of that is building a sense of connectedness to strangers, learning how to live alongside people with very different views.”

But the obstacles are many: Communities feel threatened by people who have committed terrific acts of violence. Often, they marginalize the former soldiers, who are likely to express anger or generate a livelihood in the only way they know—using violence. Also, community members sometimes feel competitive and resentful about the support and resources child soldiers receive since they too have suffered tremendous loss, been the victims of horrific warfare, and are living in desperate economic situations.

A significant impact on former child soldiers’ rehabilitation, says Morrison, is that they typically served during their pre-adolescent years, a critical time for forming identity. The boys MBB is working with spent on average five years in brutal combat, in forces who deliberately worked to form a different kind of identity centered on a “war family.”

“Many people think putting these men back in a community—a positive environment without the stressors of war—is enough. But you have to undo previous influences and teach them to think in line with what it means to be living in a community,” says Morrison.

Therefore, local partner the University of Ghana-Legon is providing *Ntu*, an Afrocentric psychotherapy. A local partner, National ExCombatants Peacebuilding Initiative, comprised of former child soldiers who have already rejoined communities, will provide mentoring. Other local partners and MBB prepare the men to generate income and contribute to the community. In tandem, these organizations will support returnees and the community, helping work through conflicts as they arise and coaching the former soldiers to respond to complex challenges in a nonviolent way.

MBB sees this as just the first step in a reconciliation process for the country, explains Morrison: “A whole generation has experienced living in survival mode. Some people describe this as an entire country in need of trauma healing. MBB’s next step is looking at how we can help foster a long-term reconciliation process. We see dialogues and high-level dialogue skills as being integral to that.” ■

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GINNY MORRISON,
PROJECT LEADER,
MEDIATORS BEYOND
BORDERS

HAPPY ANNIVERSARY!

The PCP *exCHANGE* hits one-year mark

A membership community for active friends and supporters of the Public Conversations Project, The PCP *exCHANGE* was created in summer 2007 to ensure the continued success of PCP.

With the goal of expanding our impact by building wider circles, PCP offers a menu of ways to contribute—from making a financial gift, to hosting a social event, to introducing PCP to friends and colleagues. In return members receive invitations to members-only social gatherings, special news and publications about PCP's work, and other benefits.

One year later, PCP is proud to have enrolled 64 members in The PCP *exCHANGE*. We've received numerous generous and unique contributions—from San Diego to Washington, D.C., *exCHANGE* members have hosted fifteen social gatherings, introducing PCP to 275 people in their networks. ■

THE PCP *exCHANGE*: SOME OF OUR CHARTER MEMBERS

- | | |
|---------------------------------|-----------------------|
| Anne Anderson | Deborah Hepler |
| David & Dottie Arnold | Margaret Shaw |
| James Ault | Craig Smith |
| Anne Bartley | Jeremy Waletzky |
| Sue Barton | Sally Wardwell |
| Annie Bentz | Laura Gassner Otting |
| Deanne Bosnak | David Hoffman |
| Ruth Ann Bramson | Mary Jacksteit |
| Hope Brown | David & Andrea Joseph |
| Michael Brownstein | Mopsy Strange Kennedy |
| Katharine Canfield & David King | Chris Littlefield |
| Mike Coombs | Laura Lorber |
| Loring & Louise Conant | Lynn Mather |
| Charles Freifeld | Elizabeth McCormack |
| Avril Orloff | Noel Miner |
| Bruce Patton & Diana Smith | Cherry Muse |
| Jana Rickerson | Stephanie Nestlerode |
| Judy Ringer | Nancy Norton |
- ...AND MANY MORE!

A YEAR IN REVIEW

▪ 07

August: The *exCHANGE* kicks off with an initial mailing of 1,000 invitations to potential members.



▪ 08

January: First "Taste of PCP" event is held in Washington, D.C. —discusses stereotyping.



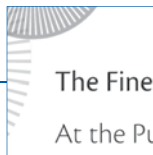
▪ 08

May: First specialized publication provides an in-depth look at PCP's work in Burundi, Africa.



▪ 07

September: Our first *exCHANGE* member is Mopsy Strange Kennedy.



▪ 08

April: Private event gives members an intimate concert with world-renowned pianist Fred Moyer, who then joined the *exCHANGE* with his wife April.



▪ 08

June: First international "Taste of PCP" event—held in Vancouver, B.C.



JOIN US! Join our friends above by becoming a member. You decide what to contribute. Time? Money? Connections? Something else? Design your own creative way to help PCP expand its reach. For more information, please give us a call at 617.923.1216 or see our Web site at www.publicconversations.org/pcpexchange

Mary Jacksteit

After several decades of work as a lawyer, arbitrator, mediator, and facilitator, PCP's newest associate applies her experience to a growing concern: unplanned pregnancy among people in their twenties. Jacksteit has worked as a consultant for PCP facilitating a dialogue forum on the use of animals in medical research over a period of four years. During that same time she worked for a non-profit in the District of Columbia on strengthening grassroots civic engagement on community issues. But her link to the issue of unplanned pregnancy goes back to the nineties when she ran a Search for Common Ground project on the issue of abortion. Through this work, she forged a relationship with the National Campaign to Prevent Teen and Unplanned Pregnancy, making her a natural to lead PCP's project to help the Campaign broaden its efforts.



Over the last decade the high rate of teen pregnancy in the U.S. has fallen. However, among twenty-somethings the rate has increased, making it the group with the highest number of unplanned pregnancies. According to the Campaign, half of all pregnancies in the United States—three million annually—are unplanned and more than one-third of all unplanned pregnancies (1.1 million) are to unmarried women in their 20s.

While three or four decades ago, twenty-year old parents were common, today, there is both curiosity and growing concern about the changing views this age group has about pregnancy.

In response, the National Campaign, with multi-year funding from the William and Flora Hewlett Foundation, has expanded its outreach focus from teens alone to include twenty-somethings.

The Hewlett Foundation provided funding for PCP to support the National Campaign, which has kicked off the project by targeting the attitudes and behaviors of twenty-somethings at community colleges. Stage two entails colleges taking the preliminary data and using it to develop programming aimed at their students.

“The community colleges give access to a difficult-to-reach population,” says PCP Project Manager Mary Jacksteit. “And, there’s the sense that community college students are at a higher risk than students at four-year colleges. These students don’t have the health care and campus services that four-year schools provide, and many study part time while they juggle jobs and other responsibilities, including kids.”

Jacksteit is learning about students’ views at Montgomery College’s Takoma Park/Silver Spring campus in Maryland just outside Washington, D.C. To address the lack of quantitative data, Jacksteit drew heavily on PCP’s inquiry process to develop questions for classroom discussions and interviews with students, faculty, and staff.

“We’ve been helping Montgomery College and the Campaign ask the right questions to gain a better understanding of this complex issue,” says Jacksteit. This is important because the twenty-something demographic group is very different today than a generation ago.

“The interesting quandary is that many people in this age group say the issue is not access to basic knowledge about sex and contraception,” says Jacksteit. “People are letting themselves get pregnant. This generation has a casualness about preventing pregnancy. There’s a curious sense of ‘If it happens, it happens.’”

She has heard repeatedly that even in sexual relationships that start casually, once people were pretty sure they wouldn’t get a disease they would stop using contraception. “They have heard the messaging about teen pregnancy, but something has really shifted in how they view the conditions needed to have children. The traditional sequence of job, marriage, and children appears to be totally irrelevant to them. The idea that you might ‘plan’ those decisions doesn’t seem to resonate.”

Jacksteit’s sense is that too many people in this population see having a baby as a single event, not long-term, and don’t think about whether they are ready and able to be a good parent.

Even though there is strong statistical evidence that single parents and their children have much less success in school, career, and marriage/partnership, stigmas around being an unwed parent no longer exist. Often families will pitch in to help take care of the new baby, easing the struggle and perhaps reducing the deterrent.

These initial findings are helping to fuel next steps: The Campaign used them for a presentation to the Association of Community Colleges, and then awarded grants to three community colleges to develop effective programming models. PCP is designing a collaborative learning process that will help grantees learn from prior research as well as from each other’s upcoming work.

In the meantime, Jacksteit is helping Montgomery College complete its learning and planning grant and begin to implement new campus activities aiming to reduce unplanned pregnancies.

“At Montgomery, part of the prevention strategy is providing opportunities for students to talk and explore the issue in ways they have not had. Because there are no quads or dorms, they’re looking at bringing the topic into classroom discussions and providing experiential learning opportunities, possibly including an action-research class, in which students become the ones studying this issue at the college and in the community.”

“THE INTERESTING QUANDARY IS THAT MANY PEOPLE IN THIS AGE GROUP ARE LETTING THEMSELVES GET PREGNANT. THERE’S A CURIOUS SENSE OF ‘IF IT HAPPENS, IT HAPPENS.’”

A NEW RX: DIALOGUE (CONTINUED)

We know how to help people have good conversations when differences are getting in the way. That's our stock in trade.

WHAT EXCITES YOU ABOUT WORKING ON HEALTH CARE PROJECTS?

It's exciting for me personally because I worked in healthcare for nearly two decades, and I've always wanted to bring the insights of PCP back into that world. I have seen how we might make a difference in how people are treated at very vulnerable times in their lives. Also, healthcare workers are in a very demanding and stressful environment; I think we can make a difference in their lives as well, by making their work easier and more rewarding.

And, PCP's larger mission is to reshape how people in this country engage differences. The workplace is where people spend the most time with different kinds of people. Making an impact in the workplace goes a long way towards PCP's aim to affect the larger culture in America. ■

ASSOCIATE'S CORNER (CONTINUED)

This could demonstrate the value of including people who are affected. "Instead of having them be research subjects," says Jacksteit, "we need the students who are part of this age group and facing this issue to be part of the research and action teams. We need their thoughts about why there is so much unplanned pregnancy and about how to address it." ■



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UPCOMING WORKSHOPS

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November 12-14, 2008, Boston area, MA, with Sallyann Roth & Bob Stains

June 11-13, 2009, Boston area, MA, with Maggie Herzig & Bob Stains

*PCP workshops have limited enrollments, sliding scale fees, and provide CE credits through NASW, APA, NBCC, and MAMFT. Workshop costs range from \$125 to \$250 per day, depending on location.