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Mental Health Care at the Margins: A Critical Ethnography of Psychological Practice in an Inner City Mental Health Setting

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MENTAL HEALTH CARE AT THE MARGINS: A CRITICAL
ETHNOGRAPHY OF PSYCHOLOGICAL PRACTICE IN AN INNER CITY
COMMUNITY MENTAL HEALTH SETTING

A Dissertation

Submitted to the McAnulty College and
Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By

Katy A. Sampson

December 2009

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ABSTRACT

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December 2009

Dissertation supervised by Leswin Laubscher

Within the past several decades, the field of psychology has attempted to improve psychological services for a greater diversity of people. However, despite these attempts, research continues to document a “gap” when it comes to mental health care services for marginalized populations. Various studies have addressed the issue of this “gap” in mental health care; however, most adhere to positivist assumptions regarding sociocultural aspects of experience, understanding culture and identity as immutable qualities existing within individuals, rather than as an interpersonal phenomenon that is negotiated between and among people and institutions. As a result of these assumptions, many past studies do not take into account this dynamic aspect of culture and the way in which it plays out within psychotherapeutic environments. In an effort to shed some light on the nuances and challenges of socioculturally sensitive practice, the current study utilized an ethnographic method in order to explore the practice of clinicians who were

attempting to offer psychological care to a marginalized population. Results demonstrated that both psychologists and clients are caught up in a “web” of systems and identifications which impact the provision of psychological services. These findings support the notion that psychologists may benefit from expanding the traditional scientific lens when it comes to exploring issues of culture in psychotherapy, particularly when it comes to addressing the gap in services to marginalized groups.

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INTRODUCTION

Three years ago, I worked as a student clinician in an inner city community mental health center, located in a Northeastern city in a largely African American community. At this center I observed a distinctly community oriented model that was shaped by, and interwoven into, the local history, customs, values systems, and struggles of the community. At times psychologists at the center seemed to be consciously trying to incorporate these sociocultural concerns into their practice, at other times their attention to culture was more implicit as they worked, embodying what appeared to be contextualized understandings of clients' experiences, relationships, and their own practice. I observed that this community model operated according to principles very much in line with traditional community psychology, such as an emphasis on the importance of contextualization, consideration of power and its effects, concern for social justice, and a particular interest in marginalized populations. These principles of course played out in ways specific to the particular geographic, historical, cultural and political context in which this community clinic was located (a lower income, urban, largely African American neighborhood). Given the complexity of the clinical work at this "Center", my interest was piqued and I began to scour the community mental health literature to help me understand what was happening at the Center and to relate what others have found to practice at this particular Center.

After reviewing much of the current and extant literature around issues of culture and community in Western psychology, at least one thing was clear – the field is still struggling to find ways to understand and address the “social” workings of human experiences (Kitayama & Markus, 2000). Diversity and difference are often recognized as important considerations in contemporary psychological literature; however, the translation of such considerations to community-based clinical practice has not only been wrought with difficulty, but has been few and far between. Indeed, a paucity of research, especially qualitative empirical inquiries, offers little guidance. To compound matters, the few research studies and initiatives that do exist, are often so reductionistic and dismissive or ignorant of the complexity of culturally oriented community practices, as to offer little more than formulaic aphorisms incapable of any substantial praxis translation. That said, many (mostly quantitative) studies have documented a “gap” in psychological services when it comes to “diverse” groups (often “diverse” in these studies refers most broadly to people living in poverty in both rural and urban neighborhoods) (see Atkinson, Morten & Sue, 1998; Chow, Jafee, and Snowden, 2003; Snowden, 2005; Stevenson, 2001). Framing the problem or “gap” as resulting from practical “obstacles” such as lack of insurance coverage, inability to obtain affordable childcare, or transportation (Chow, Jafee, and Snowden 2003), many of these studies challenge psychologists to address this “gap.” Almost never, however, is this supposed “gap,” or the challenge of a response, understood or argued in terms of how psychological services may be set up and delivered in ways that do not address these concerns, or may in fact be complicit in its very existence.

A similar tension or paradox as suggested in the previous paragraph is also evident with respect to the importance of community and culture. On the one hand, within the field of psychology there is a hue and cry for sensitivity to issues of community and culture, but on the other hand, researchers have also suggested that when individuals rely on “cultural(ly) sanctioned explanations for illness” it creates an obstacle to their motivation to seek western medical/psychiatric treatment (Chow, Jafee, and Snowden 2003). According to conclusions based on these studies, local, spiritual, or cultural understandings of illness are constructed as being at odds with, and even “obstacles” to, traditional western medical/psychological understandings of illness.

Despite the call for improvement in culturally appropriate psychological practice based on findings from these past studies, such statements regarding a person’s reliance on “culturally sanctioned beliefs” imply that cultural norms are still seen as “obstacles” that impinge upon what would otherwise be helpful treatment. Prilleltensky (2002) has also commented on a similar issue, noting that, “if a client does not fit the [psychological] paradigm, the generalizability of the theory is not questioned, but rather the ability of the client to have a valid experience is contested” (p. 1149). Although most contemporary psychologists would probably not explicitly devalue culturally or religiously sanctioned beliefs, such a devaluing can happen in more covert and insidious ways; for example when a client is considered to be “concrete” or “not insightful” given their tendency to understand their experiences in non-psychological (e.g. culturally sanctioned or religious) terms (Prilleltensky, 2002).

The field of psychology has historically been concerned with the functioning of individuals (rather than groups) and this focus has made it difficult for the field to

understand and intervene with people in more socially contextualized ways. On the other hand, the subfield of community psychology offers a synthesis of psychological and social considerations, including issues of social position and power. Community psychology as described by Lewin (1951) (who has sometimes been identified as the originator of community psychology) represented a social psychology that could study the articulation of both the individual and the collective, or what Durkheim called the “socio-psychical” (Durkheim, 1933). Following from this history, community psychologists have continued to understand much subjectively felt and behavioral phenomena in social terms – as symptoms of systemic disarray. Over the years, community psychology has become a broad field and has found expression in very diverse contexts around the world. At times community psychology is closely aligned with sociopolitical movements and action research and activism; at other times, and commonly in the United States, community psychology finds expression in more clinical realms such as public psychology clinics (Orford, 2008). However, at least one commonality is threaded throughout the various forms of community psychology: a concern for what has been termed the “macro-social” level of experience and a critique of traditional psychology for neglecting this dimension (Prilleltensky, 1994). Prilleltensky (1994), a contemporary community psychology pioneer and advocate, suggests that clinical psychologists in particular have typically tended to “dissociate” their clients from “wider systems of society that share her or his behavior extensively, thus creating an ahistorical and asocial image of individuals” (p.102) On the other hand, although Prilleltensky (1994) argues for community psychology as a legitimate alternative to overly individualized psychological practice, he also observes that community

psychology has room for improvement when it comes to really applying their theories, understanding the experiential dimension of various social conditions/positions, and involving themselves in the political arena. As such, one of the first aims of this study is to examine psychological practice in one particular community clinic for the obstacles and innovations in culturally oriented community practice.

Outside of the field of community psychology, much has been written about diversity in general and the need to incorporate issues of difference in clinical practice (Atkison, Morten, & Sue, 1998; Kitayama & Markus, 2000; Sampson, 1993b; Sue, Arrendondo, & McDavis, 1992). Some diversity considerations have arisen from traditional quantitative survey research and other considerations have arisen from personal narratives, qualitative studies, and philosophical/political theory. Much of the mainstream multicultural psychology literature has focused on defining social categories such as race, class, gender, ethnicity, etc. and critiquing past research, personality models, testing, and understandings of psychopathology for its' Eurocentric, masculine bias (Atkinson, Morten, & Sue, 1998; Sue, 1998;). Despite multicultural psychology's emphasis on these important issues, most research tends to focus more on the quantitative study of social categories still defined according to positivistic and often individualistic standards rather than exploring their function, meaning, and construction (Cosgrove, 1995). Multicultural empirical research regarding culturally sensitive practice tends to focus on psychologists' adherence to "cultural competency" models, and/or manipulating various variables, such as client and therapist ethnic or racial "matching" and measuring effectiveness of psychotherapy in those instances (this issue will be discussed in more detail in Chapter 1) (Gamst, Der-Karaberian, & Kramer, 2000; Maramba & Hall, 2002;

Sue, 1998; Sue, Arrendondo, & McDavis, 1992). Although such studies may provide some insight into diversity issues in practice, they still do not address the larger systemic issues that permeate the practice of psychotherapy, nor do they typically take an interpersonal, dynamic approach when understanding culture/race/ethnicity in the first place.

Various psychologists who work within a multicultural or community framework have begun to adopt more critical ways of looking at diversity which has helped to shed some light on why it continues to be difficult for psychologists to effectively take culture and community into consideration in clinical practice (e.g. Altman, 1995; Javier, 1996; Prilleltensky, 1994; Smith, 2005; Sonn, 2004). Also, many academic theorists from fields such as anthropology, philosophy, feminism, and critical race theory have emphasized a more dynamic, intersubjective conceptualization of social identity that incorporates issues of diversity, difference and/or power (e.g. Butler, 1990, 1993, 1997; Foucault, 1978; hooks, 1990; Geertz, 1973, 1983; Shweder, 1991).

Despite all of the theory and research regarding diversity issues, very few texts and research actually look at what happens or how the question of diversity is answered at the level of actual clinical practice. Therefore, a second aim of the current study is to respond to the question of diversity by examining and staying close to the sphere of actual clinical practice. I will draw from a few qualitative studies such as the self-reflexive narratives of community psychologists included in Altman's (1995) and Smith's (2005) reflections on their clinical work in urban community clinics. I will also draw from qualitative studies conducted by James and Prilleltensky (2002) - research which sought to explore integrated community practice and constructions of community by

interviewing and observing practitioners – as well as research by Gubrium (1992) and Bloor, McKeganey, and Fonkert (1988) whose ethnographic studies explored some of the systemic concerns related to residential psychiatric services, psychiatric hospital care, and family therapy respectively.

The current study seeks to broaden the scope of prior research by including a consideration of the system of care within which psychology is practiced as well as analyzing the way that issues of power, identity, and culture are integrated into practice in a specific clinical setting. More specifically, this research is an attempt to explore one clinic's attempt at providing culturally informed, locally situated, community oriented psychological care at an inner city community mental health clinic (which I will refer to as "the Center"). In this account, I am concerned with how clinicians at the Center– who provide psychological care to a mostly African American community living in a lower-income urban neighborhood– have approached and articulated their work. Not only could it be argued that these clinicians "do" community psychology by virtue of the organization and aims of psychological practice at the Center, but the clinicians self-identify as community psychologists as well. I am also interested in articulating the larger social, cultural, and historical frame within which clinical work is situated as it assumes that cultural context and psychological practice shape and inform one another continually. In doing so, I hope to provide a glimpse into the workings of community psychologists at the level of everyday practice, and also show how community psychologists are already embodying many of the tenets of multiculturalism that traditional psychology is still struggling to translate into practice. Of course, the study

will also remain attuned to ways in which multiculturalism in practice – even in community psychology practice - may be obstructed, constrained, or otherwise limited.

This study is motivated by questions that arose for me during my own clinical work at “the Center,” by interests/concerns of staff at the Center, and by current debates in the field regarding issues of race, class and social inequality in psychotherapy. By conducting an ethnographic account of psychological practice that is tailored to a specific, typically “underserved” population, I hope to contribute to psychologists’ understandings of the integral role of race, class, and culture in clinical practice and the everyday challenges of addressing social issues in the psychotherapeutic endeavor. Furthermore, I articulate and explore the dialectical relationship between the social and the psychological, practitioner and practice; self and other (such views are prevalent in Shweder’s (1991) theory of cultural psychology). I will pay particular attention to power from a Foucaultian perspective and incorporate some of Butler’s consideration of the issue of power.

As mentioned before, many theorists, several from outside of the field of psychology, have explored questions about culture, diversity and difference in psychology and as such I seek to draw upon them in this study. Given my interest in investigating the many facets/challenges of community psychology and its expression within a particular context, as well as my specific interest in diversity, qualitative research methods seemed a most well-suited vehicle towards achieving these aims. In addition, community psychology literature supports the use of qualitative methods as most appropriate to exploring the practice of community psychology and other topics within this field (Orford, 2008). I use interpretive ethnographic methods to explore

diversity and power issues as they are integrated into psychological practice as well as to explore the culture, systems of meaning, and social forces that shape the everyday practices of the Center. Much interpretive ethnography, which is influenced by interpretive and post-modern theory, draws from the works of Clifford Geertz (1973, 1983) and James Clifford (1986) and I, too, will draw from the works of these two theorists in my method. Interpretive ethnography embodies several characteristics that are compatible with aims of the current research, namely a critique of modernist/realist interpretations, a critique of the notion of a value-neutral observer, and an emphasis on self-reflection and incorporating the voices of participants in the written ethnographic. Although Geertz (1973) and Clifford (1986) differ on some points (which I will review in detail in my method section), they both view culture as existing in the intersubjective field of meaning between persons. In other words, culture does not exist independently “out there”; rather it is dialectically constituted between persons. I will use a contemporary interpretive approach drawn from hermeneutics, social constructionism, and ethnography to analyze my interview transcripts, participant-observations and field notes.

To summarize: this study is located at the place where my own personal and professional background, academic theory, and the actual community mental health center – in space, history and as a data source - come together around the research focus: a focus which itself arose from a joint relation between my experience there, the expressed needs of the staff, and the center as spacing (in time and experience). In providing this narrative, some constraints or qualifications are noted. For example, clients will be presented only as they were understood by staff in order to protect their right to

confidentiality and preserve the focus of the current study on *clinician's practice and understandings*. I do not therefore claim to provide a voice for clients in this study, nor a portrayal of how they might view the system. In addition, I did not observe other clinicians individual psychotherapy sessions with clients for similar reasons. However, I did draw from my own experience working individually and in groups with clients, and I was privy to numerous interactions between staff and clients throughout my work/research at the Center.

Despite the constraints mentioned above, the current research has the potential to contribute new insights and understandings to the field of psychology. First, considering the current emphasis in the field on developing “culturally competent” care that incorporates considerations of race, class, gender, sexual orientation, etc., it seems important to analyze psychological practice in a setting in which diversity issues are explicitly recognized and incorporated into practice. It is imperative for psychologists to continue to be self-reflexive about how current trends are operating in the field and what it means to address sociocultural issues from a psychological perspective. Second, psychologists participating in the current study incorporate race and class into their understandings of clients' situations, but most of them have also considered how their own cultural identifications, with particular respect to race, class, and gender, shape their own experiences both personally and professionally. This study hopes to highlight the various narratives in which such work is situated and within which diversity issues and struggles play out through psychological practice. Third, after completing a literature review, the number of studies that focus on clinical practice holistically in all of its complexity are few, and those that specifically focus on community orientated inner city

work are even fewer. The current research can thus add to this small but important and growing body of literature. Lastly, many studies regarding mental health care with marginalized populations have documented that social minorities (including people of color and the poor) often either “underutilize” psychological services or are provided with “inadequate” services that are not culturally appropriate. In this study, I focus on an exception to these findings in a clinic where typically “underserved” clients represent the majority and presumably, therapists are finding a way to meet their needs.

This dissertation is organized in the following way: first, a literature review is provided to situate the subject at hand within the larger socio-cultural and academic context and present the variety of points made within both theory and research regarding “underutilization” of psychological services among marginalized populations. Second, I provide an orientation to the field of community psychology and consider the implications of community interfacing with the clinic (as in the case with community mental health care). Third, multiculturalism and psychotherapy with marginalized populations will be considered. I will discuss a variety of quantitative and qualitative studies on the topic incorporating a critical discussion of issues presented and providing an argument for the use of critical/ethnographic methods to explore the topic at hand. Fourth, I outline an argument for my choice of methods which draws heavily from interpretive ethnographic methods, more specifically, critical ethnographic methods and hermeneutics. I also describe my stance when analyzing data which incorporates deconstructive, interpretive/hermeneutic, and more general critical theory. In keeping with these theoretical and methodological positions, I attempt to maintain a self-reflexive stance as researcher throughout my analysis. I will explain when and in what way I

incorporate each of these approaches. Last, I will provide some possible conclusions based on my interpretations of the data and offer some discussion of the research process and points for further research.

I take as my point of departure the idea that in order for psychotherapy theory to progress, insight into the real everyday clinical work of psychologists is necessary. I aim to examine the dynamic nature of psychological practice incorporating social, historical, and economic considerations. My account will inevitably be partial – bound to subjective telling of the story as well as to the particular socio-historical moment in an otherwise long history of the Center. Nevertheless, it is a story worth telling in the name of gaining deeper understanding of what psychologists face when attempting to provide ethical and appropriate care to marginalized populations in the United States.

CHAPTER 1: LITERATURE REVIEW

Clinical psychology has traditionally been concerned with the study of the individual psyche, conceptualized as an individualized phenomenon existing as separate from social context. This conceptualization is consistent with modern conceptions of the individual as a self-contained, unified entity that exists separately from others. Although there is nothing inherently problematic about this conceptualization of psyche and/or the individual (assuming, for the moment, an equivalence of sorts between those terms), Hall (2005) suggests that “in order to fully understand human behavior, individuals must be studied in context” (p.787). Others from outside of the field of psychology, such as Geertz (1979), observed that the idea of the self-contained individual, although dominant in Western cultures, is a peculiarity to many other cultures in the world where the self is understood in relation to others, as embedded within a social matrix. Geertz’ observation poses an obvious challenge to the applicability of traditional Western psychological understandings of experience in non-Western cultures and countries. Less obvious, however, is the fact that Geertz observation is as appropriate and challenging within a heterogeneous, multicultural society such as the United States.

Aside from the limitations of cultural applicability or generalizability, however, an overly individualized approach to clinical work may not only be limited with respect to questions of effectiveness, but may actually perpetuate an oppressive sociopolitical status quo. Sampson (1993) argues that when we venerate the self-contained self, particularly within a context of domination and unequal power relations, we often

celebrate it at the expense of a denigrated other; we not only honor the self but define it in terms of what it is not – the other. Several authors (e.g. Prilleltensky, 1994; Sampson, 1993; Sue 1998) have identified a dominant reference standard in Euro-America, namely that of the white, male, heterosexual, middle-class person. Against this dominant standard, marginal others include people of color, women, sexual minorities, and working class poor, constructed negatively in relation to the dominant group and in the service of that group's particular needs, values, and points of view. Arguments presented by numerous theorists, including Hall (2005), Prilleltensky (1994); Sampson(1993) and Sonn (2004) (among others) imply and often clearly recommend that effective psychological care needs to address and incorporate a consideration of social identities and the power matrices in which they are embedded in order to improve psychological care and better serve society.

Whereas the conception of the self as self-in-community finds resonance in a number of traditions outside of psychology, such as sociology (and social work), feminism, contemporary anthropology, and cultural studies to name a few, it is also true that there are pockets of support for this notion within psychology itself (e.g. Brown & Gilligan, 1992; Clifford, 1986; Geertz, 1973; Hillery, 1955; Sarason, 1974; Swenson, 2006). The idea of “self-in-community” expands notions of “self-in-relation,” emphasized by object-relations and other relationally oriented psychologies (e.g. Fairbairn, 1952; Klein, 1964; Winnicott, 1965) which focus on connection and individuation in smaller units such as dyads or families. Such relational conceptualizations of self have implications for the clinical practice of psychology when considering cultural or social aspects of identity. Bruner (1990) argued that human

psychology based on the individual alone was an impossibility, and that psychologists must study shared meanings, discourse, and concepts in order to understand our culturally adapted way of life. But the question remains as to how such ideas might be incorporated into clinical practice and what issues might arise when clinicians attempt to integrate the social with the psychological.

As a field, community psychology has historically been concerned with issues of social position and power, more specifically, experiences of disempowerment, oppression, marginalization and the psychological impact that such experiences have on communities and individuals within communities (as opposed to individuals qua individuals). As such, community psychologists are oriented towards community: either in concrete and utilitarian terms when delivering psychological services to people who might otherwise find it difficult to access hospital or agency care, but also in terms of a fundamental shift in the conceptualization of the individual (Swenson, 2006). Based on my clinical and research work in a community mental health center, I observed that psychological practice which grounds itself in the experiences of a historically marginalized community and that seeks to address entrenched social issues (e.g. classism and racism) that heavily impact these individuals, required a distinct sensibility about psychological suffering and appropriate intervention. This sensibility is multifaceted, dynamic and requires an acute awareness of complex relational, political, and economic webs within which both helper and client operate.

In the following sections, I review the existing community psychological literature and core concepts, as it pertains to this study, and continue to argue that studying the practice of community psychologists may help to shed light on the

complexity of issues that both make a more contextualized and culturally grounded practice possible, but also the issues that make it challenging. I begin the literature review with a discussion of the core principles and values of community psychology, which includes a specific focus on marginalized populations. After that, I review some of the mainstream literature regarding clinical work with these populations, including the response of multicultural psychology. I consider this literature through the lens of post-modern interpretive theory and present the thoughts and observations of researchers/theorists/practitioners who represent this perspective. Lastly, I discuss the basis for an interpretive ethnographic study of community-based clinical practice.

Constructions of Community and Definition of Community Psychology

The word “community” is of IndoEuropean origin, *kommein*, meaning “shared by all” and from the Latin word *communitas*, meaning “fellowship.” Over the years, however, “community” has been defined in a number of different ways (for example, Hillery (1955) identified at least 94 different definitions), as have the practical implications and applications of the varying definitions in community life and intervention. However, despite such differences, Hillery noted similar features that were included across almost all of the definitions of community, namely “geographic area,” “social interaction,” and “common ties”; that is there is a sense of commonality, or “fellowship,” in terms of geography or other social or historical organization. Various thinkers within the fields of sociology and even social psychology, have further refined the definition of community by differentiating between types of communities (Bell &

Newby, 1972; Sarason, 1974). For example, Bell & Newby (1972) distinguish between small versus large communities where, in the former type of community, there are high degrees of homogeneity, interaction, and commitment and low rates of change; and in the latter type of community, there is more diversity, less personal interaction, and higher rates of change. There is debate as to whether the characteristics of each of these are mutually exclusive because, of course, close personal ties may coexist with impersonal relationships within the same community and there are many communities in which these descriptions simply do not apply (for example, within a prison which is likely to be a small community, with high rates of interaction, but considerable diversity, and perhaps even high rates of change)

Despite these attempts at defining community, the concept remains rather vague and muddy. This vagueness bespeaks the complexity of interpersonal relationships and the difficulty with determining concrete definitions of such relationships. These previous definitions gloss over the many ways people form or are considered part of communities and concepts such as “social ties” and/or geographic commonality appear to be quite open to interpretation.

Perhaps, as some theorists/researchers have suggested, it may make more sense to ask about a person’s subjectively felt (psychological) sense of community instead of trying to reach some unifying “objective” definition. This subjective sense of community is of particular relevance to psychology for it speaks to a person’s sense of self-in-community (Swenson, 2006). Sarason (1974), one of the putative founders of community psychology, emphasized that people’s sense of well-being depends upon their subjective sense of community. He believed that a psychological sense of community was so

important that it served as the conceptual center for the psychology of community because it is one of the “major bases of self-definition” (Sarason, 1974, p. 157). The psychological sense of community involves “the perception of similarity to others, an acknowledged interdependence with others, a willingness to maintain this interdependence by giving to or doing for others what one expects from them, and the feeling that one is part of a larger dependable and stable structure” (1974, p. 157).

Gusfield (1975) identified two important dimensions of community: relational and territorial. Relational communities are bound by what Hutchinson (1995, p. 8) referred to as “network links (webs of communication)” which are marked by common ties or interests. Scholarly circles may be considered an example of a relational community, given that scholars are tied through similar academic interests despite often living in quite disparate geographic locations. Territorial communities, on the other hand, are defined primarily by geographic location as in the case with neighborhoods.

Defining community psychology

As with defining community, so too with defining or circumscribing community psychology: A number of competing and sometimes conflicting notions emerge as to psychological models with which to theorize social aspects of experience. Among such perspectives are community/ecological models as well as multicultural approaches. Contemporary social constructionist and narrative approaches that overlap with, or are often incorporated in, certain kinds of community and multicultural theory/practice have also emphasized social meanings and self-in-community. Some of these ways that

psychology has interfaced with community, inclusive of the theoretical tensions and challenges that arise from it, are touched upon below.

Community psychologists are concerned both with people's psychological sense of community and how this sense of community impacts their senses of self, life trajectory, understandings of the world, and relationships with others. Two prominent community psychologists, Frank and Keys (1987), suggest that there can be no individuals without groups, and no groups without individuals. As such, community psychologists tend to be concerned with non-individualized, socially oriented understandings of experience as well as the impact that social context has on individuals intrapsychically. Despite this overarching concern for social context, the practice of community psychology tends to vary widely depending upon the social and political context within which it is applied. For example, Orford (2008) notes that in Brazil the practice of community psychology has historically remained much more closely tied to political movements, resulting in even clinically oriented community psychologists becoming more involved in various forms of activism. Additionally, due to oppressive power regimes in Brazil, the practice of psychology at times (and especially during the 1960's) had to be more covert, resulting in community-based clinical practice taking place in private offices, which rarely happens in the United States (where community-based clinical practice is largely housed in public clinics) (Orford, 2008). Regardless of where or how it is practiced, though, community psychologists share a general set of principles, values, and goals. These principles may or may not have any bearing on the *clinical* practice of community psychology, an issue I will address later on.

Where North American community psychology is concerned, some of the core

values and assumptions include, firstly, privileging *context* – including social, historical, political, and economic aspects of context – and how these social factors create and sustain human existence and experience. It follows then that community psychology focuses on analysis and intervention beyond the individual level, including a consideration of interpersonal settings and larger sociopolitical structures. Not only do community psychologists focus on analysis and intervention at a level beyond the individual, they also “bring attention to the way in which [traditional psychological] analyses and interventions may compound distress by blaming individual or family victims for problems that are the consequence of the way society is arranged” (Orford, 2008, p. xii). This last quotation speaks to what can be labeled the *critical* nature of community psychology, that is, a focus on examining and deconstructing common understandings and strategies commonly used by mainstream psychologists. Prilleltensky (1994), a key figure in the field of community psychology, is a strong proponent of the critical dimension of community psychology. He argues and cautions that all too often even community oriented psychologists have reverted to taken for granted psychological concepts and interventions without due consideration of the political and economic influences on their work. From a critical (as well as a social constructionist) viewpoint, people’s sense of self is constructed by social context and thus this view can be deemed to be compatible with community psychology principles. However, despite this recognition that persons are constrained and even constructed by social forces, community psychologists tend to also emphasize personal agency. Notions of *agency* and empowerment are actually quite important within community psychological theory and practice, although not much attention is paid to the interesting tension between

understanding or conceptualizing the self as both socially constructed and as empowered individuals, able to effect personal/social change.

Another important foundational principle of community psychology revolves around issues of power: how it operates in society and how people are impacted by and utilize systems of power. Within community psychology literature, it is generally recognized that “control or power is structured by societal arrangements including relative wealth, socio-occupational stratification, gender and dominant – especially ethnic-group membership” (Prilleltensky, 1994; Rappaport, 1977). One of community psychology’s goals is to take a critical view of power and to expose ways in which certain exercises of power are damaging to community and psychological wellbeing. In addition, community psychology aims not only to analyze power, but to find ways to help people resist inequality and injustice. Consistent with this social justice aim is a deep respect for diversity, difference and working towards an equitable and just redistribution of power. Consequently, it is often the case that an emphasis on prevention, intervention, and policy change at the institutional or structural level takes place and/or is preferred as opposed to treatment at the personal level. With reference to psychology as profession and institution, such a stance may for example include a stringent critique of the status quo when it comes to traditional medical/psychological models, as well as a self-reflexive look at how community psychology could improve in terms of promoting social change (e.g. venturing out more into the political arena) (Prilleltensky, 1994). Prilleltensky and Nelson (2002) interlace critical and community psychology and suggest that “unlike typical psychological research, in which power is regarded as a variable existing ‘out there,’ affecting the behavior of the people we study or treat, critical psychologists

contend that power suffuses our very own actions as psychologists” (Prilleltensky & Nelson, 2002, p.5). As such, community and critical psychological research and practice involve a strong element of reflexivity and analysis of interpersonal aspects of clinical practice (including power as it is enacted in interpersonal relationships).

Another important and defining characterizing feature of community psychology is its emphasis on working *collaboratively* with others, especially others who are marginalized and/or disempowered. Community psychologists are interested in non-hierarchical, participatory methods when it comes to research and practice. There is an emphasis on the competence and expertise of community members vs. those of “professional” psychologists and/or researchers. In an effort to create these collaborative relationships with community members, psychologists may adopt a more *transparent* stance, sharing about themselves, adopting an attitude of not-knowing and curiosity, and trying to draw on both everyday and expert forms of psychological knowledge.

Community Psychology and the Clinic

The story of community psychology as it is practiced at the community site under investigation, “the Center,” must be situated against a broader narrative canvas for it to stand out in sharper hermeneutic relief. Internationally speaking, community psychology has found diverse expression and its trajectory remained quite closely connected to sociopolitical movements. In contrast, the development of community psychology in the United States has emerged alongside the community mental health movement which is also credited by some as serving as a kind of “launching pad” for community psychology (Levine, Perkins, & Perkins, 2005, p.5; Orford, 2008). As such, much community

psychology within the United States has been joined with social services, and has taken a distinctly clinical turn. Joining the clinical and the community had, and continue to have, important and far-reaching implications. The clinical practice of community psychology, for example, is often practiced in community-based clinics or community mental health centers which – especially so in contemporary times - have often been absorbed into or by larger psychiatric and/or medical institutions. Such is the case with the Center under investigation, which operates as a satellite of a larger psychiatric hospital. It therefore makes sense to examine the emergence of community mental health centers in the U.S., which has been such a formative force in the development of community psychology, in greater detail.

A brief history of community mental health centers

Because the Center is considered a “community mental health center” – one of the last of its kind in this large, Eastern state - it carries with it a particular history that reflects socio-historical trends/ideologies of the past fifty years or so. As such, the story of community mental health as a social/systemic movement in general, is in some measure also the story of this particular and singular clinic. It behooves the investigator who attempts to understand community mental health, to keep in mind that the story is not only that of practice, but also that of a social/systemic movement.

Community mental health centers were created, in part, as a result of the community mental health movement, which is well rooted within clinical psychology. This movement picked up momentum in the 1960’s after the government passed a Mental

Health Act (1963) intended to improve care for people with a variety of mental “disabilities” (Cooper & Lenter, 1992; Cutler, Bevilacqua, & McFarland, 2003; Smith, 2005). One of the main arguments of this act was that community care was superior to hospital care for individuals with severe mental illness and/or mental retardation (Vega & Murphy, 1990). The community mental health movement also embraced ideals of the civil rights movement, and saw as part of its goal the empowerment of people of color and the revision of exclusionary institutional practices (1990). Consequently, community clinics originally developed out of the two pronged conviction that a) individuals diagnosed with psychiatric disorders would thrive outside of hospitals and that b) the plight of historically oppressed communities, such as persons of color, deserve particular attention when it comes to deconstructing and reshaping systems of psychological care. A community model not only conceptualizes community as being the appropriate environment for treatment, but it is also more likely to take into account the ways in which someone’s distress, whether it be labeled depression or schizophrenia, represents the manifestation of larger social/community problems (Prilleltensky, 1994).

Unfortunately, government funding for community mental health centers fluctuated for many years, ending up dwindling to almost nothing by the 1980’s. As a result, many of the imagined and expected community centers remained an unrealized dream and were never actually built (Cooper & Lentner, 1992). Yet, even as the community movement was undercut by lack of federal funding from the start, it has still retained the spirit of promise and an alternative, at least in some clinics. This, too, in spite of the fact that many of the community centers that remain have been absorbed into larger institutions or have emerged as a satellite clinic of a larger institution. As a result it

is common for public clinics (including the Center) to operate at an intersection of the discourse of a larger psychiatric institution (a medical model), and the discourse of a community model (Vega & Murphy, 1990).

The ideals of the community mental health movement are implied within the organization of many community mental health (CMH) centers, even though they may not be outlined explicitly in treatment plan write-ups, mission statements, etc. Both the community of the Center as well as the surrounding community are valued and integrated into therapeutic practice. Social factors are considered a crucial element in understanding psychological distress which is, at least in part, conceptualized as a manifestation/reflection of the state of the community (Vega & Murphy, 1990). However, it should be noted that the emergence of “community mental health,” although philosophically grounded in community psychology, is also integrating notions of “mental health” that are in turn infused with individualized, medical understandings of the experience. Although community psychology is often practiced within clinical settings, there remain inherent tensions between the clinic and the community. Some of the implications of the interface between clinic and community are reviewed below.

Community and Clinical Practice

So what is meant by the term community when we talk about community mental health or community psychology? And what does it mean to try to practice community psychology in a clinical setting – or to be engaged in the task of community-based clinical practice? Sessions and Lightburn (2006) suggest that:

Community-based practitioners seek an infusion into clinical mental health practice of the values and perspectives of ‘community,’ an integration of interventions that build on the healing power of the collective, of belonging to a group that contributes to a social identity and provides opportunities for meaningful, contributing social role. At the same time community-based clinicians recognize that the highly specialized knowledge base developed ‘in the clinic’ is extremely useful in ‘the community’ as well (p.4).

Lightburn and Sessions’ (2006) comment highlights the potential for mutual exchange and enrichment between the clinic and the community. For example, community, as they propose, focuses on shared experiences, collaboration, interdependence, mutual participation and perhaps even a feeling of “fellowship” (as is suggested by the definition of community in the American Heritage Dictionary, listed earlier). The term “clinic” on the other hand, evokes images of hospitals or other medical centers, where the emphasis is on science, objectivity, professionalism and pathology. Relatedly, “clinical” conjures up a long history of research, diagnosis, assessment, and intervention that sought to remove people from their social contexts in order to more objectively measure, study, observe, and treat them. As mentioned, Lightburn and Sessions (2006) believe that the clinic and the community can enhance one another: the clinic can offer psychological knowledge gleaned from its’ more “sterile” environment, such as knowledge about human development, about psychological trauma, family and group theory, and ideas about psychopathology; whereas the community can feasibly benefit from applying this knowledge to understanding their own lives and facilitating community growth. Clinical knowledge is only useful if it can be shared with and used by the community and

transformed as a result of feedback from the community. As such, the clinic needs the community to ensure its continued utility and the community can benefit from resources provided by clinical knowledge. Not all theorists are as optimistic as Lightburn and Sessions (2006), however; Swartz (1996) for example, argues that by attempting to practice clinical psychology in the community, psychologists risk the extension of the “medical gaze” – “a mechanism of the production of desire and hence social control – the pushing of the boundaries of psychology becomes at base an attempt to place boundaries and controls around people and to interfere with and police their lives in an elaborate form of surveillance masquerading as service” (Swartz, 1996, p.5) This risk seems particularly salient when psychological knowledge and interventions are assumed to be “neutral” and always “just and fair” (Prilleltensky & Nelson, 2002, p. 6). Perhaps the recognition of the tension between clinic and community and the need for critical reflection when it comes to dissemination and application of psychological knowledge can assist in lessening the oppressive potential that such an interface might have.

For the current study, such a consideration of the interface between the clinic and the community, and the potential for perpetuating oppressive regimes of power is particularly important given some of the defining socio-economic features of the community in which the Center is located. The Center is located in a lower income, predominately African American, community that carries the scars of a particularly difficult and tumultuous history within the context of the larger city. Whereas I provide a fuller account of this history in Chapter 3, the purpose of its mention here is to argue, on the one hand, that community psychology and community clinics tend to be oriented towards working with marginalized populations, and to motivate, consequently and on

the other hand, for a review of some of the mainstream literature regarding psychotherapy with marginalized populations both within community centers and elsewhere, as in the section below.

Psychological practice with marginalized populations

Because “community” psychology is local, it makes reference to particular communities – communities that are often characterized according to common demographic characteristics such as, race, ethnicity, geographic location, and/or class. The Center happens to be located in a neighborhood often labeled as an African-American, low income community, and the particular mission, goals, challenges, and trajectory of psychological practice at this clinic relate directly to issues most salient for this community. If we were to utilize Gusfield’s (1975) ideas about community, this community might represent a “territorial” community – defined primarily by geographic location. However, the community is also unified by common ties, such as a shared history of oppression/marginalization which renders it a relational community as well. A significant body of literature exists regarding psychological practice with socially marginalized populations, ranging from mainstream experimental psychological studies to qualitative studies, including some post-modern critical reflections on race (e.g. Altman, 1995; Chow, Jafee, & Snowden, 2003; Clay, 2005; Javier, 1996; Mitchell, 2005; Paris et al., 2005; Smith, 2005; Wynaden et al., 2005). I will focus on some of the main themes from this diverse literature, and point out some areas that call for more critical reflection or further research. In this section, common identity terms such as “poor,”

“African American,” and “minority,” will be presented as they appeared in the literature with little critical reflection or discussion; however, a critical analysis of these terms will be included in later sections.

The mainstream, predominantly quantitative, psychological literature generally characterizes psychological services, when it comes to ethnic/racial minorities and the poor, as “inadequate” - especially in comparison to ostensibly increased rates of mental illness among these same populations (Snowden, 2005). Communities labeled as “minority” and “poor” are cast in terms of crisis, and as engaging in “troubling patterns of participation” in treatment (Chow, Jaffee, & Snowden, 2003). For example, in 1999 the Surgeon General’s Report on Mental Health stated that the needs of minority racial/ethnic groups remain largely unmet and that “premature termination” was an especially “problematic” issue in the provision of care (Chow et al., 2003, p.794). Others, such as Stevenson (2001), argued that the gap in mental health care for African American patients has persisted, partially due to the relatively small number of African American psychiatrists nationwide, resulting in few “minority” patients ever seeing a therapist who “looks like them” (Sept. 4, 2001, Stevenson, p. A.12). Stevenson is not alone in her argument; in fact, many culturally/community oriented psychologists would agree that the face of psychology is predominately white and that this can, and does, have a negative impact on the experiences of some clients of color (Atkinson, Morten, & Sue, 1998; Prillettensky, 1994; Sampson, 1993b; Smith, 2005; Sue, 1998).

Snowden’s (2005), the Surgeon General’s (1999), and Stevenson’s (2001) observations suggest that there is a disconnect between the clinic and the community – even as speculations as to how and why this situation came about are still unclear. Chow,

Jafee, and Snowden (2003) suggest that “lack of insurance coverage, a tendency to attribute mental health problems to religious and other culturally sanctioned belief systems, and lack of access to receptive culturally compatible providers” can account for the observed disparities in community members’ “service utilization” (p.2). Additionally, research has shown that the tendency among socially marginalized individuals to discontinue therapy “prematurely” is hardly a new phenomenon. Beginning in the 1960’s, researchers have been documenting the trend of “racial/ethnic minority” individuals and/or individuals of lower socioeconomic status to withdraw from therapy (Smith, 2005). Despite their usefulness, many explanations define the gap between helping professionals and clients as either the product of larger social/economic conditions, or as being caused by particular characteristics of the individual culture of clients, rather than focusing on how systems of care themselves are implicated.

The gap between psychological service providers/models and the needs, interests, and values of social minorities has been well-documented (for example, Atkinson, Morten & Sue, 1998; Stevenson, 2001; Chow, Jafee, and Snowden, 2003; Snowden, 2005); however, many of the studies cited by these authors used quantitative research methods, and were geared towards identifying problems and patterns, not necessarily towards investigating *why* these observed patterns were occurring, or what social forces produce and sustain problems. Moreover, despite over forty years of clinical research that has documented these difficulties, when it comes to clinical practice, not much has changed. For example, just a few years ago, the American Psychological Association (APA) issued a *Resolution on Poverty and Socioeconomic Status* in which they identified

poverty as “detrimental to psychological well-being” and charged psychologists with the responsibility to “treat and address the needs of low-income individuals and families” (APA, 2000, p. 23). The resolution points to an ongoing short-coming of psychology to communicate with diverse populations despite the current emphasis in the field on multicultural awareness and competence. The APA’s resolution represents a call to action for psychologists to take responsibility for looking more carefully and deeply at what it means to “address the needs” of not only low income families in general, but to address diversity and difference more broadly. Although the field has been slow in looking into the nature of psychotherapy with the poor and/or individuals of racial/ethnic minorities, some recent studies have sought to expand the exploration of this issue by using qualitative methods (Mitchell, 2005; Paris, Añez, Bedegral, André-Hyman, & Davidson, 2005; Rios, Palacios, Gonzalez, & Sandoval, 2003; Wynaden et al., 2005). Findings from these studies which are discussed below, elaborate on past quantitative studies by adding a richer, descriptive dimension.

Findings from studies examining clients’ experiences or perceptions of mental health care systems overlap across a few main themes. This feedback may represent the kind of reciprocal communication that Sessions and Lightburn (2006) suggested would assist with reducing the tension between clinic and community and also reduce the potential for the imposition of psychological practice that is incongruent with the worldview/ethos of a community. The first theme from my review of this research revolves around alienation and social stigma. Many researchers, operating within both quantitative and qualitative research paradigms, have documented the ways that marginalized communities have often felt alienated by traditional systems of

psychological care and also reported concerns about a stigma related to seeking professional psychological help (Alvidrez, Azocar, & Miranda, 1996; Clay, 2005; Mitchell, 2005; Paris, et al., 2005; Rios, Palacios, Gonzalez, & Sandoval, 2003; Wynaden, et al., 2005). The second common theme relates to the positive relationship between client satisfaction with services and the degree to which staff take a collaborative approach to their interactions with clients. Researchers have found that when there was more collaboration between staff and clients, such as allowing clients in a community clinic to sit on a governing board of the site, clients generally felt less alienated and responded better to therapy (Newberry, 2005; Wynaden, et al., 2005). The contextual nature of community mental health care was a third common theme among researchers who observed that in a community clinic or community mental health center, what is therapeutic (or not) to clients happens on many levels across many individuals in the clinic (Newberry, 2005; Phillips, 2005; Wynaden et al., 2005). For example, when a client comes to a community clinic, he or she is likely to have contact with several people, such as other clients, administrative assistants, case managers, psychiatrists, nurses, and psychotherapists. A given client's interface with a community clinic is, therefore, not limited to his or her contact with a therapist (Newberry, 2005; Phillips, 2005; Wynaden et al., 2005).

Most of these studies did acknowledge that myriad factors, such as economic, social, and religious considerations, play a role in the accessibility of mental health care outside of client/therapist interactions (Chow et al., 2003; Mitchell, 2005; Paris et al., 2005; Phillips, 2005; Rios et al., 2003; Snowden, 2005; Wynaden, 2005). At the same time, this research also presents the behavior, perceptions, and/or cultural beliefs of

marginalized populations as explanations for their disinterest in, and/or aversion to, seeking professional psychological help. For example, imagine a client who decides to withdraw prematurely from psychotherapy because her understanding of her distress is markedly different from that of her therapist. The client may make sense of her suffering in religious terms, believing in a more spiritual explanation of her experience. If we were to apply the line of reasoning presented in some of the aforementioned studies, we might say that because she attributed her distress to “religious and other culturally sanctioned belief systems” and not to the traditional medical model, this served as a barricade for “effective” treatment (Chow et al., 2005, p.2). It could be argued that to describe her beliefs as “different” to begin with sets up a situation in which the psychologist’s (or psychiatrist’s) model of understanding becomes the invisible standard against which the client’s “culturally sanctioned belief system” is compared, and subsequently labeled “different.” I use this example to highlight the way in which focusing only on the perceptions/experiences of marginalized groups to the exclusion of looking more self-reflexively at the field of psychology itself represents a blind spot for social science researchers. In other words, perhaps the existence of appropriate mental health care for individuals considered “other” (than white, middle class), says more about the practice, beliefs, values of psychology than it does about those receiving services. If the structure of psychological practice remains invisible, then it is difficult to fully consider the ways in which it is implicated in the reported dissatisfaction of marginalized communities.

These studies form a useful backdrop to the study of community-based psychological practice and are particularly relevant to the current research. Some of these past studies even point to potential challenges when it comes to addressing what have

been labeled more “social” issues as well as some effective interventions (e.g. collaboration) as it pertains to appropriately engaging communities who have been historically marginalized. However, there is little discussion in the literature regarding how psychologists conceptualize these issues (mental health, community, culture) in the first place. Labels such as “poor,” or “African American” are presented with little discussion, and as if unambiguous and neutral rather than socially constructed and political as emphasized in the guiding principles of community psychology. Most, if not all, of the studies reviewed thus far, take cultural, ethnic, or racial descriptors as the point of departure for investigation without asking what it means to use such labels to differentiate among peoples in the first place. Furthermore, as Sampson (1993a) inquired, is it really possible that differentiations based on skin color, cultural heritage, and/or level of income can be neutral when adopted within the context of white domination? Finding alternative ways to describe commonly used social categories is admittedly a formidable task; however, although I may not be able to avoid participating in this discourse entirely (for it also presents the platform for identity), I argue that social position, culture, identity are not straightforward and/or value neutral concepts and that there is a rather wide body of literature that has attempted to address these complex issues. I begin first with a review of how the field of multicultural psychology, which conceptually overlaps quite a bit with community psychology but emerged as a parallel field with little dialogue/collaboration existing between the two, has traditionally addressed the issue of difference within psychology. A variety of perspectives exist within this extremely broad field so I will stick to giving a general overview of mainstream approaches but also dialogue this

approach with some of the social constructionist/post-modern voices from both within and outside of psychology.

Psychology and multiculturalism

If one types in “multiculturalism” in any popular search engine on the internet, he or she is likely to find a variety of suggested definitions ranging from the general to the specific. Some definitions appear to avoid reference to any particular location or field: multiculturalism is about “stressing the importance of different culture, races, and ethnicities” or multiculturalism refers to “relating to or including several cultures.” Other definitions suggest how multiculturalism might be applied within a particular field: “in literature, multiculturalism is the belief that literary studies should include writings...from a number of different cultural groups” (Definitions of Multiculturalism on the web, Retrieved May 19, 2009). Despite considerable variability in meaning, two themes stand out as characterizing many of these definitions of multiculturalism: 1) the formerly popular conception of the United States as a “melting pot” of various ethnic/cultural groups has been replaced by an emphasis on celebrating several different cultures rather than one national culture and 2) there is an emphasis on the idea that disparate cultures should be equally respected and/or “tolerated” and live in “peaceful” or harmonious co-existence. This ideology of “cultural pluralism” heavily influences contemporary mainstream multicultural psychology and has been taken up in a variety of ways by multicultural theorists. In the *Dictionary of Multicultural Psychology*, Hall (2005) describes multiculturalism in the following way:

...an individual psychological and theoretical view that all cultures and national groups

are equal. Multiculturalism acknowledges that cultures and national groups vary in norms, values, worldviews, and traditions, but there is no superior versus inferior culture. Multiculturalism in psychology is an expression of the sociopolitical climate. As cultural issues, concepts, and values are explored, there is an underlying assumption of equality, irrespective of any implicit or explicit differences. (p. 121)

When it comes to defining multicultural psychology specifically, Hall and Barongan (2001) offer the following:

Multicultural psychology is the study of multiple cultural groups in the same context. Cultural groups influence one another when they are in the same sociocultural context; the strength of this influence is largely dependent on the power and status that cultural groups have in society... Thus; multicultural psychology is the study not only of culture, but also of the sociopolitical issues that ethnic minority persons face in the United States.

(p.10)

Hall (2005) differentiates between multicultural, cultural and cross-cultural psychologies by noting that while cultural psychology considers cultural influences on behavior within a single cultural context and cross-cultural psychology studies cultural differences across two or more cultural contexts, multicultural psychology is the only one that incorporates social and cultural influences together within a single social context.

In addition to a concern for the study of culture per se, multicultural psychology also developed in response to concerns regarding psychology's exclusionary practices and neglect of cultural context. In fact, the call for a multicultural perspective in counseling was originally rooted in critiques of the Eurocentric basis of traditional psychology and the ways that research, theory, and practice in psychology have excluded the experiences of persons of color, women, sexual minorities, etc. (Prilleltensky & Nelson, 2002; Smith, 2005; Sue, 1998). The multicultural movement in psychology has become so influential that in 2002, the American Psychological Association (APA) amended the Ethics Code for psychologists to add a statement regarding the importance of psychologists' awareness of cultural, individual, and role differences including those related to age, gender, ethnicity, and national origin and role differences (APA as cited in APA, 2002, p. 14).

Psychologists have responded to this call to address "difference" in a range of ways. Some have emphasized the need for culturally specific clinical practices that address the particular needs of various cultural/racial/ethnic groups (see Atkinson, Morten & Sue, 1998). Others have suggested that if psychotherapy is practiced well, it should by its very nature be sensitive to difference and thus inherently multicultural and appropriate for diverse groups of people (and therefore there is no need for culturally specific models). Hall (2005) (borrowing from the language of anthropology) describes the tension between what seem to be specific versus generalized approaches as "emic" versus "etic" perspectives (p.787). He suggests that, for the most part, multicultural psychology has attempted emic understandings of culture that are based in specific cultural contexts, whereas community psychology has emphasized more etic approaches,

attempting to apply models developed in one context to other contexts (Hall, 2005). However, Hall points out, it is more often the case that aspects of both emic and etic perspectives appear together and that they may serve to complement each other. Other theorists would have taken this critique even further to say that the binary opposition presented between “emic” and “etic” is a false one in the first place and such terms still do not make proper reference to the extent that one can never fully claim full understanding of others’ subjectivities.

Regardless of these issues of etic versus emic understandings, identity or culture is not just about how an individual is labeled externally by society, it also about the specific way that people identify with a given social identity. As Helms (1994) observes, the centrality of various cultural identities/identifications is also key to consider when attempting to develop culturally sensitive practices: “It is by no means clear that the same competencies required to deliver effective services to clients for whom racial-group membership is central are equally appropriate for clients for whom other social identities (e.g. gender, age, or religion) are more central” (p.163). Furthermore, exactly what is meant by these various social categories is debatable. Historically racial indicators have been associated more with what are considered “biological” characteristics such as skin color, hair texture, and/or bone structure; whereas ethnicity is associated more with a shared cultural history and/or similar national origin (Atkinson, Morten, and Sue, 1998). However, it has become more common, in contemporary human science theory, to view race and ethnicity not as immutable qualities existing “out there,” but as being socially/culturally constructed. In other words, culture and identity are constructed between people through complex patterns of interpretation. There has been considerable

debate as to the precise meaning of social identity terms but despite this lack of consensus and confusion as to the exact criteria for inclusion in a given racial or ethnic group, labels such “race” and “ethnicity” continue to be used in the psychological literature as if they held some distinct meaning, and possess some essentialized quality.

Given the difficulty psychologists have had with defining culture, ethnicity, and/or a unified multicultural perspective, it is not surprising that translating such theory into practice has presented a challenge for psychologists. Historically, given the dominance of positivist approaches in psychology, researchers have attempted to operationalize difficult to define or “fuzzy” concepts so as to make them amenable to study through the scientific method. Kitayama and Markus (2000) note “cultural influences may be quite pervasive, widespread, and powerful in forming the basis of ‘being’ for ordinary people, and yet, remain elusive for those researchers who have sought to understand them” (p.123). Attempts to define culture and/or the social dimension have been relatively brief and insubstantial in most psychological literature, yet the strong push towards developing culturally sensitive clinical practices has continued – most prominently in the form of the development of cultural competency guidelines for counseling (APA and Division of Counseling Psychology, 2002)

According to Sue, Arredondo, and McDavis,(1992) the initial impetus to create competencies for the practice of cultural awareness was the desire to translate multicultural principles outlined by the APA and Division of Counseling Psychology into “meaningful statements for the profession” (p.481). The notion of cultural competency breaks down into three main domains: 1) psychologist’s awareness of his or her own biases, assumptions, and cultural heritage, 2) awareness of the worldview of the client; 3)

the practice of culturally appropriate, relevant and sensitive clinical interventions (Sue, Arredondo, McDavis, 1992; Wynaden, et al., 2005)). Cultural competence, as it is commonly understood in the United States can be defined as having the knowledge, awareness, and skills to provide psychological services that promote and advance cultural diversity (APA, 2002). Various cultural competency models have followed from these efforts and have become increasingly popular over the course of the past several years; some focus more on clinician's awareness of their own cultural values, expectations, biases, assumptions, etc., while others suggest that activism and advocacy efforts are an important part of providing truly culturally sensitive care (Hwang & Schenck, 2004). In theory, according to Sue, Arredondo, and McDavis (1992) "becoming culturally skilled is an *active process*," "it is ongoing," and "a process that *never reaches an end point*" This definition recognizes the complexity and diversity of any human experience and also our limitations when it comes to becoming culturally skilled. Even still, it has been argued that cultural competency guidelines have at times been taken up by psychologists as prescriptive norms to be "achieved" rather than as a sensibility that could never be mastered, only used as a guiding framework for ethical practice. Perhaps taking a more critical perspective, one that draws from contemporary, post-modern psychology, anthropology, and philosophy can assist in deepening our understanding about diversity and difference. In the next section I will offer some alternative critical perspectives to the literature I have reviewed thus far.

Critique of Mainstream Research

Proponents of interpretive, critical, and/or post-modern approaches to culture argue that the cultural competency movement and traditional multiculturalism in psychology have done more to regulate taken-for-granted concepts and practices when it comes to culture than it has to deconstruct and transform them (Cosgrove, 2003; Prilleltensky, 1994; Sonn, 2004), for example, by taking for granted the terms “woman” and “man” or “black” and “white” as essential or natural identity categories rather than considering the social/political construction of such concepts. As such, cultural competency models in psychology have also been critiqued for overlooking complex issues of power and privilege (which are more evident when the socially constructed nature of identity categories is taken into consideration) (Sonn, 2004). Prilleltensky (1994) and Sonn (2004) have fervently argued that neglecting elements of power can lead to the imposition of various concepts, interventions, and measures developed with Western populations to those from non-Western cultures, therein perpetuating the (oppressive) sociopolitical status quo. Post-modern and cultural psychological understandings of social categories call for an analysis of the complex processes of power when it comes to diversity and identity, including the various historical, social, and political realities that accompany various social positions.

Still, we have not answered the question of *why* the issue of diversity and culture has been such a challenge for psychologists. Perhaps the philosophical basis of western psychology adheres to understandings of self that are fundamentally at odds with contextual understandings of self/experience. Maruyama (1992) argued that psychology has not yet generated the cognitive structures that allow us to think contextually when

approaching diversity, which is a foundational and perhaps cultural issue in and of itself. As such, the foundation of a psychology which is based on logical positivism and modernist conceptions of self may preclude psychologically contextualized understandings.

Rather than trying to develop alternative conceptualizations of self that would enable psychologists to think culturally, Sampson (1993b) purports that psychology has responded too hastily by using “add-on eclectic strategies” when it comes to understanding culture which has led to psychologists learning stereotypical characteristics of various cultures rather than looking at the broader understanding of the characteristics and function of culture. Furthermore, simply “adding on” a consideration of culture to the study of the individual psyche is a layering approach much like what Geertz (1973) has referred to as the “stratigraphic” concept of human being that dominate the social sciences. According to Geertz (1973), the stratigraphic model implies the following:

Strip off the motley forms of culture and one find the structural and functional regularities of social organization. Peel these off in turn and one finds the underlying psychological factors – ‘basic needs’ – or what-have-you – that support and make them possible. Peel off psychological factors and one is left with biological foundations – anatomical, physiological, and neurological – of the whole edifice of human life. (p.37)

One drawback of this approach is that culture is viewed as something extraneous to a pre-existing biological entity that would exist independently of the social environment. It implies that psychologists might be able to somehow address only the psychological

dimension or biological dimension of experience without considering the others. Geertz (1973) argues that it is impossible to understand the human being stripped of the “trappings” of culture and that to do so would provide distorted understandings of human nature.

To elaborate on Geertz’ (1973) ideas about culture just briefly, he describes three main elements that intersect to form what he calls “webs of significance” which permeate social existence and give meaning and coherence to our everyday lives. The main intersecting elements of “webs of significance” consist of worldview, ethos, and culture more generally. When Geertz refers to worldview, he is referring to the more cognitive aspect of culture that consists of assumptions (mostly unconscious) about what a person is, what motivates his or her behavior, and about what a person’s capabilities, resources and characteristics are. On the other hand, ethos is the more moral and affective component that outlines norms and standards for desirable ways of functioning and interacting – how a person ought to behave, develop, and feel. Culture consists of ethos and worldview and provides a broader framework which gives structure to the ideas about personhood and standards for behavior. Worldview, ethos and culture function together to form the webs of significance within which our behavior, interactions, constructions of reality have meaning.

Another way to conceptualize culture, from a more psychological perspective, in a way that leaves room for consideration of dynamism, power, and the dialogical dimension, is referenced in Shweder’s (1991) conception of cultural psychology, defined as:

Cultural psychology is the study of the ways subject and object, self, and other, psyche and culture, person and context, figure and ground, practitioner and practice, live together, require each other, and dynamically, dialectically, and jointly make each other up (p.73).

In essence, “culture” (including “race” “social class” etc.) makes reference to the complex way that human beings “seize meanings and resources out of a sociocultural environment that has been arranged to provide them with meanings and resources to seize and use” (p.74). And further, it refers to the way in which human beings and sociocultural environments “interpenetrate each other’s identity” and cannot be analyzed independent of one another. It is a view that sociocultural environments do not exist outside of the intentions of human beings (what Shweder refers to as “psyche”) and that likewise, individual psyches do not exist independently of a sociocultural environment (what Shweder refers to as the “intentional world.” Shweder (1991) writes:

Intentional persons and intentional worlds are interdependent things that get dialogically constituted and reconstituted through the intentional activities and practices that are their products, yet make them up (p.101).

From this perspective, understanding psychological practice in this particular setting necessitates also looking to the practitioner as they are inextricably intertwined.

Understanding diversity, difference, and culture in such a way also opens up possibilities for analysis of how various culture identities/identifications are lived-through as a process rather than defined.

In summary, the main thrust of much of the community mental health, sociological, and even psychological research mentioned here is that services for various communities of

identity according to race, class, ethnicity, etc. need to better fit the needs, values, interests of these groups. However, the concept of these communities of identity is not understood in relational terms – there is a reversion to essentialized taken for granted understandings of these groups which has, one could argue, led to this difficulty to begin with. In other words, research and practice based on positivist, individualized notions of the self have a difficult time addressing the complex and dynamics needs of communities because the very definition does not allow for their existence. Such an oversight is likely to be more of an issue with vulnerable populations due to the effects of power and history of oppression.

Community/culturally oriented psychotherapy: Alternative perspectives

When it comes to diversity/multicultural theory and practice, there is an abundance of information to choose from. Theories ranging from modernist or essentialized conceptualizations of diversity to more post-modern approaches that focus on deconstructing social categories to begin with, grapple with the social dimension of human experience and even make recommendations as to how this should inform practice. Similarly, there exists a substantial body of scientific empirical research that has sought to study psychotherapy effectiveness when it comes to working with populations historically excluded by psychologists. Some studies, such as the ones already mentioned focus on the utilization rates of minority populations, some focus on psychotherapy outcome when using empirically supported treatments for certain cultural groups or on “match” of ethnicity and/or race between therapist and client (Sue, 1998). However, far

fewer studies consider the process that psychologists actually go through when attempting to translate multicultural, community, or critical concepts into practice; how the application of this theory changes along with their interaction over time with individuals and groups of clients and how their work then reciprocally informs their evolving understandings of their clients and how to effectively work with them. Studying individual therapy sessions or even sessions over time is an extremely useful way to get at the interactions between therapist and client; however it does not take a step back to observe the context in which this therapy is occurring and further the ongoing experience of therapists outside of those individuals' sessions. Looking at the "in-between" times and getting a sense of therapists' backgrounds, understandings, and how they continue to transform interventions may be particularly important and meaningful within a community mental health center where there are many opportunities for interaction beyond the consulting room and where the boundaries between professional and personal involvement are more permeable. Talking to psychologists and observing them work can help to answer the question (or at least tell one potential story) about what does actually happen when theory is translated to practice. Do the principles of community psychology previously mentioned pan out? How is theory changed? What does it mean to have a social justice orientation from the perspective of the psychologists? What does this really entail when it is embodied instead of remaining an ideal? What is the dynamic of practicing community psychology within a medical system?

James and Prilleltensky (2002) attempted to explicate what they referred to as an "integrative" approach to mental health care by providing a description of their approach to working with one Portuguese (Azorean) immigrant community. The study heavily

emphasized the importance of situating psychological practice within the philosophical, religious, moral and cultural understandings of the community. The researchers chose to conduct ethnographic interviews with 50 Azorean community members regarding their understandings and beliefs about their experience (including perceptions of suffering). James and Prilleltensky (2002) highlighted the multiple discrepancies between traditional psychotherapists' interpretations of the community member's experiences and their own explanations. For example, community members described a condition known as *agonias*, translated into English as the "agonies" (p.1148). Clinicians reported being confused as to the meaning of this term due to the multiple ways in which it is used by community members (to refer to anything from indigestion to feeling "on the brink of death") (James & Prilleltensky, 2002, p.1148). When asked about how they chose to conceptualize the "agonies," clinicians reported that they assumed it was similar to anxiety and depression. On the other hand, community members who were interviewed suggested that a person can experience *agonias* because of any number of socially or religiously oriented experiences such as spousal abuse or having a premonition that something bad will happen (2002). Although clinicians may accept this culturally based explanation for suffering, James and Prilleltensky found that the general trend in clinical psychology is to privilege internal experience and ignore the concomitant cultural and social dynamics. As a result, clinicians are likely to rely on treatments that focus on the internal world of the individual either through individually focused treatment or through suggesting medication; whereas in the Azores this type of distress is treated by community compassion. James and Prilleltensky also mentioned a tendency for clinicians working with the Azorean clients to view them as "concrete" or "not psychologically

minded” because these clients tend not to understand their experience in terms of psychological causal relationships. The researchers suggest that this practice is commonplace among practitioners and implicitly assumes that psychological theories apply to everyone equally and if the client does not fit that paradigm, the validity of their experience is questioned (rather than the applicability of that theory). Many psychotherapists practicing in urban settings would agree that certain biases, myths, and assumptions have the potential to powerfully shape interactions with clients, especially poor clients. Foster (1996) argues that clinicians generally rely upon various metapsychological frameworks as “templates through which we see our patients and evaluate their strengths, weaknesses, and ability to undergo our method of psychic inquiry” (p.6). These psychological frameworks are also powerfully shaped by normative cultural ideas and practices dominant at the time they are developed.

James & Prilleltensky (2002) suggest an “integrative practice,” which consists of four complementary considerations: philosophical, contextual, experiential, and pragmatic which can help to address the shortcomings and mistreatment of diverse populations (p.1135). They describe these four considerations as representing a bridge between theory and action that is continually and reciprocally informed. Each of these four dimensions of practice call for different tasks and the involvement and/or consultation of different people. For example, when considering the philosophical dimension, clinician’s might ask about what a given community and clinician view as “the good life” in their respective communities and what values are dominant. Answers to these questions might be achieved by consulting philosophy, religious leaders, and/or social leaders in the community. As for the second dimension, psychologists would

consider the social, cultural and moral norms prevailing in the clients' as well as the helper's communities, and how these norms might impact the way that mental health is understood. Social scientists, researchers, and researchers involved in the study of sociocultural and economic trends that may have an impact on mental health may be useful when considering this dimension. The last two areas, experiential and pragmatic, are focused more on intervention. In considering the experiential level, a clinician may ask what is missing from the particular social context in order to improve the mental health of individuals and communities whereas, at the pragmatic level, clinicians ponder what can be done to improve the mental health of clients and the community more generally. Community members' experiences as well as agents of social change both within and outside of the community can be called upon to address these latter two dimensions.

James and Prilleltensky's (2002) approach is not only integrative in the sense that it brings together multiple considerations which have implications for both theory and practice, but it also highlights the importance of assessing the clinician's understandings, contexts, experiences, and assumptions in a continual process. The authors do not suggest to "be aware of biases" etc. as a activity to be completed a priori to conducting psychotherapy, but rather as an ongoing process of considering the context of the client – as having an experience not only in their respective communities but also in relation to one another. A few psychotherapists who practice psychology in urban community mental health settings have written accounts of their practice in which they draw upon sociopolitical and/or critical theory and research when it comes to working with individuals from economically impoverished communities. Their reflections incorporate

and highlight the ways that cultural issues are manifested in clinical practice and are congruent with the self reflexive aspect of James and Prilleltensky's (2002) integrative practice for diverse settings.

Other psychologists have also attempted to explicate the process of community-based clinical practice through writing biographical narratives about their work. Drawing on their own experience practicing psychology with low-income and/or low-income racial/ethnic minority clients, Smith (2005), Javier (1996), and Altman (1995) have written self-reflective analyses of their clinical work. Several themes surrounding the entrenched classism in psychological (especially psychoanalytic) theory and practice were prominent in their reflections. Smith (2005) tackles the realization of her own class biased attitudes while working in a predominately poor, African American/Hispanic community psychology clinic. She notes that her own attitudes reflect many common classist assumptions about doing psychotherapy with poor clients, such as the belief that: "poor people are forced to contend with so many overwhelming day-to-day problems that they either have no use for what a psychologist can offer," or that "conventional psychological services are neither familiar to nor widely accepted in the cultures of many poor and working-class communities, so that even poor people who could benefit will not be likely to use them" (Smith, 2005, p.692-3). Smith admits that the latter assumption is in line with her own clinical experience with "poor" clients; however she encourages us to consider *why* this might be the case. She suggests that the culture of the psychologist's office may be so unfamiliar or unaccepted among lower income clients because traditionally such spaces have also represented a culture of whiteness and class privilege (Smith, 2005). Smith's point is an important one, because much of the mainstream

literature on diversity in practice often focuses on the experience, culture, and behavior of clients who are considered part of a marginalized group to the exclusion of more critically examining the culture and practices of the field itself. Arguably, much less attention has been paid to the ways in which the culture of “whiteness” and class privilege factors into the equation of psychological practice with the urban poor.

Javier (1996) also addresses some of these same themes but he does so from the perspective of psychoanalysis. He addresses the common belief that psychoanalytic and psychodynamic therapies would be impractical and/or inappropriate for poor clients by showing how this assumption is rooted in classist assumptions. Both Javier (1996) and Altman (1995) suggest that from a psychodynamic perspective, the influence of social systems and more specifically the conditions of living under oppression, can be incorporated into the interpretive process of therapy, instead of representing a stumbling block. These first-hand accounts of psychological practice provide a foundation for further empirical research by providing rich “stories” about the complexities psychological practice in settings where sociocultural marginalization is prevalent.

The Current Study

From this review, it becomes apparent that in general as psychologists, we have historically struggled to understand the social and its relationship to the psychological and furthermore to integrate this understanding into clinical practice. The current study attempts to illuminate the contextual nature of community care and highlight the various principles, values, conceptualizations, interventions as well as the larger community and

psychological context in which they occur. Systemic issues such as economics, location, and political aspects of psychological care will also be considered. Moreover, although qualitative studies that focus on more holistic and integrated accounts of community practice are becoming more popular, several major figures in the field have argued that there is still a paucity of research, especially *qualitative research* that focuses on contextualized experience, subjective meanings, systems of social power and social change (Luke, 2005; Orford, 2008; Rappaport, 2000; Wolff, 2000). The current study seeks to focus on the *clinical practice* of community psychology from a contextualized perspective, which, according to Wolff (2000), is even less well represented in the research literature. He writes:

Community psychology is a field for both research and practice, yet the literature has been dominated by a focus on research and academically based practice. Many questions remain regarding what practitioners of community psychology really do, what kinds of settings they work out of, how amenable those settings are to their work, what levels of intervention they choose to become involved in, and how their practices relate to the research and theory base of the field. (Wolff, 2000, p.741).

The current study addresses this gap in the literature by investigating a setting where community psychology is practiced and by using qualitative, ethnographic research methods and asking the question: what does it mean to practice community psychology in this particular setting? By addressing practice at the local level, it is possible to illuminate some of the complexities that characterize the clinical practice of community psychology. This type of study entails addressing the issues, concerns, conflicts, ideals, values,

beliefs, struggles, challenges, history, and relationships, that come to bear on psychological practice in this particular place with this particular community.

A theoretical and conceptual revision or rethinking of issues and aspects of community implies and necessitates a parallel or concordant epistemological shift. The next chapter charts some of the epistemological and methodological dynamics attendant on this study and the topic in general.

CHAPTER 2: AN INTERPRETIVE ETHNOGRAPHIC METHOD

Debates regarding the nature of “knowledge” and appropriate means to access the social/psychological realities of people’s lives still abound in psychology in general, and perhaps even more so in community psychology in particular. Even so, however, Orford (2008) argues that many involved in contemporary community psychology support the use of qualitative research methods as a means to advance community psychology’s core values of empowering communities through understanding them in contextualized ways. To better achieve this aim, several community psychologists have seen the need for a paradigm shift from logical positivism, which supports the “reification of quantifiable data, use of reductionist methods, and neglect of context” to a method that allows for the situated nature of knowledge and the “thick” descriptions of people within contexts (Kelly, 2003; Luke, 2005; Orford, 2008, p.68; Prilletsensky, 1994). On the other hand, given the diversity of qualitative methods available, not all qualitative approaches necessarily represent a shift from the positivist paradigm. In keeping with my understandings of sociocultural contexts as being dialectically constituted between psyche (intentional persons) and culture (intentional worlds) and also with the dynamic interrelationships apparent at the Center, it seemed important to find a research method that could account for this dimension and complexity. Clinical work conducted at the Center incorporates many people interacting with each other and clients in multiple forms; psychiatrists, nurses, social workers, administrative assistants, and of course, psychotherapists, interacting with clients across multiple levels of care. It thus seemed

appropriate when attempting to study the complex practices of a community mental health center, to incorporate the multiple (often informal) ways that staff come to provide psychological services to clients. After considering a number of approaches within “traditional” psychology, my insistence on methods and methodologies that kept an emphasis on context, power, and systems of meaning, increasingly drew me outside of the field of psychology. As becomes apparent later, this movement “out” of psychology is also a movement “in,” and not so much a betrayal of psychology in an extradisciplinary sense, as much as precisely fidelity in an interdisciplinary sense that enriches and enhances. For the moment, however, suffice it to say that I initially felt both hesitantly wary, and excitedly enthused to explore ethnography as methodological possibility. It seemed to offer a rich methodological literature and epistemology, well-suited to my research aims of maintaining a contextualized, reflexive, holistic account of psychological practice. Although – in the end - I cannot claim that I have conducted a “formal” or “traditional” ethnography, I was significantly influenced by ethnographic theory and method in conducting the present study. As such I review some of the key features of ethnography that influenced data collection and analysis.

Ethnography as a theory/method emerged from the fields of anthropology and sociology and has more recently been employed as a research method in psychology. Ethnographic practice has gone through several major transformations over the past century, so major in fact, that Lincoln and Denzin (1994) have labeled these transformations the “five moments” of ethnographic inquiry, which are: the traditional, modernist, blurred genres, crisis of representation, and the present or fifth moment. Denzin (1997) has since also designated a “sixth moment” which charts the future of

ethnography and focuses on writing that has been produced since James Clifford's *Writing culture*, a collection of essays that was published in 1986. A full examination of the history of ethnography is beyond the scope of the dissertation, but the reader is directed to authors like Clifford, 1986; Denzin, 1997; Geertz, 1973, 183; Lincoln & Denzin, 1994; Madison, 2005; and Thomas, 1993 for a more in depth account.

For the current project, what has been termed the “new ethnography,” the kind of ethnography influenced by interpretive and post-modern theory and that follows from the works of Clifford Geertz (1973, 1983) and James Clifford (1986) provide an appropriate starting point. In a nutshell, and explored in greater depth below, the main features of Geertz and Clifford's theories include a critique of realism in anthropology, a critique of the notion of a value-neutral observer, and an emphasis on self-reflection and incorporating the voices of participants in the written ethnographic report.

Interpretive/Critical Ethnography

Geertz, in his two canonical works, *The interpretation of cultures* (1973) and *Local knowledge* (1983), critiques the classic realist conception of anthropology in which ethnographers are charged with the task of “directly captur[ing] lived experience” of the other and the project of re-presenting culture as text (Denzin, 1997, p.3). Instead, Geertz (1983) emphasizes the interpretive nature of ethnographic practices and the way in which “the ethnographer does not, and ... cannot, perceive what his informants perceive. What he [the ethnographer] perceives, and that uncertainly enough, is what they [informants] perceive ‘with’ – or ‘by means of,’ or ‘through’ ... or whatever the word should be”

(1983, p. 58). Geertz conceives of culture as existing in the intersubjective field of meaning between persons. In other words, culture does not exist independently “out there,” but is dialectically constituted between persons. According to Geertz, culture is not located within the perception of any one individual, but can be observed in the “webs of signification” formed between people, occurring as a dynamic force, evident through language, gestures, rituals, behaviors, and interactions (1973, p.5). According to Geertz, the task of the ethnographer is to provide as “thick” of a description as possible of the activities, relationships, structures, of an observed society, all the while gracefully tacking back and forth between “experience-near” and “experience-far” descriptors (Geertz, 1983, p.58). The goal of analysis for the ethnographer becomes a “search for meaning” within the observed “webs of significance” rather than a search for a general (scientific) “law” that can be generalized (Geertz, 1973, p.5).

James Clifford (1986) was influenced by Geertz, but presents a more radical critique of conventional ethnographic practices. His book *Writing culture: The poetics and politics of ethnography* (1986), is a collection of essays geared towards critiquing conventional anthropology and ethnographic practices and explicating alternative and innovative visions for ethnographic inquiry. Clifford, like Geertz, conceives of culture as intersubjective but also as being “composed of seriously contested codes and representations...[he] assumes that the poetic and the political are inseparable, that science is in, not above, historical and linguistic processes.” (1986, p.2). Clifford thus expands Geertz’ notion of culture by considering, more explicitly, the broader social and historical context that shape and produce textual representations of culture. In fact, Clifford would want to highlight the constructed nature of cultural accounts because to

him ethnography is “always caught up in the invention, not the representation of cultures” (p.2.)

For James Clifford (1986),

Ethnographic work has indeed been enmeshed in a world of enduring and changing power inequalities, and it continues to be implicated. It enacts power relations. But its function within these relations is complex, often ambivalent, potentially counter-hegemonic.” (p.9).

This quote forms the foundation for Clifford’s argument that ethnographers need to identify their position as one voice among many in the textual prefiguration of cultures in order to counter the tendency to slide into a position of the invisible authority writing as the voice of “Truth.” To Clifford, the voices of informants or “co-authors” of a cultural story should be equally weighted and all voices, including the ethnographer’s voices, should be positioned within a discursive field. In this way no one voice is granted authority of absolute truth, yet the “writer’s voice pervades and situates the analysis” (p.12). The once objectified “cultural” is turned into “a speaking subject who sees as well as is seen, who evades, argues, probes back” (Clifford, 1986, p.9).

“Self-reflexive” ethnographic accounts such as Clifford’s present culture as dialogical, polyphonic, power laden, negotiated realities that happen between people. The ethnographer includes his or her experience in an effort to make explicit the ways in which his or her position also forms and constructs the cultural story being crafted.

Norman Denzin (1997) has critiqued and added to the body of ethnographic theory that has been outlined thus far. As mentioned before, he picks up where Clifford’s *Writing culture* leaves off, looking critically at the new texts that have been written since the

book's inception, characterizing current ethnographic thought as being in a period of intense reflection, "messy texts," performance texts, and increased interest in narrative and multi-layered, multisubjective accounts (Denzin, 1997, p.xvii).

Critical ethnography fits somewhere among this mass of descriptions pulling broadly from post-modern theory, (post) Marxist theory, and interpretive theory for its broad foundational influences – each respectively less or more so depending on the theorist or researcher doing the critical ethnography, and the phenomenon or location in question. It is perhaps already somewhat apparent that critical ethnography defies easy and categorical definition, unfortunately so for those who seek clear and present clarity, yet strangely appropriate for the goals and values of this type of method. Born of a melding of multiple theoretical models (some of which I have already alluded to), including critical theory (counting critical race theory), feminist studies, deconstruction (e.g. Derrida), cultural studies, and/or practices of urban sociology (stemming from the Chicago school), the extent to which each of these theories may inform a given critical inquiry depends upon the phenomenon to which it is being applied. For example, if the topic of investigation centers around women's reproductive rights, the researcher may draw more heavily from feminist studies grounding an analysis in this history. However, for the current project, it seems more fitting to incorporate cultural psychology/studies, community theory, and critical/post-modern theorists who focus on systems of power, social identity, community, and mental health/psychology. Critical ethnography is thus a very flexible and very diverse type of qualitative inquiry.

Some of the characteristics that have been deemed essential to critical ethnography more broadly, include the distinction from conventional ethnography, firstly,

as “conventional ethnography with a political purpose” (Thomas, 1993, p. 4). Thomas further clarifies that “the difference between conventional and critical ethnography begins with a passion to investigate an injustice (e.g. racism); social control (language, norms, or cultural roles); power; stratification; or allocation of cultural rewards or resources to illustrate how cultural meanings constrain existence” (1993, p.36). Second, a major goal of any critical method includes investigating the taken for granted reality or that which presents itself as not requiring any further investigation (Thomas, 1993, p.3). Looking beneath surface appearances involves dialectical reasoning in which taken for granted assumptions about the world are problematized. A dialectical logic is considered an essential element of critical inquiry by some theorists who cite Marx as foundational to the practice of using dialectical logic to address materialist issues (Foley & Valenzuela, 2005; Madison, 2005; Wainwright, 1997). Marx purported a materialist conception of dialectics, emphasizing the socially constructed nature of both what we deem to be our subjective perception of the world and of phenomena as they occur in the real world (Wainwright, 1997). According to Wainwright, when we are able to use dialectics to challenge our representations, “we can recognize the historical specificity and social construction of prevailing phenomenal forms, in order that we can act to consciously transform them” (p.4). Thus the dialectical approach aims to problematize the relationship between “objective reality” and our attempts to represent it through knowledge and locates any knowledge within a particular historical moment (1997).

Examining the way that categorical representations are formed and placing them within a historical context is not only important because the world is constantly in flux, but because the categories through which we view the world also have a political

dimension, and concedes that some groups have privilege while others do not. From a Marxist perspective, certain groups have relative power over other groups, allowing them to exercise dominion, power, or control over those less powerful. Yet the exercise of power is not simply or straightforwardly a matter of one party having it, and wielding it over another but, as Foucault (1978) demonstrates, historical categories through which we view the world produce the conditions under which power can be enacted – no one actually has power in the sense that they possess it, such that those who maintain a privileged social position are conceptualized as having greater access to discourse and thus truth claims than those with relatively less power. Because power represents a matrix of relations which exists everywhere and “comes from everywhere,” the powerful and the powerless are always caught up in power relations that supersede their individual situation (Foucault, 1978, p.93). Both of these conceptions of power would support the closer examination of categories or as Foucault would say, the “discourse” through which we grasp the world in order to expose the way that they are constructed and “a product of a whole network of social and economic relations” (Wainwright, 1997, p.5).

It becomes clear that critical ethnography has been described in a variety of ways by a multitude of theorists, and that the practice of critical ethnography is equally as diverse, being applied to a range of topics ranging from campus date rape to the land rights struggles of Nicaraguan indigenous groups (Sanday & Hale as cited in Foley & Valenzuela, 2005) to an analysis of gender and power in heavy metal music subculture (Krenske & Mckay, 2002) and several analyses of poverty in the United States (Fein & Weis, 1998; MacLeod, 1995). Foley and Valenzuela (2005) point to the new, much more politically active focus of critical ethnographers who have aimed their cultural critique at

a range of topics such as corporate agriculture, environmental pollution, pharmaceutical dumping, transnational labor migration, the publishing industry, cyberspace hackers, criminalization of urban street life, and informal economies based on drugs, sex, and cultural rebellion.

Aside from examples of “critical ethnography” per se, I would like to highlight two ethnographic studies that focused on *psychological practice*, which of course is the topic of the current study. Gubrium’s (1992) ethnography of two family treatment facilities and Bloor, McKeganey, and Fonkert’s (1988) ethnographic study of various therapeutic communities represent two important projects in the history of ethnographic research into psychotherapy practices. Both studies relied heavily on participant-observation, a central technique in ethnographic methodology, and provided rich, detailed descriptions of the everyday workings of psychotherapy clinics/communities. Although each of the studies focused on different issues occurring across different settings, both set out to examine psychological practice more holistically.

Bloor et al. (1988) and Gubrium’s (1992) studies demonstrate the usefulness of applying ethnographic methods to understand how therapeutic communities and family therapy operate, respectively. McLeod (2001) has suggested that using an ethnographic approach to psychological research adds dimension to our knowledge of psychotherapy by presenting a “detailed, vivid and highly readable descriptive account of what happens in these therapy centers” and that “the reader gains a sense of what it would be like to be a staff member or patient” (2001, p.66). Rather than glossing over the details of what goes on in psychotherapy, these studies represent examples of how the ethnographic method can offer more concrete descriptions of those interactions, thus opening the

possibility of a different kind of analysis. Both Gubrium (1992) and Bloor et al.'s (1988) methods were based on an analysis of the use of language at clinics, routine interaction patterns, and physical surrounding as a way of demonstrating the way that the experience of being a therapist or client at a psychotherapy center is constructed.

More specifically, Bloor et al.'s 1988 study represented a comparative analysis of ethnographies of eight different therapeutic communities including hospital communities, foster family communities, halfway house communities, and concept houses, to name a few. Taking an ethnographic approach, the researchers kept copious notes of their participant-observations of the various therapeutic communities. They were attentive to the daily activities of each setting: including observing psychotherapy groups and individual sessions, spending time with patients during activities, interviewing staff, and attending staff meetings. Bloor, McKearney, & Fonkert (1988) also included self-reflections which included their reactions and experiences of the various communities as another source of data. The precise role of the researcher varied across research study and setting. For example, in most of the studies researchers adopted roles akin to a "junior staff member" whereas in one study the researcher actually participated in a concept house as a resident (Bloor et al., 1988). All of the studies relied upon field notes, although additional materials such as documents, audio recordings of conversations and groups, of interviews, and panel discussions were also used in some settings. The data was then analyzed and organized across themes which were agreed upon by the researchers. The implications of the findings were assumed to vary according to "audience" and therefore were written with three specific audiences in mind: therapeutic community practitioners, sociologists, and general readers (1988, p.72). As this

organizational framework suggests, the findings of the study are presented in the form of both concrete suggestions for clinical practice as well as a philosophical and sociological analysis (including Foucaultian notions of power) of the work being done in these therapeutic communities. In this way the researchers take a closer look at both the implications of specific everyday clinical practices and also at the meaning the therapeutic endeavor has for society in general. For example, the authors mention that the practice of “making fellow residents responsible for keeping residents in treatment” (Bloor et al., 1988) had evolved at one center as a way to address premature termination of a day treatment program.

Bloor et al.’s studies are an example of how ethnographic research can be used in the service of evaluating and learning more about the everyday practices of mental health/medical professionals. They point out that although many studies (psychological and medical) have focused on specific aspects of practitioners’ *conduct* (case conceptualization, examination processes, intervention) and on doctor-patient communication, patient satisfaction, and patient control, much less attention has been paid to practitioners’ *work*, that is, what *practitioners themselves* see as the core features of their everyday activities. Moreover, adopting an ethnographic approach – at least in the sociological and anthropological vein the authors subscribed to – left the precise question or exact topic to be investigated somewhat open, and for participants to lead researchers to important subject matter. Because their research adopted a post-modern epistemology, more specifically drawing upon Foucaultian notions of power, they incorporated a reflexive consideration into their research – turning the researchers gaze back upon themselves. In addition to being a useful way to explore the often overlooked

dimension of power in psychological practice this approach, I would argue that a critically informed ethnographic approach to studying practice at the Center also opens up a space for culture to be acknowledged and explored.

Preliminary Observations, Assumptions and Questions

Critical ethnography is more than a method; it is an epistemological stance and “begins with an ethical responsibility to address processes of unfairness or injustice within a particular *lived* domain” (Madison, 2005, p.5). At the same time, critical ethnographers such as Madison, claim that “politics alone are incomplete without self-reflection” and that “critical ethnography must further its goals from simply politics to the politics of positionality” (p.6). Proponents of reflexivity understand positionality as essential to the project of the new ethnography, which presented itself as an alternative to the supposed “value neutral” inquiries of past ethnographers and many other empirical methods (cf: Cosgrove; Denzin & Lincoln, 2005; Fine, 1998; Madison, 2005; Thomas, 1993; Wainwright, 1997).

Proponents of the new ethnography warn against the consequences of conducting research under the banner of objectivity, such that cultures become reinvented and remolded to fit the categorization and philosophical systems of the researcher without any acknowledgement of this happening. Self-reflexive research methods expose the way that a researcher is always first and foremost a human-being with intuitions, perceptions, biases, emotions with which he or she makes sense of the world. When the researcher’s position is covered over they run the risk of unwittingly forcing others into their

unexamined framework. From a self-reflexive position the researcher is considered a co-participant or as Conquergood might say, a “co-performer,” thus immediately acknowledging the roles of both the researcher and research participants (as cited by Madison, 2005, p. 168).

The Current Study - Preconceptions

It is probably not usual for the same heading as the one above, to be represented in two subsequent chapters. The reader will recall from the previous chapter that, given the literature review, this dissertation positioned itself to study and explore community psychological practice in a specific setting. This chapter argued that that exploration and examination had to be of a certain kind – that there needed to be a synergy between the theoretical and methodological, between the ontological, anthropological, epistemological, and methodological. Hence, given my argument to conceptualize culture in a complex and dynamic manner, my epistemology (and in the next chapter, my methodology and procedures) had to be able to manage, tolerate, and in fact celebrate such complexity. Critical ethnography at first glance seem able to do just that, and to that ethnographic end – almost as a first step of sorts, it bears emphatic mention that many of my experiences, reflections, and assumptions are interwoven throughout this dissertation (and especially highlighted in Chapters 3 and 4). Here, in line with the express demand for the researcher’s voice, I begin with a consideration of some of my preconceptions.

My main research interest and curiosity regarding community mental health was prompted by several personal experiences. Many of these experiences took place at the

community mental health center where I conducted the current research. As a practicum student I conducted intake assessments, provided individual counseling services, co-facilitated a psychotherapy group, and consulted with psychiatrists and psychiatric nurses regarding my clinical work. During my work there I noticed that it was different from work in university counseling centers in a variety of ways, but among the most striking, was that the clinic utilized a community psychological model. From my very first introduction to the Center I was faced with a clinical orientation with which I was not yet familiar. For instance, during my orientation as a practicum student at the Center, the director at the time (although he is no longer working there) guided myself and two other new practicum students into “the group room” which also resembled a conference room of sorts. A long, worn-looking cafeteria table served as our conference table in this relatively small room with narrow rectangular windows that hung horizontally at the upper most place of the wall. I recall expecting to receive some information about the Center and about what was expected of us. Instead we were presented with a barrage of questions regarding what we knew about the Center. I recall being unprepared for this line of questioning, as this meeting had been called an “orientation” session, during which I had imagined I might become more oriented about the center and the surrounding community which it served. Instead, I left feeling somewhat disoriented and perhaps this was purposeful. The director began by putting each of the new practicum students on the spot, one by one, asking questions like: What did we know about this community? And what did we assume working there would be like? Underlying these questions there seemed to me to be other implicit questions: Why do you want to work here? What kinds of prejudices and assumptions are you bringing with you? Most of all, who are you

and how will that impact your work here? This line of questioning was a surprise to all of us, who had not been prepared to have this discussion quite in this way. Perhaps if the meeting had been framed as an interview, I might have been more prepared for the questions. In hindsight, the issue of difference, that we happened to be three Caucasian clinicians coming to work at a predominately African American clinic, was probably present from the beginning of this line of questioning – however it was just never explicitly addressed. After questioning us, the director quickly realized that we were a bit dumbfounded trying to find our bearings in a new place that we did not know much about. He presented us with a large map and began describing the surrounding neighborhood, including a brief history of the surrounding community and the Center's place within it. He told us about the neighborhood's long history of being home to immigrants, first to a largely Jewish population and then, later, to a predominately African American population. I do not remember much of what he may have told us that day about our clinical responsibilities at the Center, however I do strongly remember the feeling of how important the center's location in that particular community was.

This incident stands out in my mind, perhaps not only because it was my first interaction with this practicum site, but also because it represented the first among many moments of my acute awareness of difference as a white student therapist coming to work at a clinic where the majority of the staff and clients identified as African American. Maybe even my expectation of what an "orientation" should be like was based on a model of other sites at which I had worked and of course, my own cultural and class background as a middle-class, white woman.

As such, working at this site, I was confronted with a variety of challenges to the way I had previously been taught to conceptualize psychological practice. I recognized that the notion of “community” was a prominent discursive organizing figure in the daily practices and structure of the center as it had not been in other psychology clinics in which I had worked. “Community,” as the term was often used, and as I will use it here, referred to residents of the community surrounding the Center– but it also made reference to the turbulent history that this community had endured. Periods of great cultural and economic prosperity followed by destructive urban renewal efforts splintered communities by displacing families from homes and creating serious economic consequences. Within this clinic the meaning of the term “community” was overdetermined, making reference to experiences of continuing conditions of economic and social oppression as well as tremendous community resilience and spirit. I noted that clinicians were engaged with clients on a variety of levels, sometimes as therapists, sometimes as advocates when involved in community action meetings, and sometimes in less formal ways as when client-therapist lunches were arranged. The fluidity of boundaries was something that was both exciting and challenging for me as I had been encouraged to keep a relatively strict “frame” with my clients which did not include having significant contact/relationships with clients outside of the session time. I wondered what the conceptual model behind such an approach might be.

I also noted that many clients seemed to experience the Center as somewhat of a home away from home. They would spend time there, socialize with other clients, and attend social action meetings, all outside of their regular psychotherapy and psychiatric appointments. I had the distinct sense that the Center must be providing them with

something if they chose to spend so much time there. Of course, some clients were living without a home-base of their own. Without the amenities of a home, they used the Center to assist with everyday needs like showers, clothes laundering and simply a place to find shelter during the day.

Initially I was interested in client's perceptions: what made them want to come back? What was helpful or not about their experiences at the Center? However, aside from the ethical and practical issues of engaging vulnerable populations as research participants (i.e. those who are diagnosed with mental disorders and have a right to confidentiality and privacy) I decided against going in this direction for other reasons as well. When reviewing the literature it seemed that far more qualitative studies had focused on factors that would encourage or inhibit various marginalized groups from utilizing mental health services. As illustrated in my literature review, this heavy emphasis on the "underserved populations" seems to keep the focus on the clients as the main issue – often to exclusion of a thorough examination of the system providing care to those populations. Smith (2005), Altman (1995) and Javier (1996), commenting on their work with inner city populations, have all suggested the complex ways in which mental health care systems are seen as inaccessible to these communities. These observations made me wonder: Is there some way in which mental health systems are set up in a way that is experienced as unfriendly, inaccessible, or undesirable to those who choose not to use those services? And, alternatively, are there ways in which mental health care might be better arranged so as to be more relevant and helpful to those who might typically avoid such services? The literature suggests that people of color, especially people of color in the lower socioeconomic bracket, are among the least likely to utilize

psychological services (see Atkinson, Morten & Sue, 1998; Stevenson, 2001; Chow, Jafee, and Snowden (2003); Snowden, 2005). I am reminded of a casual conversation I had with one of the therapists at the Center who told me that she believed most of the “Black” clients prefer to come to the Center as opposed to the several other satellite clinics in the area because they felt the other clinics were more “white” clinics. This therapist’s anecdotal observation is supported by findings from Mitchell’s (2005) study regarding African American women’s perceptions of mental health care, suggesting that these women felt alienated by traditional psychological services. But then I wondered - what is it that makes the Center so different? Are there specific practices or a given orientation that might make psychological services seem more relevant or welcoming than other clinics? Certainly a comparison across various community mental health clinics would have been very interesting and important research – however for the sake of the current smaller-scale dissertation project, I decided to begin with an exploratory study; one that highlights some of the contextual factors of practice in this Center that are geared specifically towards engaging an inner city community.

I also noted that many systemic, economic, and clinical demands weighed on clinicians in their everyday work at the Center. They seemed to have tremendous caseloads, modest salaries, and limited external support for resources. The structure of the clinic itself was a testament to the lack of resources with which the clinicians had to work. I thus also became interested in how the clinicians managed this situation. I believe that systemic factors, beyond the individual practice of the clinician also played a role in the provision of those services. This systemic level is also often excluded from much psychologically oriented research. Attention is often paid to specific psychotherapy skills,

or “factors” without due regard to what the clinician has to go through personally and professionally to provide those psychotherapy services in different “delivery” systems or communities. As such, I felt it would be imperative in a space like a community clinic where those strains seemed to be felt on multiple levels to incorporate a contextual dimension into my research. My assumption here is that the economic, political, and professional context in which clinicians provide services has an impact on those services.

In addition, I would like to give attention to another concern of mine when embarking on this research project. In one of my research methods classes during my graduate program, a professor brought up the idea that conducting research with marginalized populations, especially when the researcher is positioned in a position of relative power as a member of a dominant group, in my case a white woman from the academy, has the potential to be “colonizing.” I took the possibility that my research had the potential to be colonizing seriously as I proceeded with my research design. bell hooks (1989) has suggested that “when we write about the experiences of a group to which we do not belong, we should think about the ethics of our action, considering whether or not our work will be used to reinforce and perpetuate domination” (p.43). She argues that so often dominant groups are seen as subjects whereas those in positions of relatively less power are viewed as objects. Thus, as a member of a dominant social class, doing research in a marginalized community, I risk perpetuating this dynamic. On the other hand, hooks (1989) also suggested that writers should not completely avoid writing about a group to which they do not belong simply because of the risk of further domination. However, she argues rather that the voices of the marginalized group should be heard and considered as valid, alongside voices from more dominant groups. Although

I recognize that there is no concrete way around this issue, I tried to find ways to increase the agency of my participants in the research process. One way I attempted to address my concern regarding power was to engage several of my participants in the planning stage of this research. I requested their input as to what kinds of research questions would be most interesting or useful to them and used some of their ideas to further guide my research questions (I will discuss this aspect of my research in greater detail in Chapter 3). A second way I addressed this issue was to pay close attention to my interactions with participants and how they might be experiencing me. The fact that our relationship had preceded the research and I had in fact been trained by several of my participants, complicated the way that power arranged itself in our relationships (for example, I had been evaluated by some of my participants in the past and thus was in a position of relatively less power). Of course, regardless of my attempts to be sensitive to power dynamics and potential for my participation in oppressive power dynamics, from a Foucaultian perspective, power is dynamic and constitutive of all human relationships and thus there would be no way for me to account for the multiple ways in which power would arise across my research project. Discussing the issue of power in an interview, Foucault (1997) stated that:

In human relationships, whether they involve verbal communication such as we are engaged in at the moment, or amours, institutional, or economic relationships power is always present: I mean a relationship in which one person tries to control the conduct of the other. So I am speaking of relations that exist at different levels, in different forms; these power relations are mobile, they can be modified, they are not fixed once and for all (291-292).

I therefore kept both Foucault and bell hook's comments regarding the workings of power close at hand during the course of this research.

In conclusion, I take as my place of departure the question of what it means to practice psychological practice in this Center with specific emphasis on the psychologist's situation, understandings, challenges, and the way that the community theory is translated into practice/action. And, moreover, that to respond to that question necessitates a particularly robust and complex method and procedure, part of which is already demonstrated in this very section. In the next chapter, Chapter 3, I will go into more details regarding the background of my research setting and the specific ways in which I implemented critical ethnography, including the modifications I made to this method, given the specific demands of place, theory, and the discipline of psychology.

CHAPTER 3: METHOD, PROCEDURE, AND BACKGROUND TO

THE CENTER

My review of the vast and diverse ethnographic landscape thus far has been general in order to set up a conceptual framework within which I can now situate myself more specifically. My stance as a researcher during every phase of this research, including formal data analysis, drew from interpretive, constructionist, and ethnographic theory. My own observations, interactions, and experiences while working as a student-clinician at the Center prompted my interest in exploring, in greater depth, what it was that was happening there and my particular interest in using an interpretive ethnographic stance. During my practicum, I took note of the way that staff worked with limited resources and often found themselves at the intersections of the urgent and sometimes conflicting needs of the clients, clients' families, the psychiatric institution, and the city/community. More specifically, several aspects of the Center's work were particularly interesting to me: 1) the way in which psychological services were structured and molded around the interests and needs of the community 2) the difficult position staff found themselves in trying to address and meet the needs and interests of the community while simultaneously adhering to the goals (sometimes business oriented goals) and vision of the larger psychiatric institution (and field in general) 3) staff's consciousness and integration of contextual and specific knowledge that they had acquired through both personal experience and their work, and 4) the way in which staff responded to

contradictions and tensions between their work and personal experience, and the mandates and assumptions of clinical psychology in general.

I also noticed that both clients or “patients” and therapists at the Center took on multiple roles beyond the consulting room. Given that this mental health clinical also served as a community “drop-in” center, people spent time there socializing with each other, even at times briefly with the therapist. What was considered therapeutic or “therapy” seemed to extend beyond individual or even group psychotherapy sessions. “Help” or assistance was offered in many forms, directed both at what are often conceived of as the more “intrapsychic” struggles (say, depression or anxiety) and/or examining these aspects of the Center’s work that has the potential to contribute to a deeper understanding of many of the complexities embedded in systems of mental health care today, particularly with regard to addressing the needs of socially liminal populations such as inner city African American communities. Furthermore, it has the potential to open up and help us question psychology’s taken-for-granted understandings of social positioning, for example such as race and class, and their meanings within a psychotherapeutic context. In the next section I describe the Center and the community in which it is embedded (I use pseudonyms throughout). I also describe the particulars of my method both theoretically and procedurally, but I trust it is clear already, in so far as my observations are presented from a particular vantage point and described from a particular perspective, that data analysis has already begun. There is therefore much less of a rigid demarcation of method, procedure, results, and discussion than is often the case in research dissertations. Not only does ethnography “proper” or “traditional” follow a wholly different kind of structural unfolding, but so too does my reworking or adaptation

of critical ethnography. Furthermore, the very structure of such mainstream and traditional psychological research studies are themselves wrought on a natural scientific or logical positivist anvil – one this very study resists. Hence, even as I – for the most part – keep the borders and appellations of such a traditional dissertation presentation, I sail on the borders and margins thereof. That is, this dissertation, as a written record, retains elements of both ethnographic tradition (e.g. first-person descriptions of data interwoven throughout various sections) as well as structural elements of a traditional psychology dissertation (e.g. separate section for analysis of narrative themes). This section on method therefore both elucidates the method in greater detail *as well as* marks the beginning of my presentation of results.

Research Setting and Community History

This study was conducted at a community mental health center where I worked as a practicum student for roughly 1 year in 2004-2005. This Center operates as one of several satellite clinics of a psychiatric hospital which runs under the auspices of a large university medical center. The Center is located in an inner city neighborhood in a moderate sized city in Pennsylvania, and emerged as a result of federal funding granted to its parent hospital in 1967 for the development of a community mental health center. The physical site of the Center, however, was itself was not in operation until 1972 (WPIC Annual Report, 1968-69; Freidman, 1999). Before the Center emerged as a centralized community location, the hospital relied on several ambulatory “teams” to bring mental health care to various “catchment” areas in the community. These mental

health care teams brought services directly into people's homes, schools, and various community programs. The goal was that each team would eventually have a specific physical location in the community. An annual report from the hospital describes the team charged with the task of serving the 8th district community in the following way: "this team has been in existence since the Community Mental Health Center and has had a relatively intense relationship with the black community" (WPIC Annual Report 1970-71, p.63). There is talk in this report of merging with a rehabilitation center drug program and the emergence of a drug program in the form of a therapeutic community that was already accepting patients. Although the precise history of the Center is somewhat sparse, one can get a sense from these annual hospital reports that during the late 1960s and early 1970s there was an emphasis on community and community programs that served as the basis for the eventual development of actual physical community clinics. This emphasis on community care was motivated by a common issue experienced across the nation – namely, individuals who spent time in psychiatric hospitals were sent back into a community where they often had few resources or social networks for support (Vega, 1990). As a result, the conditions of newly discharged patients would often deteriorate rapidly and the former patient would wind up back in the hospital. Community services, both the ambulatory "team" approach described above as well as community clinics, such as the Center, were developed to help prevent relapses and rehospitalization for patients within given communities.

The Center officially opened its doors in 1972 as an "outreach facility"; it was at the time and remains today, housed within a larger community organization building. The building is located on a main road, close to a major intersection which leads directly into

the downtown area. Despite its relative proximity to the city's major business district, the 8th district is geographically cut off from the surrounding area by a large public arena on one side and by naturally occurring slopes that exist along one edge of the neighborhood. According to demographic statistics there are approximately 17,000 people living in the area, most of them identified as African American and working class. The Center is juxtaposed to what appear to be housing projects and across the street from a small strip of stores.

The Center is located within a moderate sized building that is actually home to several other community organizations (e.g. a child care program, an employment assistance program, a community initiative program); together these organizations form "Phoenix House" (not the real name). The walnut brown structure stands only two-stories high and was built in a 1970s architectural style. Outside of the building there is a long pathway leading up to the entrance and a large window where I often noticed children playing in the daycare center. On one side of the building is a play area for the children in the daycare and on the other side there is a large court area that leads to another building that is often used for community events. Just inside the main doors of the building there are numerous plaques paying homage to those who have supported Phoenix House and other revered community members. The main doors lead directly into a large lobby area that is overseen by a receptionist who can assist in directing visitors to the appropriate office. Decorating almost every wall of the lobby are large plaques outlining the mission of Phoenix House and depicting historical photographs of the community. It is important to mention that Phoenix House and its many contingencies have been instrumental in bringing jobs, education, and support for families to many

community members. The house has been active politically speaking, getting local and national politicians to speak at the community event center in order to inspire political activism and empowerment in the community. Phoenix House operates according to a simple philosophy: “awaken each person’s power to reach their potential. Positive change in individuals strengthens families; and ultimately transforms communities.”

The Center is thus but one small, yet important branch of this House. As mentioned, it is also considered a satellite clinic of a psychiatric hospital and thus operates as both a part of a for profit medical institution and within a community-based not-for-profit organization which makes for an interesting dynamic to which I will return later. It is located in a relatively small suite on the second floor of the building and contains rooms for both community oriented activities as well as clinical “therapy” rooms. The setting of the clinic itself will be considered in further interpretive detail in the following Results and Discussion Chapters. I consequently turn now to a comment about the history of East city (not the real city name) and in particular the unique and troubled history of the 8th District. This history has significant bearing on the practice of psychology at the Center.

Community history: A beginning point of ethnographic access

I first visited East city because I had been invited to interview for acceptance into a graduate psychology program there. On the day of my interview, I caught a cab to the university and had a brief yet memorable conversation with the taxi driver. As we turned around a bend and approached the university, he motioned to his left and stated that I

should “never” go in “*that* direction”— that is, “unless I had a gun.” Being completely new to the city, I was perplexed and curious and really had no sense of the context of his comment. From his description, I imagined it must be a very dangerous place, yet at the same time I wondered to myself what this person’s idea of dangerous was. Somewhat ironically, the very same area that this taxi driver had warned me about came to be the place where I would complete a practicum and develop as a researcher over the next few years. Although I did not “need a gun” to go to my practicum, I did often hear stories from community members about shootings occurring, 8-year-olds being sent out to deliver narcotics, and the fear of going outside because of chronic violence. I was often caught, both in my clinical work and as a researcher, between balancing what I heard about the realities of people’s lives with the way in which this community had been constructed as a dangerous and violent place. To say that this area is “constructed” as dangerous is not to invalidate the subjective experiences of those who live there, but rather to point out the reciprocal way in which social communications, via media and word of mouth (and via taxi driver) shape what we experience as reality. It is likely that this neighborhood was not the only area in which there was violence and drug running, but it had become the city’s scapegoat. In constructing an area in such a way one could feel more in control of avoiding the issues that this area came to represent. My very first interaction with anyone in the city was a testament to this construction.

The 8th district went through several transformations before it came to be what it is today. At the turn of the 20th century, the community was home to many European immigrants, mostly Irish and German-Jewish families, and later it was also populated by Italian, Russian, Polish, Romanian, and Slovakian immigrants (Goldman, 1968). Later in

the century even more diverse groups came to settle in the area, including Syrian, Armenian, and Lebanese immigrants and finally a large influx of African Americans from the southern United States. M.R. Goldman (1968) writes in his memoir of growing up in the area that during this time it was truly a “human cauldron or an American melting pot” mixture of a very diverse group of people. Cultural and economic shifts occurring during World War I, including the cessation of European immigration, led to the opening of East city’s job market to African Americans. This prompted a migratory wave from the South which increased the northern black population by more than 500,000 between the years of 1910 and 1930 (Trotter & Smith, 1997).

During this period, the 8th District, located just outside of downtown East city, was a virtual Mecca of culture, art, music, and entertainment. Many of the nation’s finest jazz musicians were drawn to the area and the 8th district was also home to many talented writers and artists, an area that "was thriving, bustling, and safe--a center for music, art and literature"(Pittsburgh Department of City Planning, Retrieved on July 19, 2007). The 8th District community was home to many activist groups, Black run businesses, and even a baseball team. A newspaper was founded during this period and became the nation’s largest and most influential black paper. The paper was committed to creating a sense of community and promoting black interests by chronicling issues such as housing, education, job opportunities, and political awareness.

Despite the 8th District’s cultural prosperity during this time, the community was still struggling economically and politically. African Americans were prohibited from securing jobs because of segregation and discrimination laws, and with the decline of industry in the area fewer jobs were available. As deindustrialization ensued, after World

War II, a splitting of black experience among class lines ensued due to deindustrialization of the region. The consequences of the loss of industry were devastating for working-class African Americans, economically speaking. To complicate and perhaps aggravate these difficulties, movements to begin an “urban renewal” project began as part of the city’s preparation for soldiers returning after WWII. Interestingly, the 8th district’s contribution, culturally speaking to the city, in terms of music, literature, sports, and politics, did not prevent prominent community figures from claiming that the 8th District was “a slum not worth saving (as cited in Trotter & Smith, 1997, p. 425). Admittedly, this dissertation does not intend to present a complete history of the 8th District, and therefore an exhaustive literature on the topic was not reviewed. However, after reviewing several articles on the subject, I was hard pressed to find any articles that contested this view of the 8th district. For example, one member of City Council wrote the following in a newspaper article in 1943: “Approximately 90 per cent of the buildings in the area are substandard and have long outlived their usefulness, and so there would be no social loss if they were all destroyed” (Evans, 1943). He goes on to say that because the renewal of this area would not involve displacing any major manufacturing plants or “important industries,” only residential housing, that the area is “well adapted” for redevelopment. Quite coincidentally, as I wrote this section, I happened upon a report of archaeological excavations in Indianapolis (where a similar African American community was razed to make way for the University of Indiana) uncovering that the argument of the day, of a community of decay and blight, was not altogether the case, and that in fact there was a thriving, middle class community in place (“Dig finds a thriving Mecca,” National Public Radio, July 23, 2009).

The argument of “urban renewal,” made by members of City Council, and in the submissions for building a large sports arena in the area, hardly makes mention of, or considers, the residents of the 8th District, the majority of whom were African Americans. The residents and small businesses of this area seemed invisible in these stories of reconstruction, as if they did not even exist. According to my interpretation of these articles the implication is that the residents of this neighborhood did not matter as much as the displacement of any “important industries” when it came to plans for demolition and reconstruction of this area. In the 1940s, legislation was passed permitting condemnation of the area and its consequent “renewal”. Demolition was authorized in the early 1950s, which uprooted 1500 black families in order to make way for a domed Civic Arena and luxury apartments. Uprooting was sudden and no provision was made for resettlement – housing conditions did not improve but these people were crowded into nearby neighborhoods, forcing the middle class out of those areas. A second setback for the local black poor was the inability to get governmental agencies to respond effectively to their needs. The federal war on poverty failed, as did the activism of local community agencies, largely because of the geographic dispersal of community members into 7 neighborhoods, making unity difficult because of competing interests and priorities. This failure of the War on Poverty clearly contributed to the riots of the late 1960s, which some saw as a “political” statement by the poor to call attention to their continuing plight of African American residents. Others suggest that the assassination of Martin Luther King, Jr. prompted the riots at this time. Regardless, the cumulative effect of a deracinated community, an infrastructure ravaged by riots, and a city government that seemingly had very little concern for, or interest in, the needs or demands of the

remaining residents of this district was an increasing volatility and desperation in the area, accompanied by a population decline from more than 50,000 in 1950 to as little as 15000 by 1990, most of whom lived in public housing then.

As the cab driver's comment to me, referenced earlier, suggests, the 8th district still has not fully recovered. The community reports some of the lowest median incomes in the city, while public housing projects seemed to concentrate poverty. It remains unclear how the recent destruction of public housing projects and construction of market-rate housing will impact the community. Community members and staff members at the Center continue to be concerned regarding some of the plans for urban renewal in the area. Most recently a plan to build a casino on the perimeter of the 8th district has prompted protests from those concerned about the negative impact such an industry could have on the surrounding community. I attended a local community meeting in which this was the topic of discussion and several attendees raised concerns about the rise of drug abuse, gambling addiction, and crime that often occurs because of casino activities. It is unclear whether or not the 8th district community has more of a voice politically speaking than it once did, but there is certainly a push to invigorate the community from the inside out – to get community members engaged in determining the future of the neighborhood and attracting the attention of major politicians (John Edwards recently spoke at the community center connected to the Phoenix House during the 2008 campaign).

As mentioned before, my analysis of the Center includes a consideration of local context and thus my analysis has already begun with this description of the setting and community history. In the next section, however, I delineate more concretely the methods/procedures I used to formally obtain and record this data.

Data Collection: Participant-Observations and Interviews

Material for this study was drawn from two main data points. First, I conducted participant-observations of psychological practice at this clinic, drawing on my own experience working as a student therapist and my observations of the workings of the clinic itself. These observations included descriptions of the material condition of the clinic itself as well as everyday practices and conversations regarding treatment and diagnostic decisions, common interactions/rituals among staff, etc. Material gained through these observations does *not* include specific clinical information about any clients, even as some descriptions make reference to staff's interactions with clients. I also took into account various important forms/documents utilized at the Center as a way to illuminate the more formal and inscribed story of what it means to provide psychological service through this institution.

Semi-structured interviews with four staff members formed a second major data point in this study. Although going into the project I had anticipated drawing equally from participant-observations and interviews, in some ways the detailed narratives I received in the interviews provided me with a wealth of information that felt like it overshadowed other data points. At the same time, I found that participant-observations and interviews were reciprocally informed. My experience as a practicum student and observations as a researcher led me to particular participants and particular interview questions, and participants' answers to these in turn pointed back to, and further illustrated, many of my observations. Using multiple sources of data is consistent with

ethnographic methods because it lends itself to a “thick” description of the studied phenomena from several perspectives.

Before even beginning to collect formal data, I had a number of casual discussions with staff members at the Center regarding how they felt about research being conducted at the Center and what kinds of research might be interesting or beneficial to their work. All of the staff members I approached expressed enthusiasm for research being conducted at the Center. Many of their research concerns revolved around how to continue to improve services for clients. Interestingly, sometimes staff’s concerns at first were presented in psychiatric terms. For example, one staff member stated that he would be interested in patient “compliance” with medication and how to improve patient compliance. However, he quickly began wondering aloud about the social, political, and economic factors that might be contributing to what was typically understood as “non-compliance.” He mused about the possibility that sometimes clients do not follow-up with medication or appointments because they are afraid to leave their homes due to violence in the person’s building or neighborhood, or because they could not find child care, or afford to pay for the medications. This staff member presented several practical examples from his experience in which this had occurred with his clients. These early conversations, coupled with my own experiences as a clinician at the Center, helped to inform my research focus and interview questions. I eventually became most interested in how psychologists at the Center managed and navigated competing demands of the psychiatric system, clients' needs, community needs, as well as their own needs.

After completing and having my dissertation proposal approved by my committee, I moved to the next phase of obtaining approval from the university’s

Institutional Review Board (IRB). Because I was conducting research in a clinic associated with another university, I had to obtain consent not only from Duquesne but also from the university medical center of which the Center was a satellite. In order to obtain IRB approval from this university medical center, I had to first find a faculty member at this university to “sponsor” my research. Eventually a psychiatrist agreed to sponsor my research and I began the rather lengthy process of preparing an IRB proposal that would be suitable for this institution’s purposes. Approval for the study was eventually granted by the review boards of both the medical center and Duquesne university. Staff at the Center were presented with informed consent (located in Appendix A) on an individual basis so as to guard against the potential for feeling coerced into participating in the study that might happen more readily in a group setting.

Participant-observation

I spent about 6 months in the Center recording my participant-observations. My role in the Center at the time was both as a clinician and as a researcher. I kept a detailed journal of my reflections, observations, emotional reactions, thoughts, and even my own embodied sense of what was happening in the Center. These journal entries typically took the form of little “snippets” of interactions or experiences that stood out to me although I also described the physical space and location of the Center quite a bit. I paid particular attention to the use of the term “community” in this context which made reference to certain shared sociohistorical experiences as well as geographical “territorial” context. Both at the level of data collection as well as interpretation I tried to remain sensitive to

the way that I was positioned and positioned myself as a researcher-clinician with a different sociohistorical background in many senses. I paid close attention to the interactions I had with clients and staff alike, placing myself in locations where I could become a participant-observer of what was meant by the terms “community” and “community-based clinical practice,” as well as the dynamic interplay of race and class within the context of the Center and perhaps how, if at all, I could be included within this context as a member of the “community.” Clinically speaking, I took particular note of the everyday struggles that the therapists faced in their practice as they wondered how to address the manifestation of psychiatric/biological symptoms that were expressed by an individual while simultaneously understanding such distress as symptomatic of larger social (community) issues. I followed many of the suggestions outlined by Emerson, Fretz, and Shaw (1995) in recording these field notes – suggestions such as writing in the first person to emphasize my presence as the researcher and reactions, paying close attention to interactions and discourse, and describing the characteristics of those around me, important events, and various conversations. At the same time, because I was often engaged at the time of the event or conversation I typically took time to reflect and transcribe what I had experienced after the event rather than writing notes at the time. I believe, as Emerson, Fretz, and Shaw (1995) point out, that as a “newcomer” clinician, I was in a prime position to access some of the more covert clinical understandings and practices at the Center; they write: “[the newcomer’s] struggles, mistakes, and questions” during training, has the potential to reveal the “implicit knowledge and skills most long time staff members take for granted” (p. 47). Although it was difficult to decide how these notes should be presented, I have chosen to integrate some of them throughout the

dissertation. Some of my participant-observations are highlighted in specific quotes in my results section and others took more of a background role in helping me to determine questions to ask during interviews or are present in my description of the clinic space and my research participants.

Interviews

I chose to use interviews as a means to access how staff might describe their clinical work at the Center. The structure of these interviews was heavily guided by my prior clinical work at the Center and my participant-observations. As Coffey and Atkinson (1996) suggest, I engaged in ongoing analysis of my participant-observation data in order to inform subsequent interview discussions. I recognize that there are pros and cons, so to speak, of using interviews as a primary research method, especially with a project that is attempting to examine the more dynamic and practical concerns of clinical work. For example, I was concerned that interviews would get at the intellectualized understandings of clinical work and might neglect the social dimension of how therapists talk to each other about their work. I originally thought that a focus group or a discussion group would be more in keeping with a community spirit and get at a spontaneous discussion of clinical work. However, I was aware, based on my own clinical work at the Center, that staff barely had time to convene for one staff meeting per week, let alone get together for my research. Given the arrangements of the clinic and relatively small staff I thought bringing the majority of clinicians in the Center together for a focus group might prove to be a difficult task that might be also be disruptive to the activities of the clinic.

Furthermore, being in a focus group with fellow coworkers and their director could potentially have inhibited staff members from speaking freely. I imagine, based on some of what participants shared with me, that they may not have been so candid had a fellow employee been present. I understood my interviews with participants as more like continued conversations from our earlier discussions and work together. In fact, although I did arrange for formal interviews with each of my participants, I also understood interviewing in a broader sense as merely “talking with people” in a more casual sense (as suggested by Devault & McCoy, 2002). My semi-structured interview guide included questions informed by experiences and observations in the field and thus continued to change in light of my observations (a copy of this interview guide can be found in Appendix B). In addition, my interview questions changed slightly with each interview in light of participants’ responses. As I learned which kinds of questions might elicit more interesting or in-depth responses I could adapt my interviews accordingly. I believe that an iterative approach to interviewing (rather than a pre-planned structured interview) is in keeping with a constructionist perspective and an emphasis on the dynamism of culture and also the general dynamic spirit of the Center.

Interviewees were chosen based on their knowledge and involvement in the Center. Each participant was contacted separately, some more formally than others. All interviews took place in the participant’s office and ranged in length from 30 – 90 minutes. Before beginning the interview I presented the participant with informed consent forms from both Institutional Review Boards and offered to respond to any questions about my research. Each participant signed a consent form allowing me to utilize data from our conversations in my study. Participants were also offered a \$20 gift-

card to a local supermarket in exchange for their participation in this study. Interestingly, every one of my participants stated that they intended to either use the card to purchase necessities for the clinic or to donate it to local charitable organizations. Signed consent forms were stored in a lock file cabinet in my house. All interviews were digitally recorded using recording software on my laptop computer. Audio-files were then compressed and stored in password protected files on my computer. Written transcripts of these interviews can be found in Appendices D-G.

Research participants

I aspired to have the kinds of relationships with my participants that Conquergood (1989; 1992) recommends and in this spirit, I built relationships with most of my potential participants over the course of a few years – first as a practicum student and then as a researcher. I had the most contact with a few of the main therapists at the clinic and worked in various capacities with each of them as a student therapist before beginning this research. Each of them has played a role in guiding my clinical and professional development. I have had relatively less contact with other potential participants, such as psychiatrists, social workers, medical residents, and administrators; however, to many of them I believe that I was a familiar presence. I chose to return to work part-time as a practicum student in August of 2006 so that I could continue to build relationships with participants and gradually get a sense for the kinds of issues that are most salient to them. I chose participants based on their involvement in providing the majority of services at the Center and their interest in reflecting on their work. The

following is a brief preliminary description of each of the participants. Additional details about the participants are also integrated into my results section (Chapter 4). I used pseudonyms for each of the participants to conceal their identities.

Tom

Tom(P1), a 60-year-old African American therapist, agreed to participate in a formal interview after several conversations about my research. By the time of interview, I had known him for approximately 2 years and had worked under his supervision for a 1 year practicum at the Center. He expressed interest in my research and also contributed to the initial focus of my research project. Tom had many potential research questions about the work the Center was doing, especially with regard to how they could better serve their clientele. He displayed passionate interest in the meaning of his clinical work with the community, particularly with respect to “community trauma”. Tom had worked in the field of psychology for 30+ years, the majority of which he had spent as an administrator and clinician in a hospital substance abuse unit. When this hospital closed, he came to the Center and by the time I interviewed him, he had served as the Center’s director for approximately 3 years and was preparing for retirement. Tom shared with me that he had completed all coursework for a Ph.D. in clinical psychology, except for his dissertation.

On interview day, Tom was dressed in his typical business casual attire – khakis and a blue buttoned down collared shirt. The door to his office was open that day and as I approached the doorway he greeted me in his usual friendly style. Tom looked up from his work and said, “Hey, how ya doin?” He was eating lunch while working (a common practice at the Center because there often was little to no time for extended lunch breaks

away from the centre) and motioned as if he would stop when I came in. I encouraged him to keep eating and he continued to eat as I set up and we chatted about the many changes that the Center was going through. Most notably, the Center had finally been awarded money for renovations – money that, according to Tom, the Center had been requesting for several years. I surveyed Tom's office and noted that it had been freshly painted just before the interview but in most other respects his office looked pretty much the same as it did before the renovations. There were the same African masks on the wall, a painting of a little Black boy playing and a large potted tree near his desk. Tom's office was also cluttered with stacks of papers on just about every surface and items that had been donated to the Center, such as toys and clothing, were piled in the corner. Once we were both ready to begin the interview, Tom slid his desk chair closer to the table where I had set up the microphone for recording. He stretched out his legs in front of him, leaned back in his chair looking comfortable and relaxed and signaled that he was ready to begin.

Throughout the interview I had the impression that Tom had thought a lot about his work and had a lot to say, given the rapid pace of his speech. He also spoke with considerable emotion, emphasizing points with voice inflection and presenting examples from his own clinical work. I discovered that he had been very active in the civil rights movement during his college years in California and how he felt this social consciousness continued to shape his clinical work. Throughout the interview, Tom and I often referred back to our previous conversations giving this interview the feeling of being more of a continuation of previous discussions than some of my other interviews. At the end of the

interview Tom offered to continue our conversation if there was anything I wanted to follow-up on after the interview.

Theresa

Theresa, an African American woman in her 50s, started working at the Center relatively recently, and had only been there for a few months when I interviewed her. I therefore did not meet her while I was completing my practicum at the Center. She seemed enthusiastic about participating in my research study when I first asked her, and was friendly and casual as she welcomed me to her office on interview day. She was eating lunch when I arrived, and after greeting me, she asked me to review what my research was about. I shared with her my interest in documenting the multifaceted nature of practice at the Center including an analysis of how social/contextual issues were integrated into clinical work.

Most of what I know about Theresa I learned from my interview with her, including that she had grown up in the 8th district as a child and thus had a sense of the community transition that had taken place over the course of the past few decades. I also learned that she had worked in another clinic associated with the hospital over 25 years ago when, as she explained, psychiatry was still more closely aligned with psychoanalysis. She, too, had completed all coursework for a Ph.D. in psychology but had stopped before completing her dissertation after being offered opportunities to travel and do refugee work with the ministry. She also had experience working with anti-gang movement in the United States.

In terms of our interaction on interview day, Theresa seemed relatively friendly and open up until the point that I turned the recording device on. I can only speculate as to what Theresa may have been feeling, but I had informed her that I would be recording the interview and she had watched me fumble with the recording device for the first 5 minutes of our conversation. Theresa's tone changed considerably and she I had the sense that she rejected many of my attempts to paraphrase what she was telling me. Later in the interview process she seemed to relax more and I was able to join into the conversation more, however I believe the specific content of our interaction warrants further analysis and thus will be included in my results chapter.

Michael

Michael identifies as African American and is in his 30's. He shared with me that he had grown up in East city and had attended college there as well. He holds a masters degree in social work and was raised in a family where he was taught to "give back" to the community and that everyone has a "responsibility" to make a positive difference in others' lives. Michael shared that this type of philosophy also fits well with his Christian upbringing.

During the initial phases of the interview, I had the distinct sense of a cautiousness or distance between Michael and I. For example, Michael responded to my interview questions with only short answers at first and it almost seemed as though Michael might be trying to give "correct" answers, using more professional jargon than I had heard him use in casual conversations. As a result of this style, this interview

followed a more structured format than the previous two interviews (with Tom and Theresa). However, as the interview progressed, Michael appeared more relaxed. He began to spontaneously offer information about himself and at the end of the interview he actually stated that he had “enjoyed” the process and was “surprised” that he did. Michael admitted that he had “not known what to expect” but that it “felt good” to have half an hour of undivided attention to process/talk about his experiences as a clinician. He alluded to the fact that the primary task of most clinician’s doing psychotherapy is to listen but that they are often not given significant time to process those experiences. This is especially true at community mental health centers where the influx of patients often exceeds the time and resources available to treat them.

Sam

Sam (P4) a European American man in his 50s told me that he had been a psychiatrist at the Center for several years. He has a background in psychiatry, which is different from all of the other participants, however he made it clear that his first love was psychotherapy/psychoanalysis and he sees psychotherapy as something that is integrated into his otherwise more medically oriented treatment of clients. I had relatively little contact with Sam during the time that I worked at the Center, partially because of my limited time there, but also because he was more involved in the training of medical residents than he was in the training of clinical psychology practicum students. However on occasion I had consulted with Sam regarding medication issue or when his permission

was required to get certain resources for clients. He shared with me that he was the child of Jewish immigrant parents and that this heritage had been an important part of his identity growing up. Furthermore, being aware of his Jewish heritage sensitized him to issues of oppression and the abuses of power in other communities as well, which had drawn him to doing work in the 8th district. Sam talked about his strong commitment to the public psychiatry movement and how he works hard to bring information about this branch of psychiatry to more professionals who he recognizes are often struggling to do this work with little support.

In terms of his interview, Sam's style was more direct and factual at first but as the interview progressed he seemed to become more comfortable, asking me more questions about my research and bringing the interview to topics that were most interesting to him. I remember thinking that my interview with Sam would be brief, but to the contrary it ended up being one of my longest interviews, rich with content and thought provoking material.

Data Interpretation

Although I will begin an explicit discussion of data analysis in this section, analysis was incorporated into every phase of my research process. I approached this study guided by the question of what it means to practice community-based clinical psychology, and I used the content of early observations and interviews to further shape more specific research questions, including: How are the ideas of community and diversity understood and lived through in this setting? What are the systemic

circumstances that shape this practice? How do psychologists navigate this system and what are the tensions/challenges, disruptions to this work? Reflecting upon preliminary data content helped to further shape my research questions which in turn informed my analytic method. I found, as Maxwell (2005) suggested, that data analysis begins way before formal data analysis commences. I began to reflect upon and interpret what I observed and heard during interviews as they were occurring. Furthermore, the process of listening to recordings, transcribing, and taking preliminary notes was also an interpretive process.

Data transcription

I was surprised by the degree of interpretation that was involved in the process of data transcription. Each time I listened to the audiotapes I heard more nuances; sometimes I heard words differently or noticed a subtle pause or intonation that seemed to change the meaning of the content of what was said. I probably could have listened to the audiotapes indefinitely and heard the conversation differently each time. However, I chose to listen to each audiotape several times in an effort to consider as many different “listenings” as I possibly could within a reasonable time frame. Transcription of the 5 interviews took place over the course of several months. In the end, however, I chose to eliminate one of the interviews in my formal interview analysis, mainly given its brevity, and the fact that, in the main, it reiterated the themes and concerns of the others. This does not mean, though, that the information gleaned from this interview did not inform my understanding of the data more generally. I am convinced that the interview is present

in the data interpretation in a sedimented sense, even though it was not subjected to as explicit/extensive analysis as the other interviews. I am pleased at the time I spent with the audio recordings and spent carefully recording the words, inflections, etc. because I believe it helped to give me that initial interpretive sense of basic themes and interactional content to which I would return later. A description of my transcription coding system can be found in Appendix B.

Constructing narrative themes

In trying to make sense of interview transcripts based on my discussions with participants as well as my own notes about my experience working as a student clinician, I read a variety of accounts of data analysis. Reading this material broadened my understanding of a variety of analytic methods, however at the same time this broad and varied literature in some ways, complicated the process as much as it provided me with direction. I was left with the question: What method will help me to explore my research questions and data in a manner that also respects and gives agency to my participants? Ultimately, I found that there really isn't a pre-existing single method in qualitative methods that could serve this purpose. Instead of trying to limit myself to one single perspective, I chose to draw from various methods when it came to data analysis, incorporating what seemed to "fit" my particular topic. My first step in determining my specific procedures for data analysis involved getting a better sense of how I conceptualized the data I had collected.

After listening to the interview recordings, and reading over my transcripts multiple times, I was left with the sense that although I set out to investigate a topic – community mental health, or more specifically how community psychology is storied in one particular clinic – I had ended up with (and perhaps not surprisingly) stories about people’s lives. More specifically (but not exclusively) I had been offered glimpses into the life-stories of my participants. As they shared their personal stories with me, how they arrived at the Center, what their past experiences were growing up, their values, dreams, disappointments, and struggles, I discovered a dynamic landscape of autobiographies that were interwoven and in many ways inseparable from their descriptions of community mental health care. Their stories markedly enriched the topic at hand in ways that I had not anticipated. As their stories became more personal, I noticed myself, as the interviewer, becoming more personal - telling more about myself or my experiences and perhaps in a way that would be avoided by some in interview research. I felt compelled to participate, to reciprocate in the dialogue, to bring my “self” to the table in a way that was actually quite characteristic of the culture of this clinic. Interpersonal boundaries described (and observed during my participant-observations) between and among staff and clients were also being lived-out between myself and interviewees during interviews. Therapists at this Center were perhaps more primed to bring their “selves” to their work because of the personal investment they reported they felt in the types of struggles experienced by clients. Many of them shared the experience of being marginalized and had many personal experiences of what it meant to be a minority in the U.S. As such, their own experiences of discrimination, marginalization, and resistance to subjugation

were interwoven with stories about their clients (many of whom share this racial identification as well as other subjugated identities) about their work, and relationships.

Staff's personal stories, interests, beliefs, values, and dreams could not be separated from their work, and the important relationships they had with others at the Center. Understanding "personal" stories as revealing something social or even political, much can be revealed regarding sociopolitical issues through analysis of staff members' narratives. It is because of the way my participants appeared to be telling stories, even when my questions were not always geared to elicit a full narrative, that I kept returning to the conceptualization of my data as a collection of narratives. Perhaps even my own participant-observation notes were like stories – ways for me to make meaning of my experiences at the Center. I originally aimed to retain as much of the context of the interview as possible – keeping the narrative structure and incorporating my participation in the interview process, however when trying to integrate these rather lengthy narratives with other data points, the presentation seemed to become unfocused and unwieldy. As a result though, I really did end up analyzing my data in several different ways in order to arrive at a final analysis. Looking at interview transcripts as both whole stories as well as looking to parts of each narrative as they related to particular themes seems congruent with the kind of interpretive circle suggested by Dilthey (1900/1976):

The whole of a work must be understood from individual words and their combination but full understanding of an individual part presupposes understanding of the whole...[Thus] the whole must be understood in terms of its individual parts, individual parts in terms of the whole. (p.259)

Thus my specific procedure of data analysis took this circular form, tacking back and forth between the whole narratives, breaking them down into parts and then seeking to understand those parts in terms of the context of the whole. This circular reflective process also took place when interpreting one interview in the context of others. In the next section I will try to describe the specific procedures that I followed in conducting this initial phase of analysis.

After reading all four interview transcripts as a whole, I began to make some initial notes regarding the content. Although I did not use a systemic coding scheme, I began marking ideas that stood out to me, seemed significant in the scheme of the narrative, or related to my main research questions. I drew suggestions from Miles and Huberman (1994) and Coffey and Atkinson (1996) who give thorough descriptions of the various stages of “coding” in their work. Miles and Huberman (1994) state that “codes usually are attached to ‘chunks’ of varying size – words, phrases, sentence or whole paragraphs, connected or unconnected to a specific setting. They can take the form of a straightforward category label or a more complex one (e.g. metaphor)” (p.28). As suggested, I went through and identified sections of data that seemed to revolve around a given narrative theme or topic. I did this to get a sense of the “what” that was being discussed. I looked for repeating ideas that seemed to relate to larger themes across interviews but also paid attention to differences or points of contention. I chose particular cases in the interviews to illustrate general patterns and demonstrate range and variation on a theme. I also subjected my field notes to a similar kind of thematic analysis and compared how these observations seemed to reflect or contradict narrative themes from my interviews.

Although this preliminary “coding” process is often thought of as a way to make data more manageable, I used this preliminary analytic process to “complicate” the data as well (Strauss, 1987). Strauss (1987) describes a process of interrogating data through coding as a means to expand the conceptual frameworks and dimensions for analysis. He argues that this process can be about going beyond the data, thinking creatively with the data and asking the data questions and generating theories and frameworks. Given the sheer amount of data I collected based on interview transcripts alone, not to mention participant-observations, I spent a considerable amount of time “questioning” the data and recording preliminary insights and connections. The data was taken apart and put back together in multiple ways, each of which helped me to form new interpretations and frameworks for understanding the clinical practice of psychologists at the Center. Final “themes” for each interview were determined using guidelines for selecting themes presented by Emerson, Fretz, and Shaw (1995) which include: giving priority to topics with substantial data which reflect underlying patterns in the field, giving priority to what seems significant to participants, what they think is key, and what looks practically important and/or engages a lot of their time and energy.

Across interview analysis and intertextual reading

After identifying the main themes in each interview I conducted an across interview analysis to better organize and simplify the data. I interpreted a framework for practice based on these themes that included central community issues to which staff oriented themselves, the way they conceptualized community issues, and how they acted

or intervened according to those understandings. I listed main themes that related to each of these dimensions and included quotes from participants that I believe to support each claim.

I also conducted what can be considered an intertextual reading of interview narratives, participant-observation notes, and my observation of the physical space of the clinic and surrounding community. I explored how these multiple data points reflected, contrasted, and overlapped with one another and wrote up more fluid analytic “stories” that incorporate all three of these dimensions. These narratives are included in Chapter 4 alongside my thematic analysis.

In addition to exploring the content of “what” was said or observed during the research processes and how different data points related to each other, I also felt it was important to consider a dialogical or interpersonal level of analysis. This meant paying closer attention to my interactions with research participants and how I was involved in co-constituting the stories that emerged (both during interviews and participant-observations). Furthermore, during this level of analysis, I also considered what was left unsaid by participants, going beyond what seemed to be immediately revealed by the data to consider what my data might be concealing. In the next section I will discuss some of the theory behind dialogical analysis and deconstruction and how I went about this step of the process.

Dialogic analysis and deconstruction

After organizing and getting a better sense of the content of my data, I turned to focus more explicitly on the context of this data (although this level of analysis was present throughout the study, I gave it particular attention during this phase of analysis). I understood the stories my participants told me as jointly constructed – dialogically produced between myself and participants, and community context. As Reissman (2008) suggests: “stories don’t fall from the sky (or emerge from the innermost ‘self’); they are composed and received in contexts – interactions, historical, and discursive – to name a few” (p.105). Therefore I felt it important to go back to my data and highlight the social/interpersonal context in which data was collected and subsequently analyzed. Shweder (1991) calls this step in the interpretive process a “witnessing in the context of engagement with the other” and implies the process of representing the other is inextricable from the process of acknowledging one’s own self as part of the process (p.110) Examples of this type of analysis are present in many of my participant-observations which are written in the first person and include some of my reactions, imaginings, and reflections. Notes from my participant-observations are interwoven throughout this report and thus this level of analysis is not limited to one particular section or chapter.

With regard to the broader context of the data – I understood participants’ stories as “social artifacts” telling me something about “culture and society as well as the person” and the clinic (Reissman, 2008, p. 106). Shweder (1991) too has suggested that context or culture and psyche are intertwined – as he put it: “you cannot take the stuff out of the psyche and you cannot take the psyche out of the stuff” (p.97). For example, I

understood the material space of the clinic as an important source of information about the political, social, and economic context of psychological practice in this setting. By analyzing what the physical “space” of the clinic seems to say, I give a voice (from my perspective) to the context in a way that is central to understanding the practice of community psychology at the Center. Conceptualizing social and the psyche as interweaving in this way, the interview narratives of individual participants could be seen as “social artifacts” that revealed the working of social mechanisms or institutional practices. Various discourses or narratives spoke through each of my participants, creating a multivoiced story that was inseparable from context.

The dialogical dimension of analysis also contains within it an element of deconstruction, or as Shweder (1991) suggests, “going beyond the other” (p.109). To the extent that I assume participants’ narratives as well as other data sources made reference to complex and at times contradictory meanings, I take a deconstructionist approach. I sought to go beyond participants’ narratives and my participant-observations to look at the “unsaid” dimension. The issue of power is often to be traced through the analysis of certain utterances: “an utterance carries the traces of other utterances, past and present, as words carry history on their backs” (Riessman, 2008, p.107). I therefore sought to highlight some of the tensions I saw as underlying the foundation of practice at the Center as well as complex issues of power in my discussion in Chapter 5.

CHAPTER 4: DATA PRESENTATION AND ANALYSIS

The following presentation of results represents an integrated analysis of my participant-observations of the material/physical space of the community and the Center, the general activities of the Center, as well as formal semi-structured interviews with staff members. It should be borne in mind, again, that the ethnographic enterprise militates against the neatly ordered, almost dispassionate, presentation of results “without interpretation” that is so often the standard. While reading through my data I kept in mind my broad research focus, that is, what does it mean to practice psychology at this inner city clinic? More specific questions emerged during all phases of the research, from collecting data to organizing and interpreting it, and included: What discursive practices shape this clinical work? What are the central issues to which practitioners orient themselves? How do they conceptualize these issues and choose to intervene? How does this practice speak to the larger social, economic, and political context? What does this context have to “say” back to this work? I understood “the results” I obtained from analyzing these data sets as representing metaphorical conversations between myself, my field notes, and participant responses during interviews. Although I had multiple conversations with the data sets which could have been represented here in a variety of forms, I have selected particular aspects of that data in an effort to provide the broader picture of practice at the Center.

In asking the question of what constitutes practice at the Center, I was struck by the important ways in which the broader material and geographic/historical context

within which this work was situated and the specific clinical concerns were intertwined. I begin the following analysis looking at the broader context and then analyzing the more specific ways in which clinicians at the Center took this context into account. The first part of this results section is thus focused more on the geographic context and material space of the Center, as well as the professional context within which the work was situated. The second part of this results section focuses more on specific issues clinicians saw as central to their clinical work, how they conceptualized these issues, and then how, based on these conceptualizations, they chose to intervene, clinically speaking. This part of the process involves an across interview aggregate which focuses on the similarities across interviews. In the last part of the results section, I attend to some of the differences across interviews by highlighting a specific topic that was discussed in more detail by only one of the participants.

Returning to the Setting: A Story About Space and Location

Before beginning this analysis it is important to get a “lay of the land,” both literally and metaphorically, of the physical and social landscape of the Center. I thus begin with this orientation to the “land” and some of my personal experiences.

On one hot July day I decided to take a walk around the Center to get a better sense of the surrounding neighborhood. Leaving the Center, I walked down the stairs, past the front reception area and out onto the street. When I got outside I noticed three men standing and sitting clustered around a small ice cream stand adorned with a sign reading “Soul Ice” on the front. They look up at me momentarily as I took pictures of

the outside of the Center and down the long avenue, but then quickly went back to their conversation. There was no one else on the street directly in front of the Center aside from the men at the ice cream stand. On a typical day, there aren't many people out on the street in the area directly in front of the Center, unless they are waiting for a bus, that is. The area immediately around the Center is clean and relatively modern. The landscaping in front of the Center is kept neatly and suggests that someone (or a number of someone's) are taking care of this place. Even the housing projects next door appeared well-attended to. Walking down the street, away from the Center, however, the scene changes a bit. I notice small clusters of people on the sidewalk socializing or sitting on stoops outside of run-down apartment buildings and stores. I notice that every few store fronts or apartment buildings are boarded up, appearing abandoned and dilapidated. Small businesses characterize much of the area – barber shops and family owned supply stores. The signs and buildings are aging and bear the mark of a different decade, another generation. I have the distinct sense of a place that has been frozen in time. In between an abandoned building and a small store I see a sign that reads: “8th district community development corporation: for hope of the community,” reminiscent of local community rejuvenation efforts. I noted that churches of various shapes and sizes pepper the avenue in between abandoned buildings. I pass a YMCA where a teenage boy with headphones strapped over his ear sits with his legs dangling over a low wall. But other than him, this part of the street seems deserted. As I walk back towards the Center, I notice that the landscaping there stands out from a distance compared to the surrounding buildings. The flowers marking the exterior of the Center seem especially

bright, boasting various colors of the rainbow – yellow, pink, red, and white in stark contrast to the conditions just a few blocks down the road.

I begin with this story here to set the frame for the way that the surrounding geography and the space of the Center itself tells a story, a story which speaks to a certain political, economic, and social reality that strongly shapes the practice at the Center. It bears reminding, again, that this framing departure story, as it is told here, is the ethnographer's story, which – even as it takes the data of the space as its departure point – shapes the data through omission, inclusions, narrative style, my own assumptions, what I adjudicated as important, and incorporative of influences I may not even be completely conscious of. As an example, my experience of the community is filtered through a particular class, gender, and racial lens, so that the description above, including as it does the suggestion that buildings are “modern” or “run down,” may reflect a middle-class position. Yet, writing from the perspective of an outsider not only separates the researcher from the material and the space, but carries with it the possibility that important distinctions will be missed, or events and experiences misrepresented in some way. Hence, I used my discussions with clinicians and observations of activities at the Center as a way to “check” and challenge my perceptions and found that often my understandings were shared. The story, therefore, has intertextual resonance, valence, and echoes which now makes it both mine, and not mine.

My observations, historical texts regarding the 8th district, as well as discussions with staff and my own previous clinical work with clients were closely aligned. My

sense that large sections of the 8th district had been left behind or even forgotten was confirmed by newspaper articles suggesting that the 8th district was a “slum that was not worth saving” (Trotter & Smith, 1997). Clients often struggled with poor housing conditions and lack of available jobs in the area. Tom (P1) pointed out that the neighborhood did not even have a grocery store (aside from convenience stores) which suggested the degree to which the 8th district was viewed as a dead economy. A lack of new industry coming into the area made it difficult to spark the economy by providing people with jobs, and/or even begin to focus attention on developing the area. Theresa (P2) was also sensitive to the physical conditions of the community in her interview, and discussed driving to work in the wintertime and getting to a distinct point in the road after which the roads were not plowed or salted. At one point in the interview she described a boundary around the perimeter of the 8th district after which it is “no man’s land” – she says, “When I come to work usually I cross all the way across town and the worst roads, the ice, the snow, salt and everything stops at the top of the hill...And it must say so much to the people who live here. I keep saying what is there – is there some kind of city ordinance, ‘don’t salt the 8th district?’ Just that one thing has just made such an impression on me!” (Lines 160-168). As Theresa stated, the physical state of the community – the feeling of neglect one gets when walking through the neighborhood – must “speak volumes” to the residents. Theresa interprets the neglect of the 8th district as reflecting attitudes of the city towards the 8th district community. Broadly speaking, she suggests that undesirable traits (violence, crime, etc.) are projected onto this particular area of the city, which serves to keep non-residents feeling safe that they do not live in one of “those” communities. I, myself, had various

interactions with others throughout the course of my research (not to mention my interaction with my taxi driver) during which they expressed concern that I was working in the 8th district or otherwise wondered why I would bother. However, before continuing with an analysis of important ways in which constructions of the 8th district are shaped through discourse (the way people talk, write, sign about it), I now provide more of a detailed sketch of the landscape of the Center itself, perhaps even in the concentric focusing manner of a “classic” ethnography.

The Center

The Center, as a material structure and a space for certain kinds of social interaction, represents a liminal space. It has strong roots in the community and community not-for-profit organizations while also remaining dependent upon the funding of the university medical center. The Center is located within the Phoenix House which is home to a variety of community organizations and is supported by local charities and individuals who have donated to the organization’s efforts. The Phoenix House thus stands as a figure of resilience and community support, while at the same time its very existence speaks to the destitution of the community. The Center itself could be described in a similar way - however, as a mental health clinic, its efforts are focused mainly on psychological difficulties.

The Center is located on the second floor of the Phoenix House which is a rather non-descript institutional looking building boasting a 1960s architectural style. Walking up the stairs of the Phoenix House, from the main lobby and rounding the corner, the

Center's suite is identified by a rather small sign next to the door that bears the name of the Center along with the name of the university medical center it is affiliated with. Once inside the heavy institutional door to the Center lies a modest size lobby with a receptionist window directly across from the doorway. The room contains little furniture for its size: two tattered looking blue vinyl couches are positioned against the adjacent and distant wall, which also contains a window to the receptionist area. Slightly further down the distant wall, a half-door marks the entrance to a long hallway. The farthest part of the room to the right opens onto another smaller room that contains a table with various clothing items piled on top, or hung on, a nearby rack. The clothing reminds me of the informal donation program that the director had started (or rekindled) to collect necessities such as clothing for community members who may be in need of them. The paint on the walls is an institutional beige color and is dull, smudged, and cracked in some places. The walls are checkered with a smattering of flyers and framed posters that convey inspirational messages about "achievement" and "integrity." The posters are off center within the frames which seem to be struggling to contain their contents. The look of such inspirational messages within such decrepit looking frames is a bit ironic, and in some ways bespeaks the very paradox within which therapists find themselves working on a daily basis. That is, working towards great empowerment for the community with relatively few resources. Aside from the posters, a laminated notice listing "patient rights" is tacked in the corner by the entrance to the long clinical hallway. The floor is a worn laminate material that bears the marks and cracks of many years of foot traffic. A small table in the corner holds a large thermos with coffee, creamer and sugar. I am reminded of the issues surrounding clients taking all of the sugar and creamer because

they were hungry. This type of behavior reflects the kind of poverty that many of the clients were living in.

The entryway to a long hallway containing the clinical offices is marked by a “half-door,” which is literally a Dutch style door which can be opened horizontally in two parts. This door serves as a gate of sorts, guarding the entryway to the interior of the clinic. During business hours the top part of the door is propped open while the bottom part remains closed. In order for anyone to get through they must be identified and “buzzed” through by the receptionist who unlocks the door through an electronic system that makes a buzzing noise. During busy times the perpetual “buzzing” sound of the door being locked and unlocked marks the flow of people going into and out of the Center, giving it a distinctly institutional feeling. I often wondered about how clients experienced this door. In many clinics, people are simply asked to wait in a lobby area until they are called, the assumption I presume, is that they will not get up and wander through the clinic uninvited. However, at the Center, this door represented a strong boundary, one that at first glance seemed anomalous to the otherwise open and familial atmosphere at the Center. When I spoke with Tom (P1) regarding the door he suggested that the clients appreciated this door, even though it made them dependent upon a designated authority figure to let them in and out. Tom claimed that clients “never complained” although they might get impatient at times and adamantly demand to be let out. Tom suggested that the relatively permeable boundary between the Center and the community created a vulnerability which, according to Tom, needed to be managed. He suggested that it was possible that the locking door served a protective function for both staff and clients alike. From my perspective, the half-door was an ambiguous structure. As Tom mentioned,

perhaps it kept people inside safe, but it also kept them confined, dependent upon the actions of an authority figure to determine when and how they would come into or leave the Center. Given that this Center was originally created by the university medical center in the 1970s to act as a step-down between hospitalization and the community, perhaps the door represents a remnant of mechanisms of control used on an inpatient psychiatric unit. The fact that the door remains half-way open, may symbolize the way that clients at the Center were, historically speaking, often “half-way” between living the restricted life of psychiatric hospitalization and living autonomously in the community. It should be noted however, that although the Center was initially set up mostly to address the needs of the “severely mentally ill,” it has since expanded its function to clients with less severe psychiatric issues and many clients have actually never been hospitalized. Another interpretation of this half-door (which may be more in line with Tom’s view) is that perhaps because the clinic is open to anyone as a “drop-in” center, the door is helpful in distinguishing between community members who are there for “official” psychiatric treatment and those who are there to “hang out” in the front areas but were not involved in counseling. According to this interpretation, the door marked the end of the “public” community space and the inside “private” space where clinical services were conducted.

Beyond the half-door, the interior or “clinical” area of the Center is comprised of a long hall-way with clinical offices lining either side. This narrow hallway opens into another smaller waiting area and rather large crescent shaped reception desk containing a computer, printer and phone. When I first began my practicum work at the Center, a second administrative assistant sat there but since she left several years ago, this second reception was, for the most part, abandoned. There were eleven clinical offices during my

practicum (although over the course of my research, construction was underway to build more office space), seven of which were used for counselors, psychiatrists, social workers, psychiatric residents and psychology practicum students; one was used by the psychiatric nurse, another one was used by the administrative assistant's office and the remaining two rooms were used mostly as group rooms/conference rooms. Each of the therapy offices used by full-time staff were decorated differently depending upon the therapist's taste, however the paint, furniture, and electronic equipment had not been updated in some time and the offices were all uniformly small. Offices used by trainees or part-time staff were shared and thus decorations were fairly minimal. One of the group rooms contained a long conference table and a white dry-erase board and was well lit by small windows around the perimeter of the room. The other group room looked as though it had been a kitchen at one time because it contained a sink and counter top in one corner but had been effectively transformed into a meeting space, equipped with several metal and vinyl chairs and a white dry-erase board on one wall. Various self-help workbooks and markers were stacked along the window sill.

The walls in the clinic were extremely thin, representing yet another semi-permeable boundary in the Center and as such, when walking from room to room in the Center, one could often over hear voices from other rooms. The material space of the Center, all of which I just mentioned, the cracked tiles, the worn decrepit couches, outdated office furniture, the chipped paint, and thin walls, reflected the clinic's position within the professional and social hierarchies. To Tom (P1), the director of the Center, these conditions were deplorable and offensive. He felt that the conditions of the clinic represented physical evidence of the medical center's dismissive attitude towards the

Center. He railed against the hypocrisy of a medical institution that touted “community values” but chose every year to ignore his requests for funding. During my interview with Tom, he questions “where’s the commitment?” when it comes to funding. He compares the funding that the Center received to those of other satellite clinics in the medical institution and raises concern about how the deteriorating conditions at the Center may impact clients experience as well. He states: “[clients] see, they go to [other clinics associated with university medical center] and then they come here and they look, it’s got a floor that’s all tore up, we got furniture’s a throw-back, it’s 60s stuff, and they’re going ‘whoa!’ some of ‘em even mentioned it, it was like...people even homeless people, it’s real interesting, um come in here and they still there is a sense about ‘em looking to see whether or not they’re welcome here” (Lines 329-337). In this particular excerpt, Tom suggests that part of the clients experience of mental health services or psychotherapy may be impacted by the very material space of a clinic as well as the experiences they have with people therein. He even goes so far to say that clients may not feel “welcome” in a space that appears to be neglected, as this type of neglect may be taken personally by those seeking services (feeling that they are not valued).

Despite Tom’s frustration regarding his sense of marginalization within the medical center, he as well as other clinicians could be seen finding ways to resist this marginalization, each from his or her own social and professional position. For example, Tom as director of the Center, reported “yelling” about the material conditions of the Center for “three years” and that he finally got the university medical center to agree to renovate. He also resisted what he felt was unfair distribution of funding through more covert actions. During one of our conversations Tom recounted an incident in which he

had helped a homeless client get a copy of his birth certificate so that he could apply for housing. He used the clinic's credit card to obtain the birth certificate and was reprimanded by the administration for using the card in this way. Tom said that he told them it was an emergency situation for the client but that they reprimanded him anyway and took it out of his pay check. In this instance, instead of appealing to change on an administrative level, Tom decided to take matters into his own hands, using his authority as director to redistribute resources.

Michael (P3) similarly agreed that the Center struggled with funding and “resources,” but he emphasized that these material issues seemed much less salient to him than they were to Tom (which is likely at least partially a function of Tom's position as director of the Center and Michael's relative distance from these issues as a non-administrator). Michael focused more on the metaphorical space of the clinic. He believed that the space took on a social function of being like a “home” to clients, many of whom felt they had a stake in the space as their own. He told me a story regarding his first experience at the Center whereby clients reminded him that this was “their clinic” and that as a new therapist there, he would have to integrate into *their* clinic. During the interview Michael explained: “When I first started here... and there was a woman that said,... ‘you know, this was our clinic long before you got here and it'll be our clinic long after you're gone’ and I said ‘okay.’ And then she said to me ‘it's nice to have you.’ Now what I took from that was, we're happy that you're here, but understand this is our house and right now you're a guest you know and 7 years later, I'd like to think that I'm a little bit more than a guest but I understood it. I wasn't offended by it. I completely understood it, I'm a stranger to them initially.” (Lines 213-224). In this excerpt, Michael

brings to life how some clients have an investment in the Center as a home-base and may even feel protective of this space. After recounting this narrative, he also shares that he credits the clinical staff's explicit efforts in creating a welcoming atmosphere of caring and acknowledgement for some clients' apparent investment in the Center.

The fact that some clients felt such a sense of investment in the Center bespeaks a collaborative rather than authoritative administrative style where clients also have a sense of shared responsibility for the functioning of the Center. Interestingly, I too experienced this feeling of being at home after only a short period of time working at the Center. Despite the rundown conditions, there was a sense of the staff and clients inhabiting the space in such a way so that it created a certain atmosphere of familiarity, of togetherness, and of safety. Tom struggled to describe this element of acknowledgement and welcoming in the Center and settled on the word "ambiance," although he did not seem quite satisfied with this description. The general ambiance of the Center, the psychological sense of home created therein, represents one of the ineffable qualities of therapy or healing provided by the Center. It also demonstrates how what is healing or therapeutic extends beyond the consulting room or specific therapy skills.

Discourse and practice

The landscape of the Center and the community is constituted not only by the physical space of the Center and surrounding community, but also by the way that people talk about the community, how staff and clients view themselves within this context, as well what is written about this community. I have so far alluded to the ways that staff and

clients talk about their community and the physical space of the Center, however, I have not yet addressed the larger sociocultural discourse regarding the Center and the multiple discourses - professional, economic, and personal - that shape practice at the Center. In this section I discuss how the way that people in general talk about the 8th district as well as the Center constructs them as particular kinds of places. I also discuss in more detail the process clients go through when coming to the Center, not only as a community center but as a mental health center, and the ways in which community, psychiatric, and business discourse interweave in the everyday practices at the Center.

Arriving at the Center one day early on in my research project I was greeted by one of the therapists at the reception area. This type of situation was not uncommon and one could often find everyone at the Center, including the director, putting in their time to fill in at the front desk for short staffing. Once I was “buzzed” through the door, I stopped by the front reception office and introduced myself to this therapist and explained my role as a researcher at the Center. We discussed what she perceived to be the clients’ experience of the clinic. She shared that she had worked at multiple sites throughout the medical university system and felt that clients from the 8th district preferred to come to the Center, not only because of its location, but because it was seen as a “Black clinic.” The therapist drew a distinction between “Black” and “White” clinics, stating that the working class African American families in the area felt more comfortable in “Black” clinics. The therapist was vague about what she meant by the term “Black clinic” and unfortunately I did not have a chance to talk in depth with her about her comments, given the many distractions present at the reception area. I was left to speculate as to what made this clinic a “black” space. My first thought was that the Center, unlike many psychology

clinics in which I had worked, was predominately staffed by self-identified African American therapists, which creates an environment within which, even just on the surface, clients of color may not immediately encounter the sense of difference that they might at majority “White clinics.” Secondly, the Center is set up in such a way that communicates an interest in and valuing of the local culture and community. By incorporating community interests into practice, the Center provides recognition and valuing of community identity and the impact of this specific location on residents lives. For example, staff involve themselves and clients in community organization meetings/events, including voting registration and city development planning. They also travel outside of the Center with clients to lunches and educational activities.

The Center’s association with the surrounding community and informal designation as “a Black clinic” may have significant implications in terms of its’ perceived accessibility to the community. For example, as the therapist I spoke with pointed out, some clients preferred to be seen at the Center versus other clinics within the same medical system because they felt more comfortable there. The Center’s alignment with the plight of the community and integration of local knowledge into healing practices creates a space where the social dimension of experience is recognized as important. On the other hand, the Center’s association with the 8th district and with public mental health also made it subject to the same type of social and economic marginalization that the community faced. For instance, Tom received a phone call one day from someone inquiring about services at the Center. When the woman discovered where the Center was located, she expressed apprehensions seeking services at the Center. Tom explained to her that she would be no less safe than she might be in any

other area of the city; however, the woman apparently did not believe him and declined to initiate services. Virtually all of the participants in this study commented on negative perceptions, such as those expressed by this woman, of the community and the Center. The 8th district is often perceived as an undesirable, poor, and/or dangerous place that ought to be avoided by many city residents. Sam (P4) suggested not only is the community viewed in such a way but community members are deemed to be the cause of such “urban problems,” rather than the victims of systematic racism and oppression. Michael (P3) touched upon this issue of the attribution of social problems by distinguishing between the “deserving” versus the “un-deserving” poor. According to Michael, “poor impoverished communities of color” are perceived as “undeserving” of assistance or “compassion” whereas more socially dominant communities receive more compassion. Michael clarifies that this type of thinking also applies to other groups such as gay men – for example, when HIV was “just a gay” problem, people remained relatively unconcerned, until the issues began to touch the lives of dominant groups, such as those of a heterosexual sexual orientation. The analogy here is important in that it reflects an important process that each participant highlighted, that is, the parallel process of marginalization that both the community and Center experienced. Tom described feeling like the 8th district as well as the Center were “outta sight, outta mind” when it came to the medical center’s attention. He went even further to say that “for lack of a better term, it’s like the scapegoat of the system” with administration brushing the needs of the Center off by saying “oh that’s just the 8th district” (Lines 356-357). The feeling of being “outta sight, outta mind” was echoed in my impressions of the surrounding landscape of the community as well as Theresa’s experience of having to travel through

the “worst roads in the city” to get to work. It is interesting that the Center’s strong alignment with community concerns may have served to build stronger community ties and improve cultural sensitivity, however, such practices may have also in some ways alienated the Center from the rest of the medical center.

As I have begun to demonstrate, the Center is situated within a particular constellation of discourses, some of which are more explicitly related to social position, context, and community and others which are more specifically related to clinical practice at the Center. It is where these discourses intersect to produce what I understand to constitute practice at the Center. One particular aspect of the discursive framework of the Center involves the physical space of the Center, the landscape of the community, as well as how people talk, write, and otherwise communicate regarding the Center and the community. We have so far seen how staff are situated within and take up various ways of describing the social dimension of their practice, however, we have not yet discussed the professional and clinical discourses which are also threaded throughout practice at the Center.

Various threads of psychological/psychiatric/sociopolitical discourse are interwoven into practice at the Center however, because the Center continues to be financially sustained by a university medical center, traditional psychiatric thinking and discourse have a dominant presence in many of the practices at the Center. To begin with, despite the predominant community orientation at the Center, certain clinical practices demonstrate the equally strong presence of psychiatric traditions within the Center. For instance, when initiating services, a client (or patient as they are sometimes called) would be scheduled for what is called a “psychiatric evaluation.” When the client comes in for

this scheduled appointment the evaluating clinician would fill out a series of forms with him or her, which includes the following information: demographics, referral source, other members of the client's household, emergency contact, insurance, level of income, history of state hospitalization, and "type of income" which includes government aid. Clients also have to sign an affidavit verifying their level of and source of income (e.g. SSI, welfare). At this first appointment the client would be interviewed regarding their reason for referral to the Center or their own personal interest in seeking psychological/psychiatric services. In addition a psychosocial history including psychopathological symptoms, family history, experiences of trauma, medical conditions, and past treatment would be assessed. Similar intake interviews take place across most clinical settings, but it is noteworthy that this same fairly traditional psychiatric interviewing process would still appear at the Center. Clinicians utilize interviewing templates created by the medical center and that rely on the language of Diagnostic and Statistic Manual of Mental Disorders (DSM). The forms provide a space to describe clients' "presenting illness" and to code this illness according to DSM codes. The use of formal documents created by the medical center bespeaks the Center's continued dependence on this structure and at least partial participation in medicalized (individualized) understandings of distress. However, although I clearly perceived an interesting tension between psychiatric and community oriented language and interventions, this tension did not seem to be as salient to clinicians, at least on a theoretical level. For instance, although I had intended to elicit conversation regarding what I perceived to be the use of multiple theoretical models (e.g. medical vs. contextual) and how staff reconciled those differences in practice, when I asked participants to

comment on this issue, most focused more upon the material/political relationship with the medical institution. During my interview with Michael, he mentioned the ways in which he strongly believed that the Center must not conceptualize the person coming in “as a problem” but rather see them as a person who is struggling “with problems” and within a social context that in some ways creates those problems. At other points during our conversation he also spoke in the language of symptom management and medication compliance which communicates a different understanding of client’s distress. Michael’s ability to switch rather seamlessly between psychiatric and community/social discourses suggests that perhaps staff were often not explicitly concerned with the philosophical or conceptual roots of their treatment model but rather approached their work more pragmatically, from a social justice orientation. According to this social justice model, it is possible that a biological or illness model of distress could be utilized without issue because it would enable the client a certain recognition (via diagnosis) and access to services (e.g. via insurance reimbursement).

In addition to more explicitly medicalized or psychiatric models of care, the Center staff also drew from a number of other discourses, including the addiction/recovery movement and humanistic traditions. Sam (P4) spoke most about the recovery movement which actually is associated with a current trend in psychiatry. The recovery movement focuses on the person’s strengths and ability for resilience in the face of psychological disorder and life adversities. The movement represents an important shift from conceptualizing the individual as a patient who is sick, to an agentic individual who has some choice as to the future direction of his or her life. On the other hand, because the movement is still couched within the field of psychiatry, biological models of

understanding are still dominant and medication is still the default treatment of choice (even if psychiatrists who are involved in the recovery movement might be more likely to intervene in more socially oriented ways as well). Michael highlighted the ways in which humanism infiltrates his clinic work when he talked extensively about “respect” and treating a person “with dignity” and the kind mutually collaborative relationship that he sets out to have with his clients.

The various discourses that shape clinical practice at the Center underlie the multiple treatment modalities available at the Center - individual psychotherapy, group counseling, advocacy/community groups, not to mention, of course, psychiatric treatment. For example, from a community perspective it is important to offer various groups, including both psychotherapy groups and community advocacy groups and thus a variety of such groups are offered at the Center (e.g. anger management, drug and alcohol, women’s wellness, client advocacy, community improvement). To the extent that clinicians still relied on biological/illness models of distress, the prescription of psychiatric medications was also offered.

Last, clinical practice at the Center is always operating within a particular economic climate influenced by both the culture of insurance companies as well as the concern for productivity. Clinicians felt pressure to assign formal DSM diagnoses to clients, even when none were appropriate in order to assure that clients could have their care taken care of through insurance companies. The discourse of market theory was evident in conversations with the director who concerned himself with “productivity” – a business term that has infiltrated mental health services. Gradually, over the past several decades, human service organizations such as mental health centers have been impacted

by pressure to be “productive” in business terms in order to maintain reimbursement. Tom’s comment about his “outrageous” caseload of over one-hundred people, and his slight embarrassment when recounting this number suggests some conflict between “productivity” up (which translates to providing services to as many people as possible within a given business day) and his value on high levels of client care (which to Tom included significant engagement with clients and taking the time to get to know them).

Across Interview Analysis

In order to zero in more on how staff described their clinical work during interviews and distill their comments to a more concise format, I conducted an across interview analysis of the narrative themes that emerged with regularity across all interviews. In so far as my participant-observations helped to guide interview questions they are included implicitly in this section, however they will not be explicitly highlighted.

Reflecting upon what it means to practice psychology at the Center, various issues arose with regularity. Clinicians were concerned with what they saw as needs, interests, concerns, of the surrounding community which included issues of: social marginalization, social class, race, community trauma, emotional/psychological distress, and cultural identity/identifications. I analyzed the interviews to highlight how these issues were understood by clinicians and found that clinicians often understood these problems in contextualized ways, with particular attention to local understandings, and they also understood these issues in relational terms (both including the “self” of therapist and others in the client’s life). Clinicians also included an awareness of power and privilege

and the intrapsychic impact of oppression on clients. By virtue of these understandings, clinicians strove to enact this understanding through particular interventions such as: working collaboratively with clients, awareness of self in relationship to the client and use of self, acknowledgment and recognition, and fostering agency/empowerment. The main clinical issues, conceptual understanding of these issues, and interventions are presented below according to how much they were emphasized across interviews. In this section I focus much more heavily on interview analysis, how participants described their work with minimal reference to my participant-observations, however, I did integrate these observations more in the next chapter (chapter 5).

Community trauma

When looking across interviews, one theme that particularly stood out revolved around the idea of “community trauma.” All of the participants mentioned trauma as a prevalent issue which staff spent much time considering and attempting to address through their practice. The issue of trauma, whether conceptualized in the traditional sense or according to a community conceptualization was the most commonly repeated theme throughout each interview. Several of the **staff suggested that they that actually interpret various aspects of client’s experience and behavior as symptomatic of community trauma:**

One of the things they’ve been talking about here is a whole conceptualization of whether or not we’re just talking about a post-trauma person...or maybe we’re talking about a traumatized community (P2)

Our entire community is suffering from PTSD (P1)

People lose their homes, they lose their identity, and that really is a form of trauma – a historical trauma (P3)

This is an area that's under trauma and what looks like, is there a certain kind of trauma that people are subject to, you know, violence and scratching at our survival is a way of life so uncommon to the majority culture (P2)

It was clear that staff saw the surrounding community and clients who participate in services at the Center as suffering from significant trauma across multiple dimensions of their lives. Thus staff considered such trauma across these multiple dimensions. Staff even went beyond the recognition that clients may have shared many similar traumatic experiences in a solely linear and material manner to pointing out a less direct causal relationship, suggesting the existence of an “historical” trauma that gets passed down through generations within communities or cultures. In this way symptoms typically related to trauma may be inherited (in a cultural sense, of course and not necessarily in the biological sense). The idea of community trauma seems a more collectivistic way of conceptualizing experience, a way of understanding what might be labeled “disorder” as a culturally shared wounding which may manifest in the form of certain behaviors (e.g. hypervigilance, substance abuse, difficulty with emotional regulation) rather than as an individual pathology. Yet, on a few occasions, staff also questioned whether there could be such a thing as “community trauma” which conceptualizes the impact of trauma as a shared social experience – almost as if their understanding is not validated or articulated by their profession such that its reality or “truth” becomes questioned.

Interestingly, and perhaps related to the last comment above, although trauma may be understood as a community dilemma, cultural norms may prevent the experience of the impact of this trauma from being acknowledged and shared. Thus according to staff members, Tom in particular, individual clients are viewed as suffering alone with the impact of social and historical trauma as well as familial trauma (e.g. abuse). Tom

suggested that a cultural imperative in many African American communities “not to speak” about personal problems outside of the home has prevented many individuals from within this community from gaining support and healing from such traumas.

A third dimension in which staff considered trauma was at the existential level – not just historical shared trauma passed down through generations, or the more general impact of racism, or classism, but the daily experience of “scratching at one’s survival” that Theresa mentions. This idea is repeated by Sam in a later interview when he discusses the way in which African American and Native American communities have been “systemically oppressed,” which he sees as distinct from the “serious poverty” found elsewhere in the world - the “systematic” way in which certain groups, like African Americans and Native Americans, are forced into poverty within a context of relative wealth in the U.S. distinguishes it from other groups where presumably the circumstance of a singular historical or natural event like war or natural disaster, or effort, or immigration, or some such “accidental” or “personal” factors are the reasons for their economic predicament.

Another central narrative theme revolved around the psychological impact of social oppression/marginalization and **the way that staff considered the intrapsychic impact of oppression/marginalized identities**

*We understand that you [clients] are locked out of the American dream (P3)
There’s actually no way to explain to a person who’s not of color how much being of color defines your encounter with the world. (P2)*

The most important perception of who you are is not society’s perception but your own perception...that’s something that has to be developed because when it’s been crushed it’s a tremendous challenge (P3)

People start to believe [regarding politics] it’s not gonna apply to me, how could I make a difference (P1)

There’s no one who’s been more disenfranchised than African Americans (P3)

There's a sense of being of two nations, because we're not Africans, we're not 100% most of us are not 100% African, so what happens is we're like a people afloat (P2)

There are many places where you find serious poverty, like I said, it's not just a matter of being poor so there's many other places where you find serious poverty but the Native American population um, and the African American population has been systematically oppressed by every level of American life to very present day so I think that's atrocious (P4)

It is an “unspeakable” impact, and an existential experience that cannot be put in words, especially not to someone that does not share or otherwise is able to access that experience. Put another way, this intrapsychic experience of oppression and marginalization can only find some understanding resonance in an interpersonal relation with another psyche that can access a similar experience. Moreover, this sense of the “unspeakable” is exacerbated by a clear sense that whom one is, is not whom one “really” is, or wants to be – that is, that one struggles all the time against an image of whom one is, and while for other people it may come “naturally” as a simple sense of self, for oppressed groups it's something to be “developed,” it's a “challenge,” and a debilitating struggle to continually enfranchise oneself, one's psyche, as it were in the face of a systematic and sophisticated oppressive disenfranchisement of both the material and the psychological, or at the level of the material that comes to bear on the psychological.

This conceptualization of “psychological distress” in social terms, also comes to bear on the staff's understanding of **the social construction/function of poverty and racial discrimination and its impact on their community:**

...You know we have something in this country called the deserving poor and the undeserving poor...often in a poor impoverished community of color, you have a lot of undeserving poor – that's the perception but you take similar folks in similar situations and somehow there's a little bit more compassion (P3)

Certain behaviors are attached to certain communities and locations are a critical part of that, so you have that coming at you all the time (P2)

What is the psychodynamics? Do we have a need to have places that we can point to and say, well, we're the good people but not those people there – oh we're safe (P2)

We kinda unconsciously and sometimes consciously value certain life over other life (P3)

The worst road, the ice, the snow, salt and everything stops at the top of the hill...it must say so much to the people who live here (P2)

I really feel there has been a systematic process of establishing, creating and maintaining the kind of distress and disorder that people see as “urban problems” – the problems of the African American community the problems of the poor, etc. (P4)

Staff were not only concerned with the way that being marginalized and stereotyped might impact individuals living within that community psychologically, that is the “psychic” impact of poverty – they were also concerned with understanding the psychology of social oppression itself – the function it serves in a social system. For example, when Theresa asks about the “psychodynamics” of stereotyping poor communities or when Michael says we “unconsciously value certain life over others” – both are alluding to some deeper psychological function of marginalization of certain communities of people. Theresa specifically offers the hypothesis that it may be that people feel they are “safe” if they are able to identify and designate certain communities or people as being the dangerous, violent, untrustworthy, (fill in negative disowned quality) people. In essence, it is about being able to protect an identity as the “good people” and disowning and projecting those aforementioned negative qualities onto those designated as “other.”

Clinicians’ understandings of trauma as a collective experience, one which is fundamentally social in nature, appeared to inform their choice of specific

interventions/practices. For example, the interest in creating a familial/group/community atmosphere at the Center could be seen as a way for community members to experience a sense of safety and cohesiveness that may be missing from their experience of their community outside of the Center. Or, it may be a way of replicating or extending within the Center a sense of community that is operative outside the Center, undaunted by (or perhaps as bulwark against) a stressful and challenging reality. In either case, communities such as the 8th district that have experienced significant marginalization and fragmentation, may benefit from having a safe place within which community connections are fostered and/or further developed in the community outside of the Center. Staff members thus made sure to create an environment within which clients could come to connect with each other as well as with therapists. I often observed therapists making it a point to engage incoming community members in casual conversations when they could, and remember details about their lives so as to communicate caring and friendliness. As a new therapist and researcher, I was encouraged to engage clients on this level as well, and was often invited to luncheons or picnics during which I got to know clients, and they me, in a more casual way. It is my understanding that such practices were not just “for fun” but rather were born from the strong intention to provide a space of community healing, to help forge a more positive, cohesive, and meaningful community identity and assuming that this was a possibility if the appropriate space and opportunities were to be provided.

Contextualized treatment model

Consistent with staff members' focus on the social underpinnings of psychological issues, many of them also described ascribing to a psychological **practice model that was non-traditional, contextualized and non-hierarchical:**

I think this is a very unique clinic you can get some examples in terms of how the clinic is made up, in terms of the community etc., but I think that this is probably one of the few truly community based mental health facilities in the city (P3)

We needed to fix traditional ways of looking at things...involve the clients, and empowering them and saying – what do you need? Would you like to belong to this? What do you think about this?(P1)

I can't help you [clients] using a standard that historically has been negative for you, then it means I'm doing you an injustice (P3)

We try to provide cohesive services within the community (P3)

We don't see the person as being faulty, we see their conditions as being faulty (P3)

From a strength-based perspective, a holistic approach, we don't see them as a problem, we see them as a solution (P3)

We have to incorporate everything as much as we can" (P1)

It's not just about how you feel, but it's about dealing with obstacles in your way, because you can feel wonderful but run into obstacles every five seconds" (P3)

I do not uh agree with the view that says this is simply a matter of people being poor or simply a matter of people being uneducated or simply a matter of people not wanting to do better for themselves so I really feel that there is a systemic problem here and in order to understand it you have to have that kind of historical and social political position – that's my position on it (P4)

One staff member in particular, Michael, pointed out that not only do psychologists need to be cognizant of the psychological impact of oppression and attempt to be aware of their own biases, etc., but psychologists also need to think about how certain models of care or treatment models may, at base, be oppressive in and of themselves. Michael's statement implies that one cannot simply tack cultural awareness onto a model of care that has "historically been negative" for a group of people; rather the model itself may need to be revamped, or rebuilt from the ground up.

The revamped, more “contextualized,” model of care (not something entirely new but one that is at the crux of community psychological models) includes several features or characteristics. A contextualized, community based model that addresses the experiences of marginalized communities includes a shift in conceptualization and also actual practice/behavior of clinicians. Thus staff described specific ways that they conceptualized problems according to a contextualized model and also the interventions that would follow.

First, virtually all of the participants described the social way in which they understood clients’ presenting concerns - in essence they seemed to **understand emotional distress or problematic behavior as a function of systemic problems:**

Because someone’s a little louder, doesn’t mean they’re gonna get violent you know, because...someone may appear to have an attitude, you don’t know what just happened to them, maybe they should have an attitude” (P3)

I see work within the African American community as a response to racism and social injustice and the human cost of that so I really feel there has been a systematic process of establishing creating and maintaining the...sort of distress and disorder that people see as ‘urban problems’ the problems of the African American community the problems of the poor, etc. (P4)

So I do not uh agree with the view that says this is simply a matter of people being poor or simply a matter of people being uneducated or simply a matter of people not wanting to do better for themselves so I really feel that there is a systemic problem here and in order to understand it you have to have that kind of historical and social political position – that’s my position on it (P4)

The community psychiatry outlook is for me okay, basically an issue of social justice and all these other problems around the structural problems the historical forces that kind of create and perpetuate a social injustice, it’s not just about being humane and nice (P4)

Based on my experience at the Center, staff’s concern for the intrapsychic impact of oppression was most evident in their careful considerations of case conceptualization (interpretation of client’s distress and behavior) and subsequent interventions. Although staff might feel compelled to diagnose according to psychiatric standards (DSM) as was

discussed earlier, they still struggled to find a way to balance this medical understanding with something more community oriented. One of the ways in which this was done was by frequently returning back to basic assumptions regarding the experiences of marginalized/oppressed groups – that is their symptoms/behavior must be interpreted in light of the struggles, which are often unvoiced or unarticulated of living under such conditions. For example, clinicians could be found responding to clients who were visibly upset and might be described in typical clinical settings as “acting out” and/or as dangerous, by giving them the benefit of the doubt and assuming that there was something for them to be legitimately angry about. Approaching these clients with an attitude of curiosity (albeit within strong boundaries to be sure to protect themselves and others around) did not necessarily preclude the necessity to sometimes hospitalize certain individuals, however, it did at times have the effect of diffusing the situation and calming the individual. Assuming that the client’s perspective and behavior is legitimate, according to his/her own point of reference (even if this does not match with what most others around them perceive at the time) is not only a skill inherent to culturally sensitive practice, but to any kind of empathic connection with another person.

Another important element of this model, as identified by several staff members, revolves around **acknowledgement and openness to the other:**

Setting up when people come through the door, the acknowledgement, a sense of acknowledgment, that’s one thing we really work hard about...we acknowledge that people are here because often enough people here are disenfranchised and they’re sensitive to how they’re being treated, or mistreated” (P1)

You speak to people like they’re valued as people, it makes a difference, those are things that we practice” (P3)

We respect them, they respect us, you treat people with dignity and humanity at all times, you don’t stereotype people, because somebody is different than you doesn’t mean they’re a bad person (P3)

You choose to treat someone like a human being and with dignity and respect and often you'd be amazed at how people don't get that in any area of their life (P3) part of it is nuts and bolts basics of being a decent person beyond any skill professionally [I: Mhm] so just by brining your humanity your concern your caringness to people with an interest in doing the right thing by what's best for them – um I think by best for them means what's best for them in terms of what they think is best for them (P4)

This openness encapsulates a sensibility about addressing the fundamental struggles with which clients are struggling (e.g. lack of acknowledgement, marginalization) and this sensibility motivates the way in which therapists interact with clients. For example, Michael mentions how important it is for clients to feel like the Center is “their home” and that they have a say in how things operate there. Tom also mentioned the importance of the “ambiance,” of creating an atmosphere of welcome and safety. I often observed staff greeting clients in a casual tone, sometimes even joking with them or asking about family members. Staff might take a moment to introduce themselves to a new person in the community area of the waiting room or to acknowledge someone else’s ongoing client.

A second important feature of this contextualized community model has to do with collaboration and several staff members mentioned the specific way that they acknowledged and worked with the inherent power differential in the therapist/client relationship. During the interviews, participants spoke of **seeing themselves as collaborators rather than authority figures (this also involves collaboration with other professionals as well):**

*I'm responsible to a certain extent and the client is responsible to a certain extent and the nature of your relationship will really entail how it plays out (P3)
We try to make people feel comfortable with the idea that this is their clinic, this is their home, we are here to serve you (P3)*

*It doesn't mean there won't be times in the relationship when there are disagreements, but a good therapeutic relationship you talk about that (P3)
One of the things we really instill is the fact that there's not a right way or wrong way to feel. You feel how you feel. We accept you where you are, that's the key (P1)*

Sometimes people will say things and I consider myself to be pretty hip but sometimes you'll get a younger clientele and they'll use words and I'll think to myself, can you tell me what that means?...I'm not afraid [to ask] and you can't be afraid to put yourself out there like that and say help me to help you, help me to better understand you (P3)

We try to understand from their vantage what the problem is, from their vantage what is important, from their vantage, what are the obstacles to life looking more like they would like it to look and then we go to work (P4)

Find ways to um, engage connect with and support the many provider agencies...who share this concern... getting a sense of what their lives are like and getting a sense of the way they do their work, and um engaging them we are now doing this in the process of changing attitudes, changing practice, generating new ideas, generating support, um, commitment, collaboration (P4)

Collaboration was central to clinicians at the Center, not only in their work with clients, but also with each other. This was evident in their interactions with clients, by eliciting client feedback regarding their therapy services and generally engaging clients as active participants in their own process of healing. In my own experience as a practicum student at the Center, I was often struck by the casualness with which the director might engage me, or the way in which he seemed to level any appeal I might have to his authority by making a joke or otherwise making the interaction seem less formal. As a practicum student, I appreciated his style of interaction because it gave me a sense that we could work together side-by-side, despite the fact that he was essentially my supervisor and had much more clinical experience than I did. It gave me a sense of safety in expressing my clinical opinion or concerns without fear that they would be rejected based on my (lack of) status. Based on my observations of how clients interacted with staff, sometimes in a joking or casual manner (although also still respectful) I

imagined that perhaps they too experienced a sense of safety or comfort in expressing their voice when staff members engaged them in this collaborative manner.

Culture

Of course the theme of culture cannot be separated out from the aforementioned themes.

Cultural considerations are a part of every aspect of treatment from conceptualization of trauma to implementation of a more general community model. At the same time, the specific ways that staff addressed the issue of cultural sensitivity in practice deserves to be considered as its own theme. Staff did not necessarily agree with each other or with themselves for that matter as to how to understand cultural consideration in psychological practice but **staff generally conceptualized culture as something that is both inextricable from, yet simultaneously separate from, identity and experience:**

We're multifaceted complex individuals (P1)

What we want to do often is to paint race and class with a broad brush and incorporate everybody as an integral part of that, your this race or this culture or socioeconomic so everybody gets that and I think that's a BIG mistake that everybody makes because everyone's different of course...we may be alike on one perspective or two perspectives but we still have different things that's unique to us (P1)

The challenge often is getting people to understand that yeah, we're the same because it's mental health treatment, but we're also different (P3)

Race and class is not everything, but it's an integral part of who we are (P1)

I'm a Black man but I don't see myself as a Black therapist (P3)

we see individuals who are white here and of other cultures and I approach it in the same way in terms of the same mindset – the person is the strength – now the problems may present differently now that's where the interventions might be different but my mindset is strength, strength, strength, strength... (P3)

There is some things that are culturally specific, but I believe that strength-based perceptive, the holistic approach is good treatment across the board (P3)

If you're a good therapist you can help anyone (P3)

*There's like an internal part of the clinical work okay, when you have people dealing with their own race and cultural identifiers, whatever they are especially here...that means working through the emotionality and psychology of that and creating working environments in which that reality is kind of part of the work and that is part of the understanding that it is safe and valued to dig into it (P4)
We're all [the staff] part of a process which is extraordinarily healthy and open about. dealing what it means to be who and what we are (P4)*

Staff both highly value the integral role that social identifications (race, gender, class) play in a person's experience, yet also strongly resist stereotypic or overgeneralizing identity recourse when it comes to understanding various cultural groups. Participants call for a consideration of both the specific and the general, the universal and the local, but various participants emphasize different aspects at different points even within an interview and those tensions are left unresolved. The issue of culture is left as a "both/and" idea which participants allowed to remain unresolved.

Many of the staff also made specific reference to their own cultural backgrounds and **personal experiences of oppression/marginalization which then served to inform & motivate clinical work:**

I'm very passionate about my work here because I understand the ramifications of not having certain things and the consequences of being locked out (P3)

The level of care that these people are receiving is not because the institution is supporting it, it's because African Americans with a high level of training are sacrificing to be with them (P2)

I wanted to work with an underserved population, I wanted to work with people of color, African Americans...obviously I'm African American, so that's gonna be near and dear to my heart (P3)

The same issues of racism and exploitations, we all know because we're living it, we're giving the highest quality of care because we're living it! (P2)

I see myself as somebody who carries the fire - so I was raised in a Jewish home and the European holocaust was a formative experience of my childhood and I grew up very frightened and uh, very limited very unsure of myself and [2] um, so I feel like I've been tuned into where the atrocities are being committed (P4)

We talk about ourselves where we are and where we come from and also how this all plays out with the work with our patients/clients (P4)

Participants' descriptions of their own experiences were intertwined with their understandings of and reactions to work with clients. In fact, participants tended to emphasize how their own backgrounds, be they cultural, religious, racial, gendered, etc. not only influenced but also grounded, perhaps even motivated their clinical work. Clinicians at the Center included themselves in any analysis of culture rather than focusing solely on the background of the client. This process of self-reflection was in some ways seamlessly interwoven into their interventions with clients, however, as Sam (P4) pointed out, they also took time to process identity issues more explicitly with each other during meetings. This theme of how personal identity and identifications were integrated into clinical work is illustrated with an example from my participant-observations in Chapter 5.

CHAPTER 5: DISCUSSION

“There are those who choose the swampy lowlands. They deliberately involve themselves in messy but crucially important problems ... when asked to describe their methods of inquiry, they speak of experience, trial and error, intuition, and muddling through” (Schön, 1983, p. 43)

In this dissertation I set out to explore what it means to practice community psychology in an inner city community mental health setting (“the Center”). However, I was not only interested in exploring potential answers to this question but also in developing a methodology that could adequately address the complex issues of culture and power implicit within this research question. Through the use of contemporary ethnographic methods, influenced by post-modern and interpretive theory, I was able to gather rich data that touched upon the complexity of practice in this setting. My analysis confirmed some past studies (for example Bloor et al., 1988; Gubrium, 1992; Phillips, 2005) which demonstrated that psychologists (especially in more community oriented centers) are embedded within complex contexts and draw upon multiple discursive frameworks in their practice. The main principles of community psychology (e.g. contextualization, power, and collaboration) represented a primary organizing discourse at the Center and these principles were enacted in culturally specific ways in accordance with the values, needs, and interests of the surrounding community. Given that a crucial element of implementing community psychology theory consists of adapting community principles to a particular cultural milieu (in this case an inner city, largely African American community) my analysis focused on the issues that were most salient to this

particular community practice. Also, because the issue of context was so central to this practice, my analysis included an examination of the community context: history, physical space/location, and current social climate. Results based on this study suggested that such contextual issues are inextricably linked to practice at the Center and have a “voice” all of their own that can, as one participant suggested, “speak volumes” about the community and the nature of community practice. At the same time, other discourses, such as the discourses of psychiatry and market theory also shape practice at the Center and thus the issue of tensions among discourses will be addressed in this discussion section.

My theoretical foundation for this study drew from ethnographic/anthropological theorists, such as Geertz (1973) and Shweder (1991), and post-modern thinkers such as Foucault (1978) and Butler (1997; 1993; 1990) and thus I used this theory as a lens through which I understood my data. According to Geertz (1973), culture is an intersubjective phenomenon, existing between persons, rather than a static entity that exists external to individuals. He suggests that culture exists in the use of signs and symbols that makes experience intelligible through “webs of signification (p.5). Shweder (1991) too has argued for the intersubjective nature of culture, but he also brings in more explicitly the psychological or intrapsychic dimension. “Culture” as Shweder defines it, would not exist without psychic processes, and psychic processes are similarly constituted by culture. Although I started this project imagining that these theories of culture would help me to understand more about how *clients* are interwoven into social contexts and how psychologists might usefully consider those contexts from this intersubjective perspective, I began to conceptualize the culture of practice itself in this

way. According to Smith (2005), when trying to understand how to improve psychological services for a greater diversity of peoples, it is important to consider the climate or the “culture” of the practitioner’s office. As such, I understood practice at the Center to represent a culture comprised of certain actions, rules, rituals, discourses, values, interests, and mythologies that were sustained in dynamic fashion through interactions between and among both practitioners and clients.

From a Foucaultian (1978) perspective, one cannot address culture, as it is understood from this discursive perspective, without also addressing issues of power. According to Foucault, knowledge, power, and discourse are inextricably linked and these intersections sustain and are sustained by institutions and institutional practices, including psychology. To Foucault “knowledge” represents a particular common sense view of the world that prevails in a culture at a given time, and “discourse” refers to a set of meanings, images, metaphors, stories, that together produce that particular version of events. It is discourse that defines and produces the objects of our knowledge and frames how we define or represent reality. Power, as understood by Foucault, is an effect of discourse and in the instance of psychology/psychiatry, scientific rhetoric and discourse puts the psychologist/psychiatrist in a relatively powerful position relative to those seeking mental health care services. However, Foucault does not profess a customary view of power whereby one person or group “has” the power whereas others do not. Instead, he adopts a more complex view of power, believing that power represents a matrix of relations which exists everywhere and “comes from everywhere” and as such, clinicians and clients alike are caught up in power relations that supersede their individual situation (Foucault, 1978, p.93). Although from this perspective

psychologists/psychiatrists would have greater access to discourse and “truth claims” about their clients (and thus to power), Foucault also suggests that there are always a number of alternative ways in which events can be construed which leaves room for the rejection/refusal of dominant discourses. These points of resistance are an integral part of the power matrices that Foucault describes. In my analysis, I used Foucaultian theory to highlight the ways in which clinicians at the Center and clients are caught up in (and resist) these discursive frameworks within which power is shifting and fluid.

These theoretical influences served as lens through which I interpreted my data, helping me to pick out certain themes or urging me to pay attention to the intermingling of discursive/cultural contexts and psyche. However, in Chapter 4 where I formally analyzed the data, I did not incorporate specific concepts from these theories, preferring instead to use more of my own language to describe and analyze the data. In chapter 4 my data analysis was structured around identifying themes in the data that addressed my research questions: What comprises practice at this Center? What is the trajectory of community psychology principles in this setting? And what are the specific nuances, tensions, challenges present in practice at the Center? In this chapter (chapter 5), I dialogue my analysis more explicitly with relevant theory.

Based on my data interpretation, I found that psychological practice at the Center occurred within a vastly complicated array of sociocultural and discursive contexts. Psychologists at the Center drew from both discourses of the profession, such as the rules, vocabulary and mythology of psychology/psychiatry, as well as from the local understandings, rules, and language of the community. Using the metaphor of narratives (or discourses) to understand these different traditions, one could say that psychological

practice at the Center represented an interplay of the meta-narratives of psychology/psychiatry and as well as the local narratives of the surrounding culture of the 8th district. The dialectic between professional and local understandings and language is at the crux of clinical practice at the Center, and understanding better how this process happens has the potential to illuminate the nuances and challenges of culturally sensitive care with marginalized populations. It is especially important to explore this process when working with marginalized and often particularly vulnerable communities in order to improve our ability to not only “adequately serve the needs” of these communities but also how we may continue to allow our professional understandings to be shaped by local values, customs, knowledge, etc.

In the following discussion I explicate the perpetual dialogue, between local and professional discourses present in psychological practice at the Center, a task accomplished first by discussing practice at the Center in light of past research on community mental health services and community psychology principles/theory. I will examine the trajectory of community psychology principles such as contextualization, power, and collaboration within the context of this particular Center. I will also include a discussion of how data from the current study comes to bear on previous discussions within multicultural psychology (as was reviewed in chapter 1). In addition, I will integrate other relevant theory into this discussion (e.g. Foucault, 1972, 1978, 1982; Geertz, 1973, 1983; Shweder, 1991). I then suggest a synthesis between previous empirical studies, regarding community practice, data gleaned from this study, and post-modern theories of culture, identity, and power.

Second, in order to explore some of my sub-questions regarding how staff were constellated within particular discursive and cultural contexts, I proceed to examine the particular ways in which staff were “caught” within these systems, how they dealt with it, and in what ways such constellations did in fact limit, constrain, or disrupt practice. Butler (1997b) discusses a central tension inherent in identity formation regarding our “fundamental dependency on a discourse we never chose, but that, paradoxically, initiates and sustains our agency” (1997b, p.2). I discuss the various ways in which I perceive Center staff and the practice itself to be caught in this dilemma of identity. Although practice at the Center (or probably in any clinical setting) is enormously complex and multifaceted, I have chosen to highlight that which stood out as most salient to me in my practice there, to my participants in interviews, and in my participant-observations.

In the third and final part of my discussion I address some of the limitations of the current research and potential ways in which this research can contribute to the field of psychology. I also suggest some ideas for future research regarding this topic.

A Response to the Research: Exploring the Practice of Community Psychology

Past research has documented a “gap” in mental health care services when it comes to marginalized communities (Atkinson, Morten & Sue, 1998; Chow, Jaffee & Snowden, Stevenson, 2001; 2003; Snowden 2005). In this study, I have focused on the practice of psychology in one particular community mental health center that serves a lower income or “underserved” population as a way to gain insight into how psychologists are trying to address this “gap” in services. It has been suggested that

perhaps psychology, as it is conventionally understood and practiced, may not adequately address the needs of non-dominant groups. That is, when issues of social position, power, and culture are central to the experiences/suffering of certain communities, psychology's individualistic (or focus on very small interpersonal contexts) may be a poor fit (in its' tendency to exclude issues of power/privilege). In my literature review I argued that, at least from a theoretical standpoint, community psychology - with its focus on social context and power - might offer guidance as to how psychologists could improve psychological services for those groups typically left "underserved" by psychologists. Despite the fact that psychologists at the Center rarely identified what they were doing as "community psychology," their descriptions of their work and their actions reflected virtually all of the main tenets of community psychology.

Pushing the boundaries between community and clinic: Contextualizing care

Several previous studies have documented the contextualized nature of community mental health care (Newberry, 2005; Phillips, 2005; Wynaden et al, 2005) which is perhaps not surprising given that contextualization is one of the organizing principles of community psychology. However, much less literature has focused on what the context of care looks like when it comes to psychological practice and how psychologists working within this a community model conceptualize their work. Based on my data analysis I found that the process of contextualization, similar to what Schön (1983) has observed, involved a process of "muddling through" various issues, discourses, and constraints in their everyday activities (Schon, 1983, p.43). Yet, despite

the fact that clinicians at the Center were often in the position of managing enormous amounts of information and forced to “think on their feet” this is not to say that their clinical work was completely ad hoc or without some underlying conceptual framework. Quite to the contrary, staff operated from a model that strongly (although at times implicitly) understood context as a central component of psychological care. Given the particular history of the 8th district, clinicians at the Center were especially concerned with issues surrounding race, class, and power. This emphasis on context also speaks to the importance staff placed on the sense of self-in-community discussed by Sarason (1974) and revisited by other theorists such as Fisher, Sonn & Bishop (2000) and Swenson(2006). Not only did staff place emphasis on client’s sense of self-in-community, but they also emphasized their own engagement as community members. For example, staff often met with each other, sometimes including clients, for various gathering, luncheons, picnics, outings that helped to foster group cohesiveness and community between staff and between staff and clients. Once the Center sponsored a holiday party during which one staff member in particular shared a favorite story of his with the group (which included both staff and clients). Staff were also politically engaged in groups and organizations outside of the Center which also bespoke their sense of connectedness to the community.

Participants understood both clinician and therapist as embedded within historical, social, political, and personal contexts. Community experiences of fragmentation, marginalization and individual psychological experiences were assumed to be intertwined and co-constitutive. According to this conceptualization, a central task of the Center’s practice revolved around addressing social marginalization and/or the intrapsychic impact

of this marginalization. When experience is conceptualized in this collective way, healing of the individual psyche is seen to require a mending of the communal fabric (the social) which makes up this psychic experience as well as attending to individual psychology. The participants' conceptualization of the relationship between individual psychology and community conditions resonates with Shweder's (1991) ideas about the interdependence of psyche or subjectivity and the sociocultural environment. According to Shweder (1991): "on the one hand, no sociocultural environment exists or has identity independently of the way human beings seize meanings and resources from it, while, on the other hand, every human being's subjectivity and mental life are altered through the process of seizing meanings and resources from some sociocultural environment and using them" (p. 74). Shweder purports that what we think of as culture and as psyche cannot be understood separate from one another. Despite the fact that none of the participants stated that they had any familiarity with Shweder's ideas, practice at the Center reflects what a psychological practice based on some of Shweder's ideas might look like. However, practitioners' attempts to work from a socially oriented model within the context of an individualistic psychiatric system was often not easy and required them to reconcile various resistances and tensions within their work. For instance, although staff did not report feeling especially conflicted about utilizing a psychiatric diagnostic system to describe client distress, despite their understanding of many symptoms as manifestations of social issues, I did experience times when staff appeared to be uncomfortable at having to diagnose a client with a psychiatric illness for practical reasons (e.g. to obtain financial/insurance reimbursement). In my time as a novice clinician at the Center I sometimes had to ask questions that would bring up this

tension – perhaps about why we were assigning a certain diagnosis that seemed to belie what was otherwise quite a different conceptualization discussed in my supervision. I gathered from the averted gaze and discouraged tone of my supervisors that sometimes these measures had to be taken in an effort to support the client, despite the way in which it could potentially also mark the client as “ill” when in fact the person might be having quite a reasonable reaction to recent or ongoing trauma.

Through exploring the work of practitioners at the Center I gained access to the issues, tensions, and struggles that are central to a culturally sensitive practice that attempts to incorporate non-dualistic understandings of human experience. For example, the issues of how and in what way to intervene in the community, the struggle of creating interventions that were based on community members needs which were of course, varied, all the while remaining within the bounds and rules of a medical institution that ultimately determined financial resources that would enable practitioners to continue their community work. It seemed that addressing social issues from a psychological perspective required a fundamental shift in the way psychology is practiced. Based on my data analysis, I interpreted that the process of shifting practice to incorporate culture involves finding ways to delicately balance between clinical and social understandings and negotiating the boundaries and limits of psychology/psychiatry and community. In essence it requires a pushing of the traditional boundaries between community and clinic.

In order to incorporate local understandings, difficulties, and interests into psychological practice, staff had to find a way to enter into the community and learn about the community *context*. Contextual factors included community history (e.g. history of the 8th district), current issues in the community (e.g. ongoing economic

deprivation and marginalization), and sociopolitical conditions (e.g. social/racial positioning). Following current trends in psychology, (such as multiculturalism and cultural competency models) psychologists might be likely to take many of these issues into account in more “traditional” practice (as opposed to community oriented practice). However, often those sociocultural issues are relegated to the background, as something to consider but such issues would not fundamentally change the way that practice would be oriented. As Sampson (1995) and Geertz (1973) argued, psychologists have often adopted a layering strategy, when it comes to culture and/or social dimensions, which involves tacking on social considerations to otherwise individualized understandings of identity. Psychologists at the Center understood that in order to better incorporate cultural/social considerations the nature of theory and practice itself might require adaptation. In my interview with Tom (P1), he helpfully distinguished between what he saw as “traditional” and contextual or “holistic” models and suggested why a “holistic” model is more appropriate when working with “disenfranchised” communities. He explained that traditional models determine the specific model/shape of clinical practice a priori, in a universal sense without specific reference to needs of community and clients, whereas more contextualized models seek to ground therapeutic technique and interventions in the specific needs of the community.

As a starting point for contextualizing their practice, clinicians surveyed community members, requested feedback from ongoing clients in individual and group sessions, and participated in grassroots community organizations and political activism as a means to orient themselves to the kinds of struggles that might come from clients themselves in individual and group sessions. The Center also held specific meetings with

the explicit purpose of giving clients a time to voice their opinions about the workings of the Center. For example, ongoing groups such as “patient advocacy” groups took place each week to give clients a space to voice their opinions about what was going on at the Center, what they liked or did not like, and any frustrations or concerns regarding events in the neighborhood. At times, clients would voice complaints about what seemed on the surface to be relatively benign issues such as wanting to have a greater variety of movies (DVDs) available for them to view. However, upon closer examination, conversations regarding what kinds of films would be shown touched upon important nuances in contextualizing care. For instance, certain movies had been chosen by both staff and clients which were deemed to be of interest to the community as a whole. The community, although it has been referred to often here and by the Center almost as if it represents a homogenous group, was of course, not homogenous. One client in particular voiced her frustration that movies depicting only the destructive underbelly of “ghetto life” were shown to the exclusion of films depicting other dimensions of her community experience. This client’s voice reflects an important point of dissension regarding the drawbacks of relying on universalist notions of community. While notions of community can provide a sense of identity, unity, safety, and caring it can also become insular, demanding “sameness” which then flattens out within group differences. This client’s negative reaction to images of “ghetto” life suggest her resistance to being characterized in stereotypical ways – an important piece of information for clinicians to take into account when determining how best to “contextualize” care. This example highlights how integrating psychological practice into any community is an imperfect process, one which requires an ongoing dialogue and process of trial-and-error. Perhaps, the Center staff had

overlooked the needs of some individuals, however by providing structured time and place whereby clients are given the opportunity to voice their feelings, the Center staff allow themselves to be educated by, even evaluated by, their clients. The very experience of being given a place to voice honest feelings, and the clinicians' implicit assumptions that clients will inevitably be disappointed with, or have a reaction to, the treatment offered at the Center, communicates a collaborative rather than an authoritative spirit when it comes to client's healing. Such collaboration may address healing at the social level as well as the intrapsychic level, an idea to which I will return later.

Based on staff experiences with clients and information they gleaned through surveys, they also learned that many clients desired more access to resources such as food, places to shower, and/or clothing. Given the Centers' high homeless population, such requests are not surprising. Within traditional models the material realities of clients' lives are often excluded however, as Tom (P1) in particular, was adamant to note, such issues were pressing for clients at the Center and could not be ignored. For instance, Tom empathized with how difficult it would be for a person to focus/process on his/her emotional reality when he/she hasn't slept, showered, or eaten properly for days. In Tom's words: "it's pretty hard to talk to somebody if they're feeling dirty and grimy and stuff." The Center's survey results and Tom's observations are consistent with findings from prior empirical studies which have found that the experience of economic poverty may create an "obstacle" to both providing and receiving psychological care (Chow, Jaffee, & Snowden, 2003; APA, 2000). However, the Center did not view these issues as "obstacles" but rather an element that needed to be incorporated into their services. Integrating the needs of the community for the Center staff stretched beyond "talk

therapy” or even specific political acts, and relied upon expanding understandings of “care” in its very foundational sense. Providing clients with a place to shower, wash their clothing, and obtain food, became part of the way that this notion of “contextualization” played out at this Center. Furthermore, providing such resources can be considered a way to address issues brought up by quantitative studies regarding the way in which physical/material realities present an “obstacle” to accessing mental health care services. Given that the Center sees itself as a “one stop shop” it can address these “obstacles” enabling clients to make use of what services are available there. In addition, Smith (2005) and James and Prilleltensky (2002) noted that powerful stereotypes regarding “poor” people shape psychologists’ attitudes towards clients. Smith (2005) in particular, claims that often psychologists will assume that poor people will be disinterested in or unable to engage in the process of psychotherapy due to the priority that basic survival needs take in their lives. The Center staff understood that individuals living in poverty may have a more difficult time participating in talk therapy given the priority of material demands, however, instead of assuming clients would not “fit” the traditional model of care, they simply shifted this model to incorporate those needs. I would argue that provision of material resources for clients might also be interpreted as an act of resistance to stereotypes regarding what type of person is appropriate for psychotherapy.

This process of contextualization of psychotherapeutic services and encouragement of critical thinking among community members is reminiscent of Freire’s (1970/2000) critical pedagogy in his book *Pedagogy of the Oppressed*. Freire (1970/2000) suggests that knowledge must be imparted in a contextualized fashion if it is to be relevant and empowering to marginalized communities (in his book he refers

specifically to communities in the Brazilian countryside). He also suggests that a critical piece of educating oppressed communities lies in the raising of consciousness regarding political and historical circumstances or what he calls “*conscientization*.” Freire’s (1970/2000) pedagogical theory can be useful in understanding why contextualization of psychological practice might be beneficial. For example, as Freire suggested with respect to education, that teachers orient themselves towards collaborating with the community in order to understand what was most concerning or interesting to them. Rather than employing what Freire (1970/2000) referred to as a “top-down” approach to learning, whereby the teachers, or in the current case, psychologists, decide what is best for students (or clients), they should ground their understandings and intervention in the interests of the community itself. Staff at the Center employed this technique when they asked clients to fill out surveys and discuss their responses to treatment offered. Open dialogue, which is at the crux of Freire’s (1970/2000) critical pedagogy, was also essential to staff at the Center in their work with clients. Meetings during which clients’ voices could be heard, especially dissenting voices, suggest an atmosphere in which love, humility, faith and mutual trust are present (at least to some extent). Freire considers such characteristics to be essential for the existence of genuine dialogue. Staff at the Center also took to participating in community events and activism as another means to educating themselves about the social and historical context of the community. For instance, staff participated in local political events, grassroots meetings regarding changes in the community, and kept abreast of city urban planning. Staff felt they played an important role, much like Freire suggests, not only in being aware of these “cultural” issues but also in educating residents about what was happening around them and how it

might impact them. According to staff, clients from the community often (perhaps due partially to impact of oppression or oppressed identities) were unaware of what decisions were being made regarding their community (on a governmental level). For example, many residents were not aware of how plans to build a casino near their neighborhood might impact them or the fact that the city planned to cut a major bus line which would further isolate the community from the rest of the city. Staff's efforts to inform clients regarding these issues is similar to Freire's process of *conscientization* – the idea that when people develop a deeper consciousness of their situation, this leads them to construe their situation as an historical reality susceptible to transformation rather than as a static unchangeable reality. The Center's efforts were not only geared towards addressing clients' experiences of the community but helping them learn ways to resist/challenge these conditions.

Through their *collaboration* with the community, clinicians at the Center not only learned about some of the material realities of the community (e.g. economic deprivation), they also gained a sense of the intrapsychic impact that these material realities had on the community. Staff interpreted their observations of suffering, stories of victimization and violence, family disruption and fragmentation and spiritual struggles as evidence for the existence of what they called “community trauma or community PTSD.” Thus the particular trajectory of community practice at this Center revolved around a consideration of the traumatic impact of systematic oppression, community fragmentation, and subsequent psychological symptoms. All of the participants made mention of “community trauma” in their interviews and suggested ways in which such trauma could be treated from a psychological perspective. For instance, Theresa (P2)

shared that one of the issues the staff had been discussing at the Center revolved around the “whole conceptualization of whether or not we’re just talking about a post-trauma person here and a post-trauma person here, but maybe we’re talkin’ about a traumatized community...I mean, there is a certain kind of trauma that people are subjected to (.) you know violence and scratching at your survival...so uncommon to the majority culture” (Lines 199-204). Sam (P4) also alluded to the impact of not only poverty itself, but the experience of economic and social marginalization in the context of relative wealth (as is the case in the U.S.). He refers to the systematic oppression of certain communities and how this type of oppression may have specific kinds of intrapsychic repercussions for individuals experiencing it. The idea of community trauma was such a central theme across all of my interviews that the topic warrants further consideration in terms of how community trauma is understood in the literature and the particular meaning it had when it came to the community served by the Center.

Although it was difficult to find much literature on the topic of “community” trauma, I did come across some discussions of “cultural” trauma. Smelser (2004) defines cultural trauma as “a memory accepted and publicly given credence by a relevant membership group and evoking an event or situation which is a) laden with negative affect b) represented as indelible, and c) regarded as threatening a society’s existence or violating one or more of its fundamental cultural presuppositions” (p.44). It is somewhat unclear how this definition might be applied to the current study, given that there is no clear “event” to which the community may be reacting. On the other hand, clinicians at the Center alluded to historical events and trauma resulting from ongoing systematic oppression as being central issues in many community members lives. Eyerman (2004)

offers a definition of cultural trauma that is more closely aligned to what staff were describing when he writes: “As opposed to psychological or physical trauma, which involves a wound and the experience of great emotional anguish by an individual, cultural trauma refers to a dramatic loss of identity and meaning, a tear in the social fabric, affecting a group of people that has achieved some degree of cohesion. In this sense, the trauma need not necessarily be felt by everyone in a community or experienced directly by any or all” (p.61). Eyerman (2004) also addresses the way that traumatic events that occurred in the distant past, such as the event of slavery for African Americans living in the U.S., still impact this community today. He goes on to explain that historical traumatic events have not been experienced first-hand by later generations and thus the events must be passed down through various forms of discourse (e.g. oral histories, visual media, written stories, etc.) (2004). Eyerman’s (2004) definition leaves room for both a consideration of the way in which trauma is mediated through discourse as well as its’ psychological impact on communities. Furthermore, he links the “articulating discourse surrounding cultural trauma” to the emergence of particular identities as a way to repair the “tear in the social fabric” – he writes: “there may be several or many possible responses to cultural trauma that emerge in a specific historical context, but all of them in some way or another involve identity and memory” (p.63). Eyerman (2004) uses the emergence of an “African American” identity as one of several possible reactions to the failure of reconstruction to integrate former slaves as “Americans” (p. 63). Perhaps, it may be even suggested that the appellation of African American identity connotes a reaction to trauma, an identity based on a history of trauma.

Staff at the Center certainly perceived the ongoing oppression of ongoing identity/community fragmentation as rooted in this history, however they also noticed the ways in which it was recapitulated as part of the ongoing everyday trauma with which their clients were dealing. For example, Tom (P1), Michael (P2) and Sam (P3) all suggest that historical and systematic oppressive practices, such as economic and educational exclusion and negative stereotypes of “poor black communities” creates multiple layers of trauma. Racism, sexism, and classism were understood as working together to perpetuate ongoing oppression of the 8th district community (among others), while also perpetuating the mythology surrounding poverty in black communities in the United States. That is, the notion that “those [poor] people did it to themselves” and as Michael noted are thus “undeserving” of public sympathy or assistance. Furthermore, they interpreted that a large component of the cultural identity/experience of clients from the community was rooted in the intrapsychic impact of this marginalization and an identity that was at least partially rooted in this history.

Similar to Eyerman’s (2004) line of thought, the clinicians conceptualized collective trauma as being a fundamental experience around which a cultural identity was formed. It makes sense then, that although clinicians’ used the identity term “African American” to identify themselves and community members, they resisted defining this identity according to some inherent characteristics. Instead, they focused more on this shared history and ongoing experiences which were felt differently across community members but nonetheless were considered crucial to consider. Staff addressed the impact of this “community trauma” from both a psychological and social perspective. Although an explicit working model of intrapsychic impact of oppression was not discussed, it can

be deduced from clinicians' interviews, as well as observing their practice, that living under oppressive conditions was assumed to do more than make life more stressful and unmanageable (as is often referred to in the literature regarding impact of poverty on mental health) – it also changed the way a person saw him or herself and the world. Participants' descriptions of the intrapsychic impact of race oppression brings to mind W.E. Du Bois' (1953/2005) concept of double consciousness. In his renowned collection of essays entitled, *The Souls of Black Folk*, Du Bois wrestles with issues of racism, discrimination and social injustice in 20th century America. Of his concept of “dual consciousness” Du Bois wrote “[it is] this sense of always looking at one’s self through the eyes of others, of measuring one’s soul by the tape of a world that looks on in amused contempt and pity” (1953/2005, p. 2), and of a two-ness, of being "an American, a Negro; [...] two warring ideals in one dark body, whose dogged strength alone keeps it from being torn asunder" (p.5). During my interview with Theresa, she considered the impact of such “dual” identifications. She noted, “there’s this um this sense of being of two nations, because we’re not Africans, you know, we’re not 100%, most of us are not 100% African. So what happens is that we’re like a people that are afloat” (Lines 225-228). According to Du Bois, the impact of having such a “double” or split self is significant in shaping people’s intrapsychic experience. Michael suggests that many clients’ perceptions of themselves have been “crushed” by negative constructions of how they are socially identified. Positive constructions of the self, a sense of spiritual connectedness, and self-esteem become difficult to hold onto or develop in the face of such ascriptions.

The finding that staff treated racial/ethnic identity as being best understood as an interpersonal/social phenomenon (rather than innate and internal), partially based on

shared experiences, lends support to comments from Helms (1994), regarding the multiple and varied ways that persons experience and understand such identities. For example, Helms (1994) suggested that instead of associating a standard set of attributes to different cultural/racial groups, a therapist might do better to assess how central various identifications are to that person in his or her life. As such, the suggestion is that therapy be tailored to the interests and needs of that particular client or group of clients, rather than determined beforehand. The staff reflected an understanding of cultural or racial identity in more idiosyncratic ways, rather than making generalizations that rest on the assumptions of homogeneity within cultural groups. These findings also lend support to Sampson's (1993b) and Cosgrove's (2003) critique of traditional multicultural psychology that has attempted to "layer" identity categories rather than understanding the interpersonal and power dimensions that create such identities in the first place. By assuming that such issues are interpersonally sustained and that power will inevitably be part of the therapy relationship, staff, at least in some ways, addressed this critique of an overly simplistic or superficial understanding of social marginalization based on race or ethnicity. I will return to a fuller analysis of power in the Center's work later in this chapter.

One of the ways that clinicians chose to address concerns regarding internalized oppression was by providing a corrective relational experience for community members through a combination of acknowledgement, recognition, and empowerment. In Tom's interview he stated, "when people come through the door, we acknowledge that they are here because often enough people here are disenfranchised and uh, they're sensitive to how they're being treated, or mistreated, and whether it be real or perceived our

perception is everything...so, what's their perception is where it is, so we really work hard...to engage everybody who comes through here" (Lines 142-148). This process of acknowledgement, and engagement with community members was one of the most striking features of practice at the Center which might differentiate it from "traditional" practice. Clinicians made it a point, through their various interactions with clients in groups, activities, etc. to know the clients, and acknowledge their presence. So, the process of acknowledgment is an active process, one that extends beyond the confines of the consulting room and permeates interactions within the clinic as a whole. It is also a relational process, one which brings to mind Levinas' (1969) concept of "facing" the "Other." As participants noted, clients have often had many experiences throughout their lifetime of having assumptions made about them, feeling invalidated, and discriminated against on the basis of being identified with a particular racial group. In Levinas' (1969) sense, these clients may have experienced a form of interpersonal "violence" which clinicians at the Center deemed would be important to address. Several participants made mention of how sensitive many clients are to the potential for this type of interpersonal violence to occur at the Center. Providing this basic acknowledgment and recognition of for clients superseded any traditional therapy interventions at the Center. The way clinicians used this way of relating was as an intervention in and of itself. As Sam (P4) stated, clinical work at the Center requires using basic care-taking skills as a human being, not necessarily learned through any kind of training. Here, traditional boundaries of traditional psychotherapy models are pushed again, with much of what is considered by staff to be healing happening in the space in between sessions.

Michael suggests an additional function of this interaction outside of session - that is, clients (especially clients who experience psychological crises and are in need of hospitalization periodically) will respond better to clinicians attempts to “help” if they feel they have been acknowledged and understood as a whole person; they will respond better during those more traditional psychological interventions which might otherwise have the potential to reenact authoritarianism and social exploitations.

Another important aspect of this contextualization piece which relates back to community psychology theory is the idea of agency, empowerment and resilience. All participants made comments about their role in helping to highlight clients’ strengths, conceptualizing them as people dealing with a “fault system” rather than as the problem themselves, as well as fostering resilience and “recovery.”

This analysis of contextualization which includes working collaboratively with the community to decipher their needs, responding to those needs through further interpretation and the emergence of an implicit model of “community trauma” and a focus on reversing the negative impact of oppression both psychologically and socially, implies issues of power. Thus far I have not explicitly discussed power issues inherent in discussion of these issues and I will now turn to this second major organizing principle in community psychology – *power*.

Bringing the Center to the Margins: Negotiating Power and Identity

Given staff’s explicit interest in social justice and civil rights ideology, many of their interventions stemmed from a customary (or Marxist) model of power. My analysis

of interview transcripts revealed that terms such as “oppressed” and “oppressors,” notions of “empowerment,” narratives about “fighting” large systems, and consciousness-raising and advocacy which reflects customary notions of power appeared with regularity.

However, although staff ascribed explicitly to a social justice orientation that understood clients’ experiences in terms of customary dichotomized understandings of power (e.g. oppressed/oppressor), implicit within their work and in their discussions with me, it was evident that staff also considered more fluid, multifaceted effects of power in their clinical work. Especially when it came to addressing race, culture, class per se, participants’ explanations became more complicated, sometimes acknowledging the need for a more nuanced understanding of the role of power.

Foucault’s (1978; 1983) conception of power presents a useful guide with which to analyze and understand the way power relations were enacted within the Center. In his *History of Sexuality*, Foucault writes the following: “Power is not something that is acquired, seized, or shared, something that one holds on to or allows to slip away; power is exercised from innumerable points, in the interplay of nonegalitarian and mobile relations...relations of power are not in a position of exteriority with respect to other types of relationships (economic processes, knowledge relationships, sexual relations) but are immanent in the latter” (Foucault, 1978, p.94). Similar to this concept of power, clinicians at the Center understood identity and power as multifaceted and relational, encapsulating both therapist and client. Client and therapist positions shifted in relation to one another and as such, there could not always be a clear “oppressor and oppressed” or person with/without power within interpersonal dynamics at the Center. Of course, as Foucault (1978) contends, some individuals within these “matrices” of power may have

more access to truth claims than others (thus more access to power) as was the case with clinicians at the Center who maintained the ability to name the client's distress according to diagnostic criteria and to determine treatment. On the other hand, such power was not "held" in the way that a possession is held, and thus such claims to power were sometimes obscured. For instance, Theresa (P2), in particular, spoke at length about how her own social position(s) as "African American" and "woman" played out in her relationships with certain clients. She described her interaction with an African American male client who was a self-identified "pimp" and the way his social position/identity was emotionally "triggering" based on the way it implicated Theresa as a woman. Theresa described the way he interacted with her, which she experienced as his "messing" with her due to his tendency to "identify and analyze" women in an exploitative way as "triggering" to her emotionally: "But, I like him as a person except for when he'll say something that's s::o da::mn sexist...And he could say some sleazy stuff about women, okay?" (Lines 759-762). Theresa (P2) identified the complexity of having to hold in mind the movement of power as it was manifested between this client and herself. She understood this client's exploitative language and actions towards others as a defensive posture, developed as a way for him to survive a social system in which he saw limited options and had limited access to power. It is here, in the interpersonal enactment of power, that the complex interweaving and co-constitution of community trauma, power and racial identity come together and become entangled at the *emotional* level. Theresa expressed a feeling of being "identified" as a "woman" by this client and subsequently "analyzed" as a commodity or object. Although Theresa may be identified as "woman" in this scenario, she is also "therapist" which affords her a different level of access to power

within the context of the Center. However, the tangled web of interpersonal dynamics as described by Theresa, was emotionally taxing and required her to have significant training in interpersonal dynamics and sensitivity to the interpersonal and intrapersonal workings of power. In this example, Theresa also struggled against acting out her aggressive self-protective impulse to tell this client to “shut his mouth” and instead managed to respond in a way that kept her connected and open with the client (by sharing with him her genuine feeling of being disrespected). According to Theresa, this interaction provided the client with an opportunity to understand his impact on others in a different way and was transformative for both parties involved. When social position, including “racial” or “ethnic” identity, is conceptualized in this more interpersonal way with specific attention to power, essentialized and/or simplistic understandings of social position are of little relevance.

In the literature, the interpersonal complexity of cultural and social identification is often avoided or if addressed, it is addressed in superficial ways. For instance, some studies suggest the preference of “matching” client and therapist ethnicity or race to promote culturally sensitive and hence more effective psychotherapy (Beutler, Machado, & Newfeldt, 1994; Gamst, Dana, Der-Karaberian, & Kramer, 2000; Maramba & Hall, 2002; Sue, 1998; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Although the role of race and ethnicity in psychotherapy is certainly an important one (and an improvement over the assumption that culture does not matter), such considerations have sometimes been based on assumptions of homogeneity among various social groups. Multicultural psychology criticizes traditional clinical psychology for assuming that Eurocentric models of behavior apply to everyone universally, which has spawned an enormous body

of research and practice regarding race, ethnicity, culture and identity within the field. However, even as such moves to consider diversity have fostered much needed attention on the topic, we must be careful not to let the pendulum swing in the other direction, paying such close attention to defining cultural/racial/ethnic differences that we begin to see these groups as homogenous. As Helms (1994) contends, making generalizations about appropriate psychological care based on racial/ethnic identity without considering the centrality (or also, I would argue, the person's relationship to) of racial group membership is likely to be ineffective (Helms, 1994). Generalized conceptualizations of race/class/ethnicity overlook the fluid, multifaceted and intersubjective nature of identity. That is, as Shweder (1991) argued, if culture and a person's psychology/psyche co-constitute one another, there could potentially be an infinite number of configurations in terms of how people experience and enact identity. Even mainstream multicultural research that proposes the preference for client/therapist "match" in terms of client retention and therapeutic effectiveness has started to consider the underlying variables that mediate these effects. According to Sue (1998), there are several mediating factors that actually determine the success of the match between therapist and client (e.g. ascription of a certain set of values or a worldview or language) which suggest that it is not some inherent qualities specific to various ethnic/racial groups that might make for a good working alliance, but rather aspects of culture and worldview.

Despite the fact that almost all therapists at the Center "match" their clients in terms of racial identity, which in many ways is experienced in positive ways by clients (given reports that it feels more "comfortable" than being at a predominately "white" clinic), there are also complicated issues of power and privilege that impact the

therapist/client relationships at the Center. According to Foucault, power is fluid and “coming from everywhere” and thus have an impact on relationships whether there therapist and client are “matched” with regard to ethnicity/race (especially when considering the multiple identities/identifications). . For example, Theresa (P2) suggests that therapists at the Center, especially African American therapists, are seen by African American clients as “the lucky ones”. During her interview, Theresa stated: “I think we struggle with that as a staff, u::m (.) perhaps we’re labeled as the ones who’ve been somewhat successful and whatever, you would call that... we’ve been properly assimilated or we’ve been assimilated a li::ttle better than others. But, so (.) that’s who we are. We’re the ones who figured out how to do it OR else we’re the ones who we’re so fortunate that we fall in the manor and come out riding the pony, you know, we’re the lucky ones” (Lines 251-258). She did not go further to suggest explicitly how this might impact the therapy relationship, however there is potential for this scenario to invoke both feelings of inspiration and envy in clients. Sometimes, although there may be an immediate comfort in a psychotherapeutic situation in which there is “sameness” rather than difference, when working with someone with whom one identifies strongly, the issue of comparison is felt more intensely. Again, this is not to suggest that this type of dynamic would be unwanted, but that these nuances and complex dynamics of power and privilege in the psychotherapeutic relationship are extremely important to consider.

The question in this situation is not necessarily as some conventional understandings of power suggest, to figure out who is more oppressed, but rather how power is shaping the dynamic and how might the persons involved in the situation understand their positioning within this power matrix. Therapists have the added

intention of finding a therapeutic way to orient themselves in this web – acknowledging their own reactions to interactions with clients, and their own social identifications, while finding therapeutic ways to respond. This is particularly difficult in the earlier description of Theresa's interaction with her "pimp" client in which she felt personally offended and threatened by "sexist" comments that her client was making. The process of negotiating identity in the psychotherapy relationship is complex and potentially rife with tension and challenge. It requires understanding and resolving issues of identity and power within the context of the therapeutic relationship.

Taking the negotiation of power to a more structural or systems level, participants attempted to utilize the access they did have to power to advocate for their clients. For example, when Tom described "fighting" with the administration for more material resources or challenging negative stereotypes of the community, or Michael organized community meetings to facilitate client involvement in local politics, or Sam saw himself as "carrying the fire" of public service psychiatry into more traditional psychiatric circles so as to gain more support for contextualized, community care. All of these actions represent various ways in which psychologists at the Center found, as Foucault might call, "points of resistance" already "present everywhere in the power network" (p.95).

With respect to the more general workings of power within the Center, people took on a variety of roles which were situated at varying levels of status. As such, hierarchies were sometimes subverted and power/status was relatively fluid. For instance, Tom's (P1) tendency to subvert typical power hierarchies within the Center by taking a familiar approach in which he used humor to offset his position of power. At other points he could be seen using his power when it came to his interactions with the medical center

or the community in general in order to advocate for the Center and the community. Specific attempts at reversing typical hierarchies or power dynamics represent both an understanding of power in terms of the oppressor/oppressed dichotomies, and the intrapsychic impact of this dynamic as well as Foucault's idea of resistance points.

At the same time, as with any discussion of power, the ways in which psychologists, even community-oriented psychologists, may inadvertently use their position to advance the social status quo must also be examined. As Swartz (1996) warned regarding this precarious relationship between the clinic and the community, when we push boundaries of the clinic into the community, we may benefit the community in some ways, but we also “place boundaries and controls around people” and “interfere with and police their lives in an elaborate form of surveillance masquerading as service” (Swartz, 1996, p. 5). Although I cannot claim to know the extent of the impact of psychological/psychiatric discourse on this community given the limited scope of this project, it seems possible that despite the Center's attempt to downplay psychiatric diagnoses, clients were nonetheless engaged within this discourse. For example, a client might be informed about a disorder such as “bipolar disorder” and the need for “compliance” with psychiatric medication. Now, perhaps this is the best that psychologists/psychiatrists can offer for a person exhibiting behavioral symptoms that are potentially harmful to themselves or others, but, despite the tempering of such treatment with more socially oriented interventions, it is likely that this person will see him or herself (if he/she believes the clinician!) differently than before they came to the clinic. Now, that said, this type of “control” can happen in a variety of ways – it can happen when persuading someone that they have a particular syndrome or disorder, but it

can also happen to convince them of their own value, of hope, and opportunity for growth. So, from my perspective, the effects of a therapist's power may forever be caught up in this web, or his "matrix" as Foucault might call it, never to be defined as essentially one thing or the other. In other words, it will continue to flow in a variety of directions and the most effective way for a psychologists to address it may be just to track its "flow." And, in tracking this "flow," the points of resistance which Foucault also mentions, and that are always already also at work in the discursive matrix, may be opened, exploited, or otherwise responded (in)to.

The Bigger Picture: Tensions and Challenges

The social situatedness of the practice of psychotherapy is an aspect of the clinical work that is often overlooked in research regarding therapy effectiveness and cultural competency. Most quantitative and even some qualitative studies have done well to identify potential challenges and deepen our knowledge of the various issues and/or problems when it comes to providing psychological services for marginalized communities. However, many of these previous studies have neglected the context within which psychologists practice. If we are to take into account the socio-cultural-political context of clinical work, one might find, as I have in this particular study, that contextual factors have a powerful impact not only on clients but also on therapists and their work. Outlining the particular challenges and tensions of this particular community mental health center cannot necessarily be generalized to other contexts, however, given that the

majority of lower income communities are often served by public clinics, it is highly possible that similar processes may be at work in other centers.

One major challenge that permeated practice at the Center related to the way that staff reconciled tensions between various discourses, most notably meta-narratives of psychiatry wherein symptoms are interpreted as evidence of psychiatric “illness,” and community understandings that see symptoms as manifestations of social/systemic problems. However, rather than being a tension between medicalized understandings versus community understandings of emotional distress, clinicians experienced the tension between psychiatric and community discourse as a conflict of recognition. That is, the tension for them was one of whether or not a culturally grounded practice would be recognized as valid *within* the larger psychiatric institution or discourse (rather than relegated to the margins of the institution). For the Center, the struggle seemed to be between the way in which advancing a culturally specific practice made them vulnerable to being dismissed or even abandoned by a system that valued traditional (Eurocentric) psychiatric models of experience. For instance, Michael described a tension between wanting to be permitted to practice autonomously as a satellite clinic but also not wanting to be dismissed as a “Black” clinic and viewed as somehow different from the rest of the institution (which may also be another way of saying “less than”). In other words, Michael was caught between wanting to provide culturally specific care and challenge the tendency towards a “one size fits all” mentality, while also remaining within, and advocating for, an equal place within the system. Once again this particular dilemma brings to mind Foucault (1978) who noted that, “discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling-block, a point of resistance and a

starting point for an opposing strategy” (1978, p. 101). As such, the Center’s appeal to the discourse of culturally specific practices provides them a place from which to advocate for their clients, however it simultaneously creates the possibility for their continued marginalization (by virtue of being labeled as different). According to Butler (1997), “subjection consists precisely in this fundamental dependency on a discourse we never chose but that, paradoxically, initiates and sustains our agency” (1997, p.2). For instance, the Center wants to be recognized and supported in its efforts to advance culturally sensitive practice that advocates for marginalized, and especially Black communities; however, in claiming this identity label, it risks being “dismissed” as a “Black” clinic and thus not included in the same privileges as the rest of the institution. At the same time, as Michael contended, if the Center does not assert that identity they might risk getting “swallowed up” in the larger system that may advance a “cookie-cutter” approach to treatment. Still, as he mentioned, there is a struggle between being frustrated by the negative impact of marginalization as a “Black” clinic, yet appreciative of the autonomy that identification provides them in determining what services they can provide (within the budget of the funding they are provided).

Despite the interest in utilizing culturally specific practices and not wanting to get “swallowed up” in the system, the Center drew upon psychiatric discourse a fair bit. As mentioned earlier, this of course showed up in official documents used by the staff which were developed by the medical system. Such forms used language such as “patient illness” which at first glance seemed antithetical to staff’s contextualized understandings of client struggles. Through my analysis I observed the way that staff straddled the line between discourses, drawing from psychiatric discourse when they need to in order to

abide by important regulations set out by the institution that financially sustains them. On the other hand, sometimes the language of psychiatry was adopted in indiscriminant ways, indicating that staff were not just using this discourse strategically but perhaps actually bought into this discourse. For instance, when Tom tells me about the importance of client “compliance” with medication, it evokes the authoritative medical approach rather than the collaborative approach. Implications of this tension are that practice at the Center must rely upon the discourse of psychology/psychiatry in order to be recognized as such an agency and continue the support and funding necessary for its existence. However, staff also may also simultaneously unconsciously and/or consciously adhere to both psychiatric and community discourses which is an interesting tension that deserves further attention in future research.

In addition to tensions between discourses of psychiatry and community psychology, there is also a tension regarding the appropriate way to understand culture and/or race. Several of the participants resisted generalized understandings of race and class, or painting these identity categories with “a broad stroke.” Tom highlights the important issue of heterogeneity within any group membership when he stated “we may be alike on one perspective or two perspectives but we still have different things that’s unique to us” (Tom). Michael suggests that he does not see his work as being particular to an African American community, although when it comes to race/culture/ethnicity, the “problems may present differently” and the “interventions might be different.” However, embedded within the issue of racial group identification lies another tension regarding the extent to which clinicians identified with and drew upon their own racial identifications in clinical practice. Michael resisted identification as a “Black therapist” stating that “I

am a black man, but I don't see myself as a black therapist." On the other hand, Theresa and Sam both discussed their heightened awareness of their own racial identities and how this might impact their work with clients. Theresa, who identified as African American shared several of her own experiences of discrimination based on race and gender, and felt a strong connection to the kind of dual consciousness that many of her clients reported. She understood her own experience as something that could help her understand experiences of marginalization. Sam (P4) who identified as "European American" professed the importance of addressing the issues of white privilege in his practice through identification with his own European and Jewish heritage. To him, addressing the issue of white privilege includes this self-reflexive practice, in which instead of focusing on "the Other" and the problems "they" have, he focuses on examining the politics of domination and white colonialism and oppression and how this is likely to play out with clients. This self-reflexive stance is something that critics of traditional cultural competency movements, such as Sonn (2004) recommend. Sonn (2004) observed that "although useful at some level, cultural competence, can be problematic because there are complex issues of power and privilege that often remain unexamined" and he suggests that "developing culturally competent practice requires moving beyond learning about the other, to examine and deconstruct our own social identities and power and privilege afforded by those identities" (p.4).

Another tension/challenge that the Center faces has to do with material consequences: lack of funding, low salaries, "enormous" caseloads, and burnout. Swartz's (1996) research documented that the lack of funding and support community health centers (and workers) receive contributes to high rates of burnout. Swartz (1996)

suggests that this lack of support for community work is at least partially a result of continued marginalization of community psychology/mental health services within the field of psychology/psychiatry. Community workers thus end up with tremendous responsibility for community welfare, and often have a strong inherent sense of obligation to the community yet have to ‘sacrifice’ in some way, even if just financially (but often also emotionally) to continue providing these services. Theresa’s comment about “the level of care that these people are receiving is not because the institution is supporting” the work but because as she put it, “African Americans, with a high level of training are sacrificing to be with them...it’s a major sacrifice” (Lines 519-521) reflects this struggle. The feeling of being marginalized, underappreciated, and undercompensated has an emotional toll for some as well. Theresa described some ambivalence between her commitment to the community and negative feelings regarding her status as a community worker.

Swartz (1996) found that heightened “burn out” rates among community workers are not only the result of poor financial compensation, but also because of the identification and often permeable boundaries between staff and community. Although this “boundary crossing” has been presented earlier as an important means to allowing staff access to clients needs, it also creates the potential for increased emotional involvement which although helpful for community – can also have negative side effects for staff. For the Center, in particular, given the boundaries it is crossing, that is into a community suffering from the destructive impact of poverty and social marginalization, they run the risk of sustaining a type of vicarious traumatization. Theresa presents a fine example of this concept, when she recounted, “I have to work with these people whose

incidents are on television. When I come – you know, get up in the morning and say “*Oh my god that’s so awful, Oh my god those poor people*” and then I come to work and find out that I know them and I still can’t get over that” (Lines 677-680).

Summary and Questions for Further Research

Although it is difficult to sum up the main findings in this study due to its breadth and exploratory nature I will attempt a summarization and then let this summary lead into my questions for further study. First, my analysis shed some light on the question of how community psychology theory is translated into clinical practice. As explained by various community psychologists (e.g. Prilleltensky, 1994 ; Orford, 2008; Rappaport, 1997) psychologists at the Center worked within a contextualized model, paying particular attention to power and working in a collaborative manner. These three principles were enacted in various ways in this particular community. Contextualizing practice included extending psychotherapy beyond the confines of the consulting room, and this boundary crossing reflected specific intentions. Given that community clients were understood as requiring both social as well as psychological healing, psychologists expanded their roles to include the role of mentor, advocate, and perhaps even fellow community member. Psychologists worked alongside clients in a collaborative manner, taking their lead from clients and allowing themselves to be corrected in terms of their understandings of clients needs.

Second, social context, “psyche” and practice were understood as co-constitutive of one another. Both client and therapist identities were understood as a result of a

complex intermingling of power, privilege, and identity that required ongoing negotiation and self-reflection. This finding challenges mainstream conceptualizations of culture and cultural competency and supports post-modern/interpretive understandings of culture (Swheder, 1991; Geertz, 1973). Also, often, social considerations in psychology focus on specific identities of clients and therapists (more often the clients) but do not necessarily consider how social context permeates clinical practice as well. The current study outlined the various ways in which power dynamics shape and constitute therapeutic relationships as well as the identities and experiences of therapist themselves (in terms of compensation, resources, etc.). The possibility that community psychology practices and conceptualization continue to be relegated to the margins was also evidenced.

Third, the ways in which complex issues of power, identity, and emotional or intrapsychic experience are interwoven was highlighted through my analysis. Although this is not a new concept, there is relatively little in the ways of empirical research that attempts the explication of this theory in terms of how it is enacted in everyday practices. Personal narratives and/or theory based on personal experience is certainly empirically grounded, however, not explicitly framed as such and so the current research sought to add upon this prior theory and research.

Although by nature, ethnographic research is meant to focus on a specific group or case, and although it certainly was not this dissertation's task, studying other community mental health centers alongside "the Center" would add complexity, and comparative breadth and depth to this study. Indeed, I often found myself wondering about psychological practice at other satellite clinics that operated under the auspices of the medical center, especially because they were mentioned several times during

interviews. Although in hindsight it would have been interesting to visit these sites even if just to get a sense of the physical space of the clinics, time and space constraints limited my analysis to the Center, and it is my hope that future research may respond to these remaining questions.

Also, as mentioned in my introduction, clients were not included as participants. I presented clients as they were seen and heard (and described) by myself and participants, however, I did not include them as participants. My rationale for excluding clients as participants mostly revolved around a concern for their confidentiality and logistics of having review boards approve my involvement of a “psychiatric population” in my study. Furthermore, given that this study was designed to serve as my dissertation research, I set out to limit the breadth of my study – although I ended up with quite a bit of data even without client participation. However, throughout my analysis, I did find myself wishing I had clients’ descriptions of their experiences to compare against my own and clinicians’ interpretations, and I do feel that this would be an important second step to the current research project.

Of course there are always ways and ideal situations one wishes for to strengthen the research and the research design. Hence, although I believe that my participant-observations of the activities of the Center and my own work there as a therapist served as important “check” to information I gleaned through interviews, it would have only added to the study to be able to dialogue these data points with an analysis of interactions between therapist and client during psychotherapy sessions. Although I was privy to interactions between therapists and clients outside of therapy sessions, and was aware of my own interactions with clients in individual and group therapy, I did not have access to

these more private conversations between therapist and client. If I were to conduct further research at the Center, I might see if I could gain access to tape recordings of therapy sessions and conduct a more in-depth analysis of the ways that complex issues of power, privilege and identity play out between client and therapist. However, that said, it was an aim of this project to demonstrate the ways in which what is therapeutic happens in a variety of ways outside of the traditional counseling session, and therefore, in many ways I *was* privy to many therapeutic encounters (e.g. in casual conversation with clients, in spending time eating lunch with a client, or organizing meetings where clients voices were elicited) during my time at the Center.

Overall, research regarding cultural sensitivity in psychological practice has a long ways to go. In this project I have suggested that one way to learn more about this complex issue is to first recognize what a complex issue it is rather than try to operationalize it. Traditional psychological models may not be appropriate for this task and thus it would benefit the field to look beyond its borders and shift paradigmatic understandings of individual psychology to include the social.

Finally, and in conclusion

Perhaps a good place to conclude is in, or with, the voice of the ethnographer or “participant observer” or researcher. As I conclude my research at the Center I am reminded of where I began and what brought me to this research in the first place – mainly my excitement regarding the work of Center clinicians which integrated social justice theory and psychology (my two personal passions). My experiences at the Center

brought to life the complexities of social context when it comes to psychological practice in a way that has greatly enriched my thinking as a researcher and as a clinician. Leaving the Center, I am left with a feeling of gratitude to my supervisors there who guided me through the very beginnings years of clinical practicum and who also generously agreed to participate in this study. My first goal, of this project, beyond its' academic utility, was really to document the important clinical work that I saw happening at the Center. It was my belief, given Center clinicians' enormous caseloads and innumerable daily tasks, that even if there was to be an interest in writing about one's work, it would be unlikely to come to fruition. I hope that my representation of clinical work at the Center does it justice or at least participants might feel a sense of resonance when reading it (and I plan to provide them a copy of the dissertation if they would like to read it).

Leaving the Center I am left with a feeling of sadness regarding the continued difficulties this community is likely to face, but also a sense of hope about the Center's potential to reach out and dig into community/social issues where many mental health centers do not. This feeling of hope inspires me to continue the important work I saw happening at the Center and to work towards bringing more awareness to the value of community work so as to ensure better support for these services.

REFERENCES

- Altman, N. (1995). *The analyst in the inner city: Race, class, and culture through a psychoanalytic lens*. Hillsdale, NJ: Analytic Press.
- American Psychological Association (2002, August). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. Retrieved April 30, 2007.
<http://www.apa.org/pi/multiculturalguidelines/homepage.html>.
- American Psychological Association (2000, August 6). Resolution on poverty and socioeconomic status. Retrieved November 25, 2006, from
<http://www.apa.org/pi/urban/povres.html>.
- Atkinson, D. R., Morten, G., & Sue, D. W. (1998). *Counseling American minorities*. Boston, MA: McGraw Hill.
- Alvidrez, J., Azocar, F., & Miranda, J. (1996). Demystifying the concept of ethnicity for Psychotherapy researchers. *Journal of Consulting and Clinical Psychology*, 64(5), 903-908.
- Bell, C. & Newby, H. (1972). *Community studies*. New York: Praeger.
- Beutler, L., Machado, P., & Newfeldt, S. (1994). Therapist variables. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy & behavior change*, 4th Edition, (pp. 229-269). New York: John Wiley & Sons.
- Bloor, M., McKeganey, N., & Fonkert, D. (1988). *One foot in Eden: A sociological Study of the range of therapeutic community practice*. London: Routledge.

- Brown, L.M. & Gilligan, C. (1992). *Meeting at the crossroads: Women's psychology and girls' development*. New York, NY: Ballantine Books.
- Butler, J. (1990). *Gender trouble : Feminism and the subversion of identity*. New York, NY: Routledge.
- Butler, J. (1993). Endangered/Endangering: Schematic racism and white paranoia. In R. Gooding-Williams, (Ed.). *Reading Rodney king, reading urban uprising* (pp. 15-22). London: Routledge.
- Butler, J. (1997). *The psychic life of power: Theories in subjection*. Stanford, CA: Stanford University Press.
- Chow, J., Jaffee, K., & Snowden, L. (2003). Racial/ethnic disparities in the use of mental health services in poverty [Electronic version]. *American Journal of Public Health, 93*(5), 792- 800.
- Clifford, J. (1986). Introduction: Partial truths. In J. Clifford & G.E. Marcus, (Eds.). *Writing culture: The poetics and politics of ethnography* (pp. 1-26). Berkeley, CA: University of California Press.
- Coffey, A. & Atkinson, P. (1996). *Making sense of qualitative data: Complementary research strategies*. Thousand Oaks, CA: Sage Publications.
- Conquergood, D. (1983). A sense of the other: Interpretation and ethnographic research. In I. Crouch & G. Owen (Eds.). *Proceedings of the seminar/conference on oral traditions* (pp.148-155). Las Cruces: New Mexico University Press.
- Conquergood, D. (1989). Poetics, play, process, and power: The performative turn in anthropology. *Text and Performance Quarterly, 9*, 82-88.

- Conquergood, D. (1992). Ethnography, rhetoric, and performance. *Quarterly Journal of Speech*, 78, 80-97.
- Conquergood, D. (2002). Performance studies: Interventions and radical research. *The Drama Review*, 46, 145-156.
- Cooper, S. & Lentner, T. H. (1992). *Innovations in community mental health*. Sarasota, FL: Professional Resource Press.
- Cosgrove, L. (2003). Feminism, postmodernism, and psychological research. *Hypatia*, 18(3), 85-112.
- Cutler, D.L., Bevilacqua, J., & McFarland, B.H. (2003). Four decades of community mental health: a symphony in four movements. *Community Mental Health Journal*, 39(5), 381-398.
- Denzin, N.K. (1997). *Interpretive ethnography: Ethnographic practices for the 21st Century*. Thousand Oaks: Sage Publications.
- Derrida, J. (1973/1967). *Speech and phenomena and other essays on husserl's theory of signs*. Evanston, IL: Northwestern University Press.
- DeVault, M.L. & McCoy (2002). Institutional ethnography: Using interviews to investigate ruling relations. In J.F. Gubrium & J.A. Holstein (Eds.). *Handbook of interview research: Context & method*, (pp. 751-776). Thousand Oaks, CA: Sage Publications.
- Dig finds a thriving cultural Mecca in Indianapolis. On *All things considered*. National Public Radio, July 23, 2009.
- Durkheim, E. (1933). *The division of labor in society*. New York: Macmillan.

- Emerson, R.M., Fretz, R. I., & Shaw, L.L. (1995). *Writing ethnographic fieldnotes*. Chicago, IL: The University of Chicago Press.
- Evans, G.E. (1943). Here is a postwar job for Pittsburgh: Transforming the hill district. From *Greater Pittsburgh*, July/August.
- Eyerman, R. (2004). Psychological trauma and cultural trauma. In J.C. Alexander, R. Eyerman, B. Giesan, & N.J. Smelser (Eds.), *Cultural trauma and collective identity* (pp. 60-89). Berkeley, CA: University of California Press.
- Fairbairn, W. R. D., (1952). *An object-relations theory of the personality*. New York: Basic Books.
- Fine, M. & Weis, L. (1998). *The unknown city: Lives of poor and working class young adults*. Boston, MA: Beacon.
- Fisher, A.T., Sonn, C. & Bishop, B.J. (2000). *Psychological sense of community, research, Applications and implications*. New York: Springer.
- Foster, R.M. (1996). What is a multicultural perspective for psychoanalysis? In R.M. Foster, M. Moskowitz, R.A. Javier, Reaching across boundaries of culture and class: *Widening the scope of psychotherapy* (pp.3-20). Lanham, MD: Rowman & Littlefield.
- Frank, S. & Keys, C. (1987). Community psychology and the study of organizations: A reciprocal relationship. *American Journal of Community Psychology*, 15, 239-251.
- Freire, P. (2000). *Pedagogy of the oppressed*. (M.B. Ramos, Trans.). New York: Continuum. (Original work published 1970).

- Foucault, M. (1978). *The history of sexuality, vol. 1: An introduction*. (R. Hurley, Trans.). New York: Random House. (Original work published 1976).
- Foucault, M. (1982). The subject and power. *Beyond structuralism and hermeneutics*. Chicago, IL: University of Chicago Press.
- Gamst, G., Dana, R.H., Der-Karaberian, A., & Kramer, T. (2000). Ethnic match and Client ethnicity on global assessment and visitation. *Journal of Community Psychology, 28*(5), 547-564.
- Geertz, C. (1973). Thick description: Toward an interpretive theory of culture. In C. Geertz, *The interpretation of cultures* (pp.3-30). New York, N.Y.: Basic Books.
- Geertz, C. (1983). "From the native's point of view": On the nature of anthropological understanding. In C. Geertz, *Local knowledge: Further essays in interpretive anthropology* (pp. 55-70). New York, N.Y.: Basic Books.
- Goldman, M.R. (1968). *Pittsburgh as I knew it*. Pittsburgh, PA: Historical Society of Western Pennsylvania.
- Gubrium, J.F. (1992). *Out of control: Family therapy and domestic disorder*. Newbury Park, CA: Sage.
- Gusfield, J. R. (1975). *The community: A critical response*. New York: Harper Colophon.
- Hall, D.E. (2005). *Dictionary of multicultural psychology: Issues, terms, and concepts*. Thousand Oaks, CA: Sage.
- Hall, G.C.N. (2005). Introduction to the special section on multicultural and community psychology: Clinical psychology in context. *American Psychologist, 73*(5), 787-789.

- Hall, G.C.N & Barongan, C. (2001). *Multicultural psychology*. New York: Pearson.
- Hammonds, D. (1986, November 27). Signs of the hill coming back. *Pittsburgh Post-Gazette*, p. C1.
- Helms, J. E. (1994). How multiculturalism obscured racial factors in the therapy process. *Journal of Counseling Psychology*, 41, 162-165.
- Hillery, G. (1955). Definitions of community: Areas of agreement, *Rural Sociology*, 20, 111-123.
- hooks, b. (1990). *Yearning: Race, gender, and cultural politics*. Cambridge, MA: South End Press.
- Hutchinson, E.D. (1995). *Toward a theory of community: enhancing the HBSE curriculum*. Unpublished manuscript, Virginia Commonwealth University, Richmond.
- Hwang, J. & Schenck, D. (2004). *Struggling with location: A collaborative qualitative study of multicultural counseling competence in U.S. psychology*. Unpublished doctoral dissertation, Duquesne University, Pittsburgh, PA.
- Jacobs, J. (1961). *The death and life of great American cities*. Random House.
- James, S. & Prillettensky, I. (2002). Cultural diversity and mental health: Towards integrative practice. *Clinical Psychology Review*, 22, 1133-1154.
- Javier, R.A. (1996). Psychodynamic treatment of the urban poor. In R.M. Foster, M. Moskowitz, & R.A. Javier (Eds.), *Reaching across boundaries of culture and Class: Widening the scope of psychotherapy* (pp. 93-113). Lanham, MD: Rowman & Littlefield.

- Kelly, J.G. (2003). Science and community psychology: Social norms and pluralistic inquiry *American Journal of Community Psychology*, 31, 213-17.
- Kitayama, S. & Markus, H.R. (2000). The pursuit of happiness and the realization of sympathy: Cultural patterns of self, social relations, and well-being, in *Culture and Subjective Well-Being*. Cambridge, MA: MIT Press, pp. 113-161.
- Klein, M. (1964). *Love, Guilt and Reparation: And Other Works 1921-1945*. London: Hogarth Press.
- Krenske, L. & McKay, J. (2002). Hard and heavy: Gender and power in a heavy metal music subculture. In S.B. Merriam, (Ed.), *Qualitative research in practice: Examples for discussion and analysis*. San Francisco, CA: Jossey-Bass.
- Levinas, E. (1992). *Totality and infinity*. Pittsburgh, PA: Duquesne University Press (Original work published 1969).
- Levine, M. (1981). *The history and politics of community mental health*. Oxford: Oxford University Press.
- Levine, M, Perkins, D.D., & Perkins, D.V. (2005). *Principles of community psychology: Perspectives and applications*, (3rd Ed.). New York, NY.: Oxford University Press.
- Lincoln, Y.S. & Denzin, N.K. (1994). *The handbook of qualitative research* (3rd Ed.). Thousand Oaks, CA: Sage.
- Lott, B. (2002). Cognitive and behavioral distancing from the poor. *American Psychologist*, 57(2), 100-110.
- MacLeod, J. (1995). *Ain't no makin' it: Aspirations and attainment in a low-income neighborhood*. Boulder, CO: Westview Press.

- Macran, S. Ross, H., Hardy, G. E., & Shapiro, D. A. (1999). The importance of considering clients' perspectives in psychotherapy research. *Journal of Mental Health, 8*(4), 325-337.
- Madison, D.S. (2005). *Critical ethnography: Method, ethics, and performance*. Thousand Oaks, CA: Sage.
- Maramba, G.G. & Hall, G.N. (2002). Meta analysis of ethnic match as predictor of dropout, utilization and level of functioning. *Cultural Diversity & Ethnic Minority Psychology, 8*, 290-297.
- Maruyama, M. (1992). *Context and Complexity: Cultivating Contextual Understanding*. New York: Springer-Verlag.
- McLeod, J. (2001). *Qualitative research in counselling and psychotherapy*. London: Sage.
- Miles, M.B. & Huberman, A.M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd Ed.). Thousand Oaks, CA: Sage.
- Mitchell, P. M. (2005). A qualitative analysis of professional psychological help-seeking attitudes among African-American women. *Dissertation Abstracts International, 65*, 12B. (UMI No. 3158980).
- Modan, G.G. (2007). *Turf wars: Discourse, diversity, and the politics of place*. Malden, MA: Blackwell Publishing.
- Newberry, J. D. (2005). The meaningful participation of consumers on mental health agency boards: Experiential power and models of governance. *Dissertation Abstracts International, 65*, 10B.

- Orford, J. (2008). *Community psychology: Challenges, controversies and emerging consensus*. West Sussex, England: Wiley & Sons, Ltd.
- Paris, M., Añez, L. M., Bedregal, L. E., Andrés-Hyman, R. C., and Davidson, L. (2005). Help seeking and satisfaction among Latinas: The roles of setting, ethnic, identity, and therapeutic alliance. *Journal of Community Psychology*, 33(3), 299-312.
- Phillips, L. (2005). Perceptions of good psychotherapy in a community mental health setting: Exploring the contextual nature of treatment. *Dissertation Abstracts International*, 65.
- Phillips, N. & Hardy, C. (2002) *Discourse analysis: Investigating processes of social construction* (Qualitative Research Methods Series 50). Thousand Oaks, CA: Sage Publications.
- Pittsburgh Department of City Planning. January 2006.
http://www.city.pittsburgh.pa.us/cp/assets/census/2000_census_pgh_jan06.pdf.
Retrieved on 2007-07-19.
- Price, M. (2008). Culture matters: Accounting for clients' backgrounds and values makes for better treatment. *Monitor on Psychology*, 39(7), p.53.
- Prilleltensky, I. (1994). *The morals and politics of psychology: Psychological discourse and the status quo*. Albany, NY: SUNY Press.
- Prilleltensky, I. & Nelson, G. (2002). *Doing psychology critically: Making a difference in diverse settings*. New York: Palgrave Macmillan.
- Rappaport, J. *Community Psychology: Values, research, & action*. New York: Harcourt School.

- Reissman, C.K. (2008). *Narrative methods for the human sciences*. Los Angeles, CA: Sage Publications.
- Rios, J. M., Palacios, F. F., Gonzalez, M. D., & Sandoval, M. M. (2003). Meaning construction about mental health in general population from marginal-urban community. *Salud Mental, 26*(5), 51-60.
- Sampson, E. E. (1993a). *Celebrating the other: A dialogic account of human nature*. New York: Harvester Wheatsheaf.
- Sampson, E. E. (1993b). Identity politics: Challenges to psychology's understanding, *American Psychologist, 48*, 1219-1230.
- Sarason, S. (1974). *The psychological sense of community: Prospects for a community psychology*. San Francisco: Jossey-Bass.
- Schön, D. (1983) *The reflective practitioner: How practitioners think in action*. New York: Basic Books.
- Segall, A. (2001). Critical ethnography and the invocation of voice: From the field/in the field – single exposure, double standard? *International Journal of Qualitative Studies in Education, 14*(4), 579-592.
- Sessions, P. & Lightburn, A. (2006). What is community-based clinical practice? Traditions and transformations. In A. Lightburn & P. Sessions (Eds.), *Handbook of community-based clinical practice* (pp. 3-18). New York: Oxford University Press.
- Shweder, R.A. (1991). *Thinking through cultures: Expeditions in cultural psychology*. Cambridge, MA: Harvard University Press.

- Spadley, J.P. (1979). *The ethnographic interview*. Fort Worth, TX: Harcourt Brace Jovanovich College Publishers.
- Smelser, N.J. (2004). Psychological trauma and cultural trauma. In J.C. Alexander, R. Eyerman, B. Giesan, & N.J. Smelser (Eds.), *Cultural trauma and collective identity* (pp.31-59). Berkely, CA: University of California Press.
- Smith, L. (2005). Psychotherapy, classism, and the poor: Conspicuous by their absence. *American Psychologist*, *60*(7), 687-696.
- Snowden, L. R. (2005). Racial, cultural and ethnic disparities in health and mental health: Toward theory and research at community levels [Electronic Version]. *American Journal of Community Psychology*, *35*, 1-9.
- Sonn, C. (2004) Negotiating identities across cultural boundaries: Complicating cultural competence with power and privilege. *Critical psychology: International journal of critical psychology*, *11*, 134-149.
- Stevenson, K.S. (2001, September 4). The mental health care system is failing African Americans. *Pittsburgh Post-Gazette*, p. A1.
- Strauss, A.L. (1987). *Qualitative analysis for social scientists*. Cambridge, UK: Cambridge University Press.
- Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist*, *53*, 440-448.
- Sue, S., Fujino, D., Hu, C., Takeuchi, D., & Zane, N. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting & Clinical Psychology*, *59*, 533-540.

- Sue, D.W., Arredondo, P., & McDavis, R.J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*, 477-486.
- Swartz, L. (1996). *Crossing or creating boundaries: Challenges in clinical psychology in the community*. Cape University of Cape Town.
- Swenson, C.R. (2006). Ideas of self in community: Expanding possibilities for practice. In A. Lightburn and P. Sessions (Eds.), *Handbook of community-based clinical practice*, (pp.63-83). New York: Oxford University Press.
- Thomas, J. (1993). *Doing critical ethnography*. Newbury Park, CA: Sage
- Toker, Franklin. (1986, 1994). *Pittsburgh: An urban portrait*. Pittsburgh, PA: University of Pittsburgh Press.
- Trotter, J.W. & Smith, E.L. (1997). *African Americans in Pennsylvania*. University Park, PA: Pennsylvania State University Press.
- Vega, W. A. & Murphy, J. W. (1990). *Culture and the restructuring of community mental health*. New York, NY: Greenwood Press.
- Wainwright, D. (1997) Can sociological research be qualitative, critical and valid? *The Qualitative Report, 3*(2), Retrieved from <http://www.nova.edu/ssss/QR/QR3-2/wain.html>.
- Wolff, T. (2000). Practitioner's Perspectives. In J. Rappaport & E. Seidman (Eds.), *Handbook of community psychology* (pp. 741-745). New York: Springer.
- Winnicott, D.W. (1965). *The family and individual development*. New York: Basic Books.

Wynaden, D., Chapman, R., Orb, A. McGowan, S., Zeeman, Z., and Yeak, S. (2005).

Factors that influence asian communities' access to mental health care.

International Journal of Mental Health Nursing, 14(2), 88-95.

APPENDIX A

PART 1

CONSENT TO ACT AS A PARTICIPANT IN A RESEARCH STUDY

TITLE: Mental health care at the margins: A critical ethnography of psychological practice in an inner city community mental health care center

PRINCIPAL INVESTIGATOR: Katy Sampson, M.A.
 Duquesne University Psychology Doctoral candidate
 600 Forbes Avenue
 Pittsburgh, PA 15282
 Telephone: 412-956-0615

FACULTY SPONSOR: Mario Cruz, M.D.
 Assistant Professor of Psychiatry
 University of Pittsburgh
 Pittsburgh, PA 15213
 Telephone: 412-586-2958

SOURCE OF SUPPORT: Self- funded

Why is this research being done?

You are being asked to participate in a research project that seeks to investigate psychological practice in an inner city community mental health setting. The general purpose of this investigation is to gain more insight into the current gap in adequate mental health care services for marginalized populations such as racial/ethnic minorities and individuals of lower SES through learning more about the experience of clinicians who provide such services.

Who is being asked to take part in this research study?

You are being invited to take part in this research study because you are a staff member of an inner city community mental health clinic. The data from interviews you provide will be added to more general participant-observations, and personal reflections in an effort to tell a story of psychological practice within your particular community mental health center. The results are not meant to be generalizable but to represent an experience-near account of the complex interplay of factors when it comes to providing mental health care to individuals of minority, lower socioeconomic status. People invited to participate in this study must be past/current staff at the Center and be of at least 21 years of age.

What procedures will be performed for research purposes?

If you decide to take part in this research study, you will be asked to allow me to interview you. The interviews will take place over a 3 month period. I will ask to meet with you for ½ to 1 hour over 1-2 interview

sessions. The interviews will be taped and transcribed. Upon follow-up I will request feedback for your input on the results of the study. All interviews will take place in a confidential setting of your choosing and tapes from interviews will be destroyed after transcription. All mention of names will be erased or changed to protect your anonymity.

What are the possible risks participating in this research study?

The possible risks of participating in this research study are not greater than those encountered in everyday life. Participants will not be expected to proceed with discussions of topics that they feel will jeopardize their employment or otherwise cause undue discomfort or tension. In accordance with IRB guidelines I will ensure confidentiality of participants and any individuals mentioned by participants during interviews.

What are possible benefits from taking part in this study?

Participants will not receive any direct benefit other than the potential to contribute to the knowledge and understanding of psychological practice with marginalized populations and in turn perhaps assisting with the development of more culturally appropriate psychological care.

Will I be paid if I take part in this research study?

Participants will receive a \$20 gift card to Giant Eagle grocery store for participating in the study.

Who will know about my participation in this research study?

Any information about you obtained from this research will be kept as confidential (private) as possible. All records related to your involvement in this research study will be stored in a locked file cabinet. Your identity on these records will be indicated by a case number rather than by your name, and the information linking these case numbers with your identity will be kept separate from the research records. You will not be identified by name in any publication of the research results unless you sign a separate consent form giving your permission (release).

Who will have access to identifiable information related to my participation in this research study?

The principal investigator, listed on the first page of this authorization (consent) form will be the only individual who will have access to identifiable information. All data obtained for research purposes will be kept confidential in a password protected file on the principal investigators computer. Possible exceptions to maintaining confidentiality of research data include: 1) if you reveal information that suggests abuse of an elderly person or child; 2) an audit of research by University Research Conduct and Compliance Office, or 3) research data is subpoenaed by court system. In accordance with University policy, research records will be maintained in a locked file for 6 years at which point all records will be destroyed.

Is my participation in this research study voluntary?

Your participation in this research study is completely voluntary. Whether or not you provide your consent for participation in this research study will have no effect on your current or future relationship with the University Medical Center, UPMC, or the Center.

May I withdraw, at a future date, my consent for participation in this research study?

You may withdraw, at any time, your consent for participation in this research study. To formally withdraw your consent for participation in this research study you should provide a written and dated notice of this decision to the principal investigator of this research study at the address listed on the first page of this form. Your decision to withdraw your consent for participation in this research study will have no effect on your current or future relationship with the University Medical Center, UPMC, or the Center.

VOLUNTARY CONSENT

The above information has been explained to me and all of my current questions have been answered. I understand that I am encouraged to ask questions about any aspect of this research study during the course of this study, and that such future questions will be answered by the investigator listed on the first page of this consent document at the telephone number given. I understand that I may always request that my questions, concerns or complaints be addressed by a listed investigator.

I understand that I may contact the Human Subjects Protection Advocate of the IRB Office, University of Pittsburgh (1-866-212-2668) to discuss problems, concerns, and questions; obtain information; offer input; or discuss situations in the event that the research team is unavailable.

By signing this form, I agree to participate in this research study. A copy of this consent form will be given to me.

Participant's Signature

Printed Name of Participant

Date

CERTIFICATION of INFORMED CONSENT

I certify that I have explained the nature and purpose of this research study to the above-named individual(s), and I have discussed the potential benefits and possible risks of study participation. Any questions the individual(s) have about this study have been answered, and we will always be available to address future questions as they arise."

Printed Name of Person Obtaining Consent

Role in Research Study

Signature of Person Obtaining Consent



APPENDIX A - PART 2

Duquesne University Informed Consent to Participate in Study

DUQUESNE UNIVERSITY

600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: Mental health care at the margins: A critical ethnography of psychological practice in an inner city community mental health care center

INVESTIGATOR: Katy Sampson, M.A. (412) 956- 0615

ADVISOR: (if applicable:) Leswin Laubscher, Ph.D.
Psychology Department
412-396-1843

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the Doctoral degree in Psychology at Duquesne University

PURPOSE: You are being asked to participate in a research project that seeks to investigate psychological practice in an inner city community mental health setting. You will be asked to allow me to interview you for approximately ½ hour- 1 hour. The interviews will be conducted in a private place of your choosing. The interview will be digitally recorded and subsequently transcribed. All identifying data will be removed from transcripts and digital recordings will be destroyed. After completion of the study I will provide you with a copy of results if you would like and request your further feedback on the process/results of the study.

These are the only requests that will be made of you.

RISKS AND BENEFITS: There are no risks greater than those encountered in everyday life.

- COMPENSATION:** You will provided with a \$20 gift card to Giant Eagle in exchange for your participation in this study.
- CONFIDENTIALITY:** Your name will never appear on any survey or research instruments. No identifying information will be included in the data analysis. All written materials and consent forms will be stored in a locked file in a locked office. All of these materials will be destroyed at the completion of the research. Any identifying information that may come up during interviews will be deleting during the transcription process.
- RIGHT TO WITHDRAW:** You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time.
- SUMMARY OF RESULTS:** A summary of the results of this research will be supplied to you, at no cost, upon request.
- VOLUNTARY CONSENT:** I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.
- I understand that should I have any further questions about my participation in this study, I may call Katy Sampson, Primary Investigator, at (412) 956-1605, Dr. Leswin Laubscher, Faculty Advisor, at (412) 396-1843, or Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board 412-396-6326).

 Participant's Signature

 Date

 Researcher's Signature

 Date

APPENDIX B

Interview Guide

Interview Guide

Below please find some sample interview questions regarding general areas of interest as well as a basic overview of the type of information the interviewer will collect. Please note the interview will follow an iterative process and will vary depending on participants' answers to questions.

- 1) Demographic information: gender, race, how long employed at the Center
- 2) Nature of training/background: type of academic program/degree, areas of interest, training in multicultural issues in psychology, preparedness for working in an inner city community clinic
- 3) Views regarding clinical work at 8th District/Center: what do you see as a main goal, function of your work with clients? some of the everyday challenges and tensions with regard to clinical work? describe the issues that were most salient in the most difficult cases; how are race and class incorporated into your clinical work? what makes working in an inner city public clinic unique from other private clinics?
- 4) Culture of center: how would you describe the culture of the Center? with regard to clients, and with regard to interdisciplinary work that occurs here?
- 5) 8th District Community: What is your understanding of the history of the 8th District? How does it or does it not impact your work here? What is your personal relationship to this community if any?

APPENDIX C

Transcript Notation Legend

Symbol	Meaning
(.)	Slight pause
(#)	Silence measure in seconds
=end of line or =beginning of line	No pause between utterances
<u>Underlined Text</u>	Words uttered with vocal emphasis
CAPITALIZED TEXT	Words louder than surrounding talk
()	Talk that was inaudible or impossible to interpret
{text}	Transcriber comments
text-	Sudden cutoff of speech
Te::xt	Syllable prolonged/extended
//text	Overlapping talk
# at beginning of line	Line number
P#	Speaker participant number

Speaker Identification

Speaker	Name	Position
P1	Tom	Director and Therapist
P2	Theresa	Therapist
P3	Michael	Therapist
P4	Sam	Psychiatrist
K or I	Katy Sampson	Interviewer

APPENDIX D

Interview Transcript: Tom (P1)

1 Interview with P1

2

3 K: I just want to thank you for agreeing to sit down with me to talk and we've had so many
4 conversations already informally that I feel have been really interesting and I've done a lot of my
5 own thinking about my work here but uh, I think that being able to sit down with you a little
6 more formally will be helpful for my research.

7

8 P1: Well good, well thanks.

9

10 K: and um yeah, I would like for this to be, somewhat structured and I only have some questions
11 but I would like for you to feel to elaborate on any topics that seem more interesting to you (P1:
12 okay, all right) or important to you. You are the director here –

13

14 P1: that is correct

15

16 K: - and what is your training as far as your degree?

17

18 P1: I have a master's degree in clinical psychology and actually I dropped out of a Ph.D.
19 program, I got like 10 credits short of my doctoral (I: Really). Yeah.

20

21 K: I didn't know that, where was that?

22

23 P1: In California

24

25 K: Okay, wow, and that was in clinical psych?

26

27 P1: Clinical psych, clinical psychology, yeah.

28

29 K: Okay, great. And so, the focus of what I want to ask you about more is your experience here.
30 And everyday work here 'cause it seems a lot of times in the literature, that's what kind of gets
31 glossed over. And in my time here, I could see that there were just so many factors (P1: hm
32 *{interested confirming tone}*) not only in our clients' lives and what they are bringing in but also
33 how we are working here and how you as the director are playing multiple roles at any given
34 time.

35

36 P1: Right.

37

38 K: So, I wondered if you could describe, you know, a typical day here. I know that everyday is
 39 different (P1: [LF] *{seemingly in recognition and agreement}*), throwing different things at you,
 40 but if you were to describe to me sort of a course of a day –

41
 42 P1: yeah (.) let me just if I could Katy, go back and talk a little bit about how I got here, because
 43 *{noise in the background from social group going in next room}* I think I might try to put it in
 44 perspective about (I: okay, absolutely) about what it is. I –I was uh, actually I was in another
 45 facility and uh, I've been here like 5 or 6 years I've done like a lot of trouble shooting kind of
 46 things, programs were having difficulty and I'd asked, I'd been asked, like oh, 2 years prior to
 47 even coming here *{noise in background, voices shouting, laughing, talking continues}* would I
 48 come over here and help straighten () the program because this program has been here like, 33,
 49 34 years, been established in the community (.) a::nd... what happened is it's never made any
 50 money – well, it's a nonprofit but () it's lost considerable money here. And the model was based
 51 primarily on a traditional outpatient model, in which you see the client for 45 minutes and for
 52 every hour you spend 15 minutes or downtime recording your work, that kind of stuff. (I: Mhm)
 53 So, at the end of an 8 hour day, you're lookin' at, oh, about 2 hours that you lose (I: Mhm) that's
 54 if everyone shows up. So, if everyone loses two hours at the end of the day, then obviously your
 55 productivity is down, if everybody shows up. But this is a tough clientele; there is a lot of reason
 56 why people don't show up, it's just not necessarily that they are not motivated for the treatment.
 57 It has a lot to do with other things, watching kids, the safety people feel about leaving their
 58 house, their house will get broken into – there's a lot of factors that goes into that. So, when I
 59 came here, I saw total chaos and I'm not trying to paint a negative picture but I just want to put it
 60 in its' proper perspective, u::m, that (.) we were losing money, u::h, there were little or no
 61 groups, the model was a mental health model, that you use in outpatient and you see the people
 62 come here (I: Mhm) who weren't doing many community based kind of things, we were pretty
 63 much isolated just here in the Center. So, immediately what we did is start to implement some
 64 things to try to change some things getting people more interested asking the clients, putting
 65 questionnaires out, what would they like to see here, (I: Mhm) that kind of stuff, so PART of the
 66 thinking, the thought process was, u::m, what does our clients need, it's not necessarily about us,
 67 it's about them. (I:Mhm) And so we needed to fix traditional ways of looking at things, sure, we
 68 could come in here and say, oh, you need this, this, this, this and that...and then, as a result of
 69 that you could do that - so, we sorta, we put out questionnaires, uh, involving the clients, and
 70 empowering them and saying: what do you need? Would you like to belong to this? What do you
 71 think about this? (I:Mhm) and those kinda things. And, u::m a lot of the stereotypes that were
 72 attached to mental health issues, u::h, the stigma attached to, if you're taking medication, you
 73 must be crazy, uh, the churches in terms of where they were, in terms of u::h, well we'll pray for
 74 ya, uh that kind of thing, as opposed to, maybe you got an illness, and lot of people are up in the
 75 churches prayin' for 'em, now I'm not against prayer but, uh, there were a lot of things that were
 76 going on there. So any way, long story – w-w-what happened was, due to what our clients were
 77 givin' us in these questionnaires and talking with 'em and involving 'em in the process we
 78 decided to switch the format, lot of non-traditional things. For example, meeting the needs, we
 79 have a high homeless population here, so there were people coming in here that, um, u::h, were
 80 sleeping under the bridge or under a tree, or you know, under a car, or you know that kind- or in
 81 a box and hadn't showered in days, sometimes weeks, so one of the things we talked about is
 82 implementing a shower (I: Mm)

83 it's pretty hard to talk to somebody if they're feeling dirty and grimy and stuff, um so that was
 84 one thing we implemented, and the other thing is, uh, they didn't have any clothes!
 85 *{said excitedly with sense of irony}* if they take a shower they didn't have any clean clothes to
 86 put on - they put their smelly clothes back on! So we purchased a washer and a dryer, a clothes
 87 washer and dryer, which helped out a lot, now that's not the panacea but it certainly helps out in
 88 terms of where one is. So then we worked with the churches and drycleaner establishments and
 89 terms of donating clothes for people (I: Mhm) u::m, so it's pretty hard like I said earlier for
 90 someone to come in and talk about oh, I'm being depressed if they haven't eaten for 2 or 3 days,
 91 if they haven't slept, and (?) something as basic as water, u::m making 'em feel better about
 92 themselves. So, we switched that whole format and we were starting to change and reach out and
 93 again we're not the panacea, but just to give 'em some insights and "hey, uh, we're about you,
 94 we're about helping you, and, it's not about us (I:Mhm) u::h we're just a part of here and what
 95 we can do to try to help you uh, little things like coffee, that was one of the things they talked
 96 about, "we want to be able to come in here and have coffee," u::h so we worked with people
 97 around food, donating food here and that kind of thing, so there's A LOT of little different things
 98 and that's what typical () so...getting to your question, your INITIAL question, is I do a lot of
 99 stuff so, I get here in the morning, I get here a quarter to 7, 6:30 - a quarter to 7, everyday and uh,
 100 I just do a little straightening up and, I-I-I typically, u::h, I have a little bleach bottle 10% bleach
 101 and I wash down the couch, cause that's (maldehyde?) so we can wash 'em down. Um, I make
 102 coffee in the morning, then I straighten up, put books out, magazines, brochures and things like
 103 'gat, for our clients, and then I get on the, uh internet and read my email, I take my voicemail,
 104 u::h...(2) and then I do a lot of administrative stuff, I do my stuff before everybody gets here,
 105 cause we don't open 'till 8:30 so I get here from that time, I just get - a lot of things I can do,
 106 administrative stuff, letter writing, uh, follow ups, I mean a lot of different kinds of things,
 107 before anybody gets here, uh, when people get here, it depends on Monday, Wednesdays, and
 108 Fridays I run groups, I see individual clients, I got a caseload like outrageous,

109
 110 K: How many people?

111
 112 P1: Oh my God I hate to say it on here, uh, I have way over 100, on my caseload *{some distress,*
 113 *shame? embarrassment? in his voice}* u::m (I: Mhm) u::h, but that's not consistent but I got way
 114 over 100 people that I do see, on occasion. So, that's just, some of the little things we do, then
 115 there's a lot of m--, I order supplies, uh, 'cause right now we don't have anybody we got a
 116 temporary help and we're hiring somebody to help take care of that stuff, so any kind of the u::h,
 117 technical things here: bill paying, all that kind of stuff, all the management stuff uh -

118
 119 K: So, you really have your hand in almost everything.

120
 121 P1: //everything, EVERYTHING here

122
 123 K:- that's happening here!

124
 125 P1: Uh, we do try to delegate some stuff, uh, and make sure that the bills are paid, I gotta check
 126 the bills, and all that kind of stuff - so now I leave here, at oh, about 6 in the evening, something
 127 like that, so it's a long day.

128
129 K: It sounds like a lot of work.

130
131 P1: It's allota work, allota work, but you know (.) part of that I don't mind because I really do
132 see, that people are getting help and I don't know if you can put time on that, I mean it's just, it's
133 just a process, and those are the kind of things that I think, you can't put a value on it but you just
134 know it's working. And, the other thing I want to say is, is, is demeanor, the demeanor, I don't
135 want to say demeanor (.) the agency, the um, I'm lacking the word now (2) in terms of, u::h, I
136 want to say ambiance but that's not the word (.) u::m, people feeling comfortable, you know, uh,
137 setting situations – you can't - I know really believe that you - we've talked about this, that I
138 don't believe you can teach that, see I think, either you have it, you have a knack to work with
139 people, or you don't. (I:M hm) Either you legitimately like people or you don't. And I don't
140 think you can train people to do that (.) and I think you, uh, you have to hav - have it. The little
141 things, I think that means a lot, and we've also talked about this, uh, setting up when people
142 come through the door, the acknowledgement, a sense of acknowledgement, that's one thing we
143 really work hard about when people come through the door, we acknowledge that they be here
144 because often enough people here are disenfranchised (I: Mhm) and uh, they're sensitive to how
145 they're being treated, or mistreated, and whether it be real or perceived our perception is
146 everything, so what's their perception is where it is, so we really work hard in terms of not a
147 fake kind of thing but legitimately find out where the people are, say "glad to see you," to engage
148 everybody who comes through there. So, I think that has a lot to do - we've seen our-ou-our
149 attendance skyrocket here. Um, and...I think a lot of it has to do with just engaging people here,
150 just say "hey, we're here for ya" there is a sense that, you know, that people legitimately care
151 about you.

152
153 K: Now, it's skyrocketed ss- since certain changes, or...

154
155 P1: -yeah, since we started implementing groups and things like 'gat that's one of the things I
156 think happened 'cause a lot of people go we::ll, people got too many issues, I don't want - you
157 know this is interesting - the talk was, you know, part of the African American culture talks
158 about u::h, what we say here, stays here, it goes in a lot of cultures but particularly the African
159 American talks about – "what you say at home, stays at home." A::nd there was a lot of people
160 that said, when we were trying to talk about groups, "oh, people won't come to these groups!"
161 "ain't nobody goin' talk about what's goin' on with them!" and that kind of stuff. (I:Mhm) The
162 key wasn't necessarily the process but just to get 'em out to socialize, 'cause we have a lot of
163 trauma here, in the 8th district and a lot of people, the majority of our clients have experienced a
164 tremendous amount of trauma and that one of the things, I guess I've often said that not only are
165 our clients traumatized but our entire community, i-i-is suffering from PTSD (I: Mhm) and I
166 think we have to do a lot of that so one of the things that's real lacking now is, we're looking -
167 and maybe I'm getting ahead of myself now, 'bout what I'm lackin,' but what we really do need,
168 and we'll be implementing that this year, uh, children and adolescents,
169 (I: Yeah) we're an adult, primarily an adult population, but we know that there is a big need to
170 address the preadolescent and adolescent, so, we're moving in that vein.

171

172 I: You know, I was just, someone was mentioning, I just took a crisis management training this
173 morning and someone brought in an article about the gangs in Pittsburgh and especially in the
174 North Side, I guess, there are a lot of, and I was actually surprised, I guess I'm removed from
175 gang activity for the most part or I don't see it, and that seems like adolescents get drawn into a
176 lot, easily -

177
178 P1: Mhm, mhm, Yeah – well gangs represent what families missed. I mean, um, it's an identity,
179 it's protection (I: Mhm) it's nurturance, it's love,

180
181 K: It's that acknowledgement on some level that you're saying that you offer here

182
183 P1: absolutely, absolutely.

184
185 K: - and validation of your existence on some level, even if it's in a way that's eventually
186 destructive

187
188 P1: absolutely

189
190 K: - well, you mentioned a lot of things, like you said we have talked about before and made me
191 think of questions...

192
193 P1: Oh, good, good!

194
195 K: Uh, and a lot of what you're saying really speaks to the way that you and other clinicians here
196 really incorporate issues of race and class into your work here, um and, more specifically, the
197 history of this particular community in the 8th district here. And...I wondered about, it may be
198 hard to reflect on this and take a step back and articulate it, but I wondered about how you, saw
199 and you touched on it a little bit, how you incorporate race and class into your clinical work,
200 either individually or as a director here and then also this specific community and dealing with
201 issues specific to this community and and dealing with issues specific to this community.

202
203 P1: Yea, first of all, I think we have to go back to you've got to start obviously with where the
204 clients are. See, i-i- a lot of times what we want to do is we want to paint race and class with a
205 broad brush and incorporate everybody as an integral part of that, your (I: Mhm, yeah) this race
206 or this culture or socioeconomic so everybody gets that and I think that's a BIG mistake that
207 everybody makes because everyone's different of course we all may be different race different
208 sexes that kind of thing, different gender that kind of thing, what happens is everyone's different
209 and perceives things different. Everyone has difference of experiences so yeah, we may be alike
210 on one perspective or two perspective whatever, but we still have different things that's unique to
211 us. And I think that's the key in terms of, of, of, of- again we can't be everything to everyone,
212 but to help to identify what's, what's significant in that individual and start where they are. Uh
213 (2) you know, it's interesting because like I said, you know we do like, there's the shoes there
214 and things like 'gat we have. Some, some of our clients will not take that because they say
215 "there's people that are a lot worse off than me." And, and we've been given a chance, and by
216 the same token people from the other perspective will take everything here and be out selling it,

217 okay? So, um, i-it's just different and you just got to take - and we've been real good about
 218 people not stealing, now we got one or two people here who still they () steal and that's just the
 219 way it is. But getting back to the race and the class we have to incorporate it 'cause that's
 220 ALSO, it's not everything but it's an integral part of who we are. It's just sayin' - me to deny
 221 that you are a woman, okay? I mean, or me a male, uh that kind of stuff. So, that's who we are,
 222 that's not all we are, but that's an integral part of who we are. So we have to take all of those
 223 things in conjunction with the other things, and if we DO NOT DO THAT, 'cause we talkin'
 224 'bout the entire person, not bits and pieces, and often times I think that's what we miss when we
 225 come in there. W-w we address, well, if someone is coming in for depression, and we just treat
 226 the depression then we're really missing the boat, mm-kay. So the same thing has to do with this,
 227 we have to incorporate, as far as I'm concerned, everything, as much as we can. Again, that
 228 becomes difficult because it's a "wow!" with all of the problems we have here, how do you do it,
 229 that become difficult, how do you do it? So we say well, we just got to sit down and prioritize
 230 what's the greatest needs that this individual has and then we got to base it and go from there (I:
 231 Mhm)

232
 233 K: With some of the questionnaires that you had given to potential clients, or clients, you did get
 234 a general sense of some of their needs and that may have been connected to class with needing,
 235 you know food (P1: absolutely) or, you know, being homeless, and, and all that but that, you
 236 know that you're saying that those are some of the ways that you take it up in a general sense but
 237 then you focus more on

238
 239 P1: //specific

240
 241 K: the individual person, what does that mean in their life? Because it could be very different
 242 like you said. One person might be very grateful to have the shoes and want to take them home
 243 and use them whereas other people, might um, might even feel ashamed?

244
 245 P1: shame, that's right, absolutely.

246
 247 K: so, like you're saying you can't really predict that but just to be sensitive to the fact that
 248 people are gonna have a different relationship to whatever that social category is 'cause that -
 249 well, I don't want to go on with what *I* think about that, but um, you have, it sounds like, a very,
 250 much more kind of complex way of looking at it than some of the multicultural textbooks would
 251 teach (P1: Mhm) um, and that kind of leads into - before we get into some of the history of the
 252 8th district and how you incorporate that - I am interested about if you feel like you were
 253 prepared in school with your training to do this kind of work.

254
 255 P1: No, no way. Not even close. See I think a lot of it has to do - goin' back to - I believe
 256 experience, u::h, is a great teacher (1) now maybe not the only teacher but just think, see I come
 257 up in an environment there's like seven in my family, a::nd, u::m, we were always, u::m
 258 taught.that. you take responsibility for your actions and it's on you and you get what you put in
 259 and that kind of stuff. (I: Mhm) Now, I chose not to follow that path 'cause I wanted to find my
 260 own thing, okay? Uh, I embarked on my own little ways of finding things, so I got into the anti-
 261 Vietnam sentiment and went to California to Berserk-ly and I did all that stuff - protests and

262 getting' arrested and put in jail and stuff like that. Now (2) I don't regret any of that, 'cause if I
 263 had to do it all over again I'd do the same thing. 'cause I thi::nk for m::e, 'cause I was always
 264 taught you got to stand up for what you believe, now interestingly enough I stood up for what I
 265 believed but it wasn't what my parents believed. (I: Mhm) so it was in direct opposition to that
 266 kind of stuff and s::o I was out in California, I was out, like I said, in Berserk-ly and it was crazy
 267 out in California, someone said like Robin Williams says "if you were in the 60s and you
 268 remember 'em, you weren't in 'em!" (I: LF) So the bits and pieces that I can recall about the 60s
 269 – but it was good for me because you're talking about social consciousness, u::h that I think was
 270 happening, and um, I look back on that I'm thinking well that helped shape, it helped shaped my
 271 thoughts and helped reinforce some of my belief systems and some of the things that just made
 272 me more ingrained and more committed to making the difference, and so I-I-I got um, like I said,
 273 schooling was one different kind even in California um, i::t was okay, I mean I wouldn't trade
 274 the educational kind of stuff but I think nothing, nothing can prepare you as far as I'm concerned
 275 until you get off and get into it, and get your hands dirty, and you know and you role your
 276 sleeves up and really find out what it's about. Because I don't know about your experience, but
 277 you can't teach as far as I'm concerned, you can't teach, you can't teach this out of a book, this
 278 doesn't come out of a book and and uh, um, I mean you can see it, I mean wow {*voice filled with*
 279 *awe*} it makes sense, well that's such {*phone ringing in office, P1 does not answer it*} and such a
 280 theory that's not gonna get it, you know. So, in answer to your question, no, I don't think so.

281 20:26

282 And I, but, but on the one hand, I don't think like directly it did, I mean it helped me to get my
 283 foot in the door, um but I think I wouldn't trade any of the life experiences for any class, any
 284 course, that I've ever taken.

285

286 K: The life experiences when you were in the 60s.

287

288 P1: Absolutely, absolutely, absolutely. And my family too, my family I think were very
 289 supportive but I just chose to do other things, I had to find me, I'm still looking but (I: [LF])
 290 that's that's who...

291

292 K: yeah that's a long process.

293

294 P1: Yea, yeah I don't know if that answered your question but –

295

296 K: Yeah, so there are a lot of other life experiences that you feel which makes sense, I mean you
 297 have your whole life and just your personal background also that you bring to your work, that
 298 any...I think your tree is falling {*tree in planter begins to fall over, P1 reaches over to catch it*}

299

300 P1: Uh-oh! Those guys came today, and were fixing it, they were fixing this dogon place today
 301 (I: [LF] oh boy) and they put new plugs in there, here I'll put it around this way, I'll put it this
 302 way. Okay.

303

304 K: [LF] maybe the tree doesn't like what we're saying or something!

305

306 P1: I offended it! I offended it! Okay, all right, that will stay up.

307
 308 K: Yeah, I'm not surprised that you're saying that in school itself, your training in psychology
 309 maybe prepared you for a certain range of issues and a certain kinds of training or sensibility
 310 even (P1: Mhm) um, but, as far as all of the issues that come into play in any kind (P1: Oh yeah
 311 *{nods}*) And like you were talking about before just describing your day, I was struck by how
 312 you know, um (2) it's hard to even describe what it was, but just how your whole self is involved
 313 in this work, you know it's not just your professional skills that you're using but you're using
 314 your nurturing skills as a human being to clean and make sure everything is prepared and to
 315 make an environment that feels welcoming to clients
 316

317 P1: Yeah that's a good point and that's one thing I failed to mention earlier and something I
 318 think we've talked about before in terms of, first few seconds, one accesses this program or any
 319 program they get an idea about what this is about, (I: Mhm) and one of my, I know we've talked
 320 about this as well, is about how this place looks, that's one of my biggest pet peeves in fact I just
 321 got told today after three years I've been yelling about this, they're gonna finally renovate this
 322 place (I:Mhm) Three years, three years in the making, so I feel good about that, but it'll, it'll, it'll
 323 give a message to our clients-
 324 *{knock at the door}* it'll, it'll, it'll give a message to our clients *{P1 is distracted by knock on*
 325 *door, he reaches over to open the door but does not open it}*
 326

327 K: we can put this on pause, that's part of the-
 328

329 P1: yea, but *{knocking stops}* so, -so our clients go other places as well and to me the message is
 330 real clear, I mean you come here and where's the commitment as far as I'm concerned, okay I'm
 331 gonna do this now, but this is my soapbox for today, is that where's the commitment? because
 332 they see, they go to Bellefield, they go to 3501, they go to all of these other clinics, they go to the
 333 Drake building and stuff like 'gat, and they come here and they look, it's got a floor that's all
 334 tore up, we got, furniture's throw-back, it's 60s stuff, and they're goin' "whoa!" some of 'em
 335 have mentioned it, it was like - (I: do they?) *O:o!* 'Very sensitive to that kind of stuff! That's
 336 what I'm saying, people, even homeless people, it's real interesting, um, come in here and they
 337 still there is a sense about 'em looking and see whether or not I'm welcome here.
 338

339 K: Mhm, yea I'm glad that you brought up the physical space of the center here 'cause I was
 340 gonna ask you about that and we had talked about that before - how it speaks volumes (P1: 'h)
 341 about um, how this space is valued or not valued (.) and definitely like you said they're picking
 342 up on it and are sensitive to that (P1: yeah, mhm). So, another piece of that that I was thinking
 343 about, you know, this is a satellite clinic, and I want to remind you that you know if anything if
 344 we talk about feels uncomfortable, anything you don't want me to write about -
 345

346 P1: -we've already talked about this, we've already talked about this, it's no big deal.
 347

348 K: -but um, you know as a satellite branch of this much larger psychiatric institution um you
 349 have a certain kind of position or role in the context of that larger institution and I wondered
 350 about, you know, what your thoughts are about what the Center provides, even though I kind of

351 have a sense already, within that system that isn't provided elsewhere and also what the
 352 relationship is, I mean you kind of are hinting at it as far as how it's valued or not valued
 353

354 P1: yea, well I think it is and if we look at a little bit of the history here, the Center was, has
 355 always, as I've been able to reflect on it has always been, "out of sight, out of mind," (.) "it's
 356 okay, you do you're thing up there" (.) i-it's um, lack of a better term, it's like the scapegoat of a
 357 system (I: Mhm) you know like, o:h, "that's the 8th district, that's just the 8th district"
 358

359 K: Now you mean the 8th district as the community or the Center here?
 360

361 P1: Here - that kind of thing (.) and I think that's been allowed to permeate over the years
 362 because if you look in terms of our productivity, you look in terms of whom we're treating, often
 363 our clients were – {*sounded like he cut himself short here*} who, who was comin' here (.) u:m but
 364 we've had to revamp the who::le system, so we had to get rid of a lot of people, um, as a result of
 365 that because it was like a cancer (.) um, here that was just infecting everything, it's a real
 366 sickness –
 367

368 K: the people who were working here.
 369

370 P1: that were working here (.) (I: okay) Everyone.
 371

372 K: So what do you mean by a cancer? That it was attracting a certain kind of-
 373

374 P1: -oh yeah. This clinic was attracting a certain u:h mentality if you will, people that was just (.)
 375 goin' through the motions (.) (I: I see) people who really legitimately didn't care one way or the
 376 other. I don't know, maybe that's pretty strong – people may have perhaps had other things,
 377 other agendas or (I: yeah, right) perhaps other things, you know
 378

379 K: but there was a sense of maybe like apathy that was starting to -
 380

381 P1: that was here for years, it's been here for years.
 382

383 K: okay -and as far as um (.) as the Center's role within the rest of the institution. Does it feel
 384 like you have a sp - function that you provide that other clinics' can't?
 385

386 P1: Well, there's no question, there's no question in my mind – and ONE of the things that I
 387 want to say about this (.) is that working within the system, I've learned early on that you have to
 388 be savvy enough to work within a larger thing, you just can't go half-cocked, and then you
 389 would just be this angry person that just reinforces a lot of the stereotypes, "oh, that's just P1 up
 390 there, raising sand" and that kind of thing (.) um (.) But I think what happens is, my philosophy
 391 is that I'm not goin' go away, and I think that the belief system has to be there that something's
 392 gonna happen. Because I've always been taught that, obviously, "if you are not a part of the
 393 solution, you're part of the problem," okay? (I: Mhm) And for me to say well, we'll just have to
 394 take these crumbs these little things that have been passed out is saying that I give into the
 395 system (.) that I'm - it's okay (.) and that, I don't buy that, that' never been my way of operating,

396 so I'll just stick with it until somethin' happens (.) it's taken us three years to do this and I bring
 397 it up every opp- I've written so many memos and, you know that kind of stuff. And I just think,
 398 and again, that's not a medal, or saying "hey, look how wonderful we're doin' things" it's just
 399 that (.) that's how I believe and I really believe that and I'm not gonna compromise - and I know
 400 the system works slow, but to me to settle for anything less, is saying that it's okay (.) (I:Mhm)
 401 And, and, and so - I guess, maybe it's also, Katy, I think (.) maybe it's because I'm sort of at the
 402 end of my career and I really don't care about what people think, (I: [LF]) you know? and I think
 403 part of me has always thought that way. I've always been a little rebel rouser, kind of stuff and I
 404 don't do it just for the sake of raising scene, cane, or sand or anything like that, it's just that I
 405 believe in that and that's - I really believe that, and if people don't believe that than u::h (2) and I
 406 don't have to be RIGHT either, but if I really believe something I'm not goin' to quit, on that,
 407 you know?
 408

409 K: And that not's always, I would imagine it's not often a popular-
 410

411 P1: Well, it's NEVER POPULAR, it's never popular HERE! *{with some humor in voice}* (I:
 412 [LF]) but that' okay, I don't have any problem with that because the way I see it - now, I don't
 413 want no medal, and for everyone to say "oh, this is wonderful stuff" but for me, it's the right
 414 thing, it's the right thing to do (.) you know?
 415

416 K: Mhm and for you, your heart is, it's sounds really in your work here, it's connected, there
 417 isn't a differentiation for you that you can say just say, well I'll split off from what I believe (P1:
 418 no) and go along with the system (P1: Mmn, no)
 419 30:05 It's interesting in my research I've been reading more about the history of the 8th district
 420 and I wanna incorporate that into my study, you know (P1: Mhm) and it just seems like there,
 421 and I haven't quite gotten there yet, but there's really some parallels in - in some of what you've
 422 described to me as the way that the 8th district clinic has in some ways been treated or viewed
 423 and the way the community has been treated or viewed in the past (P1: Mhm, mhm, mhm) in
 424 terms the city or however large you want to get, (.) u::m as far as being overlooked or um, just
 425 also struggling to (.) form some sort of cohesive community in the face of so much chaos and (.)
 426 limited resources, so to me it seems like in some ways, and you can correct in me if I'm wrong,
 427 what you're saying is that there has been a struggle here in the clinic to form that sort of cohesive
 428 unit
 429

430 P1: -absolutely.
 431

432 K: -of how are we going to do this when we are not getting a lot of resources from above or the
 433 system and we have to try to manage all of what's going on - the homelessness, the violence,
 434 post-traumatic stress, without all of that and to me it seems like people in the community have
 435 had to do that too (P1: absolutely) and especially for people who are chronically mentally ill in
 436 the community and coming out of hospitals. So that's kind of a long-winded way of saying it -
 437 but the history of and what has gone on in the community itself for many years is something that
 438 (.) is very much part of what you do here, in the back of your mind maybe, even if it's not up
 439 front all of the time. That's something I wanted to hear more about. How you would describe the
 440 way that's incorporated into the work here?

441
 442 P1: Yeah. See (.) I believe it's real simple: we talk about mind, body, and spirit. So when we talk
 443 about treatment we also talk about not also thought processes, how we view things, our
 444 perceptions, that kind of stuff (.) also taking responsibility of how are physical self and at times
 445 run down and not taking ()of diets and things like 'gat. That's a big issue, and then where we are
 446 spiritually, spiritually, often times, bankrupt, okay? And, as far as I'm concerned it's like, the
 447 spirituality often times is one of the first things that leaves the individual (I: hm) and
 448 interestingly enough, I think it's one of the last things that returns. And so but I think we're a
 449 strong uh, people, uh, spiritually and I think a lot of things, people mi- a::h, confuse spirituality
 450 and religion, but I'm talkin' 'bout from a spiritual sense, who we are spiritually and I think, one
 451 of the things, the nice things here, we do talk about spirit. About where you are spiritually and a
 452 lot of times people want to get into religion but that's okay, I think that's fine with me. Um, we
 453 have Muslims here, we have – you know it doesn't- you know? And if we can just sit down and
 454 talk about that stuff I think that's the key that's that it's okay. One of the things that we really
 455 instill is the fact that there's no right way or wrong way to feel (I: Mhm) you know, you feel how
 456 you feel. We can accept where you are. That's the key. And so sitting in some of these groups
 457 and these process groups I'm hearing unbelievable things that happened to people. I used to
 458 believe that there is no such thing as evil, but there is some evil people! I mean there is some
 459 people that's really evil. What they've done to people what they'do to people, um - victims, we
 460 get a lot of victims here. It just amazes me. Now the other thing is is that we're lookin' at in
 461 terms of perpetrators now we get all of these victims here but, where are all these perps (.)
 462 perpetrators? They're here somewhere, I'm sure they're coming through these walls, uh, why
 463 aren't we dealing with them (I: Mhm) Why aren't we addressing those kind of things that's
 464 going on 'cause we know they're here.

465 (I:Mhm) Okay? So that's my next thing I I think we really have to start looking in terms of
 466 "these people are victimized" cause it's happening in their communities, it's happening when
 467 they are kids, it's incest and all this other kinds of things that goes on there so we look at from a
 468 victim perspective. 'kay now, we also need to start bringing these perpetrators in here and start
 469 addressing those kinds of things, because they say, "oh, it was my brother, or my grandfather, or
 470 you know, my step dad, I mean all that kind of stuff goes on and what I was gonna say earlier in
 471 that what's happened is, it doesn't lend itself to get out because what we say here, stays here. So,
 472 the secrets manifest themselves, generation after generation. People internalize that stuff and it
 473 doesn't get addressed and so we're just getting this stuff over and over again! See, the
 474 community I said earlier, the entire community is like that! and we've got people attending
 475 churches and things like that, and synagogues, and and and um, temples, and one of the things
 476 they say is well, "just pray, we'll just pray," well, o:okay, that's one thing *{with skepticism}* but
 477 we gotta start putting some things in place for ourselves too, and we gotta free ourselves up we
 478 gotta start talkin' about that stuff we gotta start addressing that stuff. So, how do we incorporate
 479 that -(.) see we also, see there's a lot of people here who don't know anything about the 8th
 480 district. They live on the 8th district and don't know anything about it. Uh, they don't remember
 481 much "well my dad did or my mom, or my uncle used to live up here but you know" - they don't
 482 know much about what's goin' on up here.

483 36:22 Now, the other thing about it is, I think we talked about some of it, we talked about
 484 celebratin' black history month, but see this has got to be a- a daily thing (.) see it just can't - I:I
 485 appreciate what people are trying to do and say "hey, look we gotta acknowledge that kind of

486 stuff, but this is, are far as me— it’s everyday (it’s on?) We got to celebrate our rewards and we
 487 got a focus on by all means necessary on the negatives but we also got to focus on
 488 empowerment, what are we going to do? how are we going to correct some of these problems?
 489 (I:Mhm) For example, we did a big voters registration at the last election, last presidential
 490 election and we had people from everywhere goin’ - and a lot of people were goin’ “a:h, it
 491 doesn’t make any difference whether we vote” and sure enough it didn’t make any difference. (I:
 492 Mhm, mhm) And so that’s the - but (.) “well you still have a vote” you know, you have a right to
 493 do that kind of stuff so we’re doing a lot of stuff about that, (I: yeah) we take ‘em to (Jake
 494 Weekly’s?) right down the street here, he comes down and he talks about the importance of
 495 politics and what plays a part in that. The awareness of what goes on around you that you’re not
 496 even aware of (.) that kind of stuff.

497 {Knock at the door}

498

499 K: Do you want to open it - or?

500

501 P1: {*hesitates and turns ear towards the door, listens for further knocking*} Yeah - So anyway, I
 502 think, we talk about that kind of stuff – so, even the politics of what goes on. For example, I
 503 know you’re familiar and we talked about this, the gambling thing (I: yeah) the majority of the
 504 people here say “yeah, oh man, this is gonna be great, we’ll go down get some of these jobs!”
 505 You know, you know, “you’re not gonna get any of these JOBS, these jobs are not for you, come
 506 on let’s get real” you know? “Do you know how it’s gonna devastate this community, you know
 507 that when gambling enters everything goes up, foreclosures, divorce, violence you know?
 508 Everything goes up, you know, not good - everything goes up,” and “you’re not gonna be a part
 509 of that process, you’ll be a victim of this” so (.) things like ‘gat, I think we owe it to our clients -
 510 just like day-to-day kind of stuff, in terms of people not comin’ in here because “I won’t leave
 511 because I saw a guy get shot last night or stabbed and I know who did it, and they know my mom
 512 or something like ‘gat so I’m not goin’ to out because, they might –” you know, (I: yeah) that
 513 kind of stuff.

514

515 K: Yeah, just real, real physical// obstacles in the way.

516

517 P1: //Absolutely, absolutely!

518

519 K: and that was something else that you’re touching on with um, the advocacy, that as a therapist
 520 here you’re doing more (P1: pshh, yea) than working with people within these walls (.) you’re
 521 advocating for them and encouraging them to be there own advocates in the community and the
 522 society and all that, and voting and umm (.) that was something that also stood out to me when I
 523 was here, something that I hadn’t seen working at a private clinic um, that there’s not as much of
 524 that, where the majority of clients are middle class (P1: Mhm, mhm) that there is more of a need
 525 for it in this community here and that’s an important piece of their getting better and being able
 526 to have boundaries (P1: oh, absolutely) and feel they have value and all that.

527

528 P1: Just a typical part that, with the buses they were goin’ to cut out a main line there’s no
 529 infrastructure, little or no infrastructure here in the 8th district, no supermarkets, that kind of
 530 stuff. So, a lot of our clients go to across the Birmingham bridge to the Southside to the Giant

531 Eagle. The main bus line, it's the only bus that goes from the 8th district there. Well, the Port-
 532 Authority was gonna cut that bus (.) out. Now that would have completely isolated this
 533 community, nowhere to go get groceries, you know, there's little mom's and pop's stores, overly
 534 priced things. Um, a::nd (.) a lot of clients were not even aware, they weren't even aware that
 535 that kind of thing was goin' on. So we had to say, "hey, look you got to get down to these
 536 meetings and gotta get you" – you know, that kind of stuff. Because, here's what happens, the
 537 apathy is such that,

538 {knock on door again}

539 -"well, it's not gonna apply to me, I mean, how could I make a difference, why am I gonna make
 540 an impact on anything?" That's typically what happens, you know. Excuse me a sec {P1 motions
 541 that he has to answer knock on door, to see who it is}

542 40:12 {tape recorder is turned off}

543 P1: {opens door and to see who it is person says something like, "oh you're in here with
 544 someone" and P1 says yes and he will talk to them later, he then apologizes again to me; P1
 545 appears frustrated as he turns back to me} It's a "no brainer!" {he says somewhat playfully
 546 referring to the interruption}

547

548 K: It's okay, I feel like, you know that's part of the culture here too, you know?

549 (P1: It is. It is.) So, I'm kind of glad it's part of our interview as well (P1: yeah, okay)

550 it seems appropriate, it seems fitting

551

552 P1: You never know though, see that's the thing. See somebody could be {makes cutting sound
 553 and motion} going somewhere or we could be rushing somebody to the hospital

554

555 K: Yeah, you absolutely have to be available. I realize that. (P1: yeah, okay) The culture of the
 556 center here itself, you know is also something that I being on the periphery because I was only
 557 here sometimes, as a student (P1: Mhm, Mhm) you know, I didn't have as much of an
 558 opportunity to see how people really related to each other. I – I knew how they related to me (P1:
 559 Mhm, Mhm) and I could observe and to me it seemed like there was a much more, I know I
 560 probably have said this to you before, of that sort of, family or familial sense here, between the
 561 staff and the clients that I also hadn't observed working in Duquesne's clinic or another
 562 university clinic, and I have not very much experience but to me that was something that I took
 563 notice of as an outsider. That, wow the boundaries just feel very different here and I actually
 564 really took to that I kind of like that I think because like you said there is so much more going on
 565 with people beyond just this 50 minutes of a therapy session that um, it just can't be contained
 566 within that. (P1: No, no) So, is that a sense that you felt was among the staff also because it
 567 sounds like the staff, there were some issues there and you don't have to say too much about it.

568

569 P1: Yeah, that was exactly what was going on. We had people who were just here, there were
 570 people here who really didn't like being here, but they couldn't find anything else. And again I
 571 think what happens is - this is interesting, I think we attract u::m (.) who we are (.) and I think
 572 what happens, I think the Center is like, I said earlier, like "outta sight, outta mind" kind of
 573 thing, and so what I think what happened is, it attracted, people who were "outta sight, outta
 574 mind"

575

576 42:45

577

578 K: hmm, that's interesting.

579

580 P1: Okay, I think they just gravitated and um, and and that perpetuated the same patterns, same
581 cycles, over and over again. So we attempted to try to find out where people were do they want
582 to be a part of - and we did the same thing with staff, what are their goals, what do they wanna
583 do, you know. And, a lot of staff didn't want to be a part of that, okay? the change (.) it took us
584 time to - well they actually will weed themselves out (I: Mhm)

585

586 K: So, they didn't want to move to the model of being collaborative. Working collaboratively
587 with clients?

588

589 P1: No, no, no.

590

591 K: Any reason you think that would be?

592

593 P1: Well, I think there's a comfort level, I think that we all operate from a different comfort level
594 and I think when you go someplace and you're comfortable with what you're doing even though
595 it may be unhealthy, that you're okay with that. Just like some people get into unhealthy
596 relationships because that's there comfort zone, they're used to chaos so they stay in those
597 unhealthy situations and I think that was what was goin' on here. People were unhealthy (I: hm,
598 interesting) with their own stuff.

599

600 K: And now with new people here does it feel different?

601

602 P1: Well, we're workin' on it. Let me tell you this, Katy, I been without staff, and I'm lackin' 3
603 therapists now (.) and I been interviewing a lot of people. I-i-it takes a special person - and I been
604 yelled at about hiring somebody in here um, I would prefer to go without until we can find the
605 right fit (I: hm) u::h, because what happens is that person will weed themselves out (.) anyway.
606 So you do all of this training and stuff (I: right) and than eventually right back into the same 'ole
607 place. So I been real picky about whom we're get in here.

608

609 K: It has to be a good match.

610

611 P1: It has to be a good match - both ways. 'Cause if you got the same 'ole thing, then you
612 gravitate to the same ole thing (I: uh huh) and the whole process is outta control.

613

614 K: Now, when you interview someone, what are you looking for, what kind of qualities are you
615 looking for?

616

617 P1: Oh, first of all, I want to know - oh, you could tell. First few seconds you meet someone,
618 you could tell. I mean I'm not trying to stereotype, but just where they are, uh, their demeanor. A
619 lot of nonverbal stuff, I pick up on nonverbal stuff. I want to find out who they are, what makes
620 them tick, what are they like, what are their desires, what do they want to do, you know? Who

621 are ya? You know? Why do you want to work here, why should you work here, why should we
622 hire you to work here? Tell me why.

623

624 K: Well, what you do you think a good answer to that question would be?

625

626 P1: Oh there's a lot of good ones, a lot of good ones I'm looking for – you lookin' for a job?

627

628 K: [LF] I think it's telling as to what your values are and what's important to you in your staff.

629

630 P1: yeah, yeah, that's exactly it! We want to know what's important for you, why do are you
631 looking for this job, why are you leaving your other job, what do you know about us? What do
632 you know about this place? What do you know about the people? How can you make an impact
633 on somebody? Tell us something about someone you made an impact on. Why is it significant
634 for ya, how is it significant for ya? I want to know (.) who these people are. And the people I'm
635 getting in, it's not about– see it's not also about them (.) i::t's who, who, who they present (.)
636 because anybody can say things, a trained ape can react to certain things, but who you are as an
637 individual, it'll {pay, it'll see?}

638

639 K: Yeah, so kind of seeing what their process is. If they are reflective, if they've thought about
640 (P1: absolutely) why they do what they do (P1: Mhm, Mhm) So, just someone who's in touch
641 with –

642

643 P1: ARE THEY HEALTHY INDIVIDUALS, okay, we all have baggage but just some of us
644 have more than others, okay? And for people who have a lot of baggage - don't have time (.)
645 'Cause, this will trigger - now this is interesting I always believed (.) that our clients will get only
646 as well as we are (.) okay? So if we get unhealthy people (.) okay, as staff, we will have
647 unhealthier clients (I: Mhm) 'Cause if –if I have all of these unresolved conflicts then (.) my
648 clients are gonna trigger that for me. See just for example, if I've been sexually abused (.) a::nd
649 there's a client sitting in front of me who's sexually abused, and I haven't resolved these issues
650 {*sound of keys falling out of P1's pocket onto the floor, he bends to pick them up*} okay? I
651 haven't resolved these issues, so what happens is, I'm gonna sabotage any efforts, consciously or
652 unconsciously of that person getting well because I haven't resolved all my stuff. So, I'm only
653 gonna let that client go as far as I'm comfortable (I: Mhm) okay? and that goes with everything
654 (.) I-if I have these racist attitudes and these bigoted approaches to things, then that's what I'm
655 gonna project to my client! So I'm only gonna let me client go as far as I'm capable of
656 addressing things.

657

658 K: So is that something that especially that you're looking at, a person's attitudes about race?

659

660 P1: About everything. I mean because, my thinking is, the more rigid one is in their thinking, the
661 more unhealthy they are. Okay? (I: hm, Mhm) So, to me we're talkin' about a balance, if we're
662 talking to our clients about a balance, okay (.) then we have to be balanced, okay? (I: oh, yeah)
663 or some semblance there of. If we don't live a balanced life, how can we expect – how can we
664 talk to someone about havin' a balance in your life? okay. so yeah, I look in terms of where

665 THEY are, okay? So, it's pretty hard for me to sit and tell someone all these nice things to do (.)
 666 you know and I'm not doin' it myself.

667
 668 K: Yeah, definitely starting to work as a therapist in my Masters program motivated me to stop
 669 smoking (P1: there you go) you know because it was just too much like "how can I sit here and
 670 push people to work through what's hardest for them (P1: absolutely) if I can't try, at least try,
 671 like you said, we'll always have unresolved issues. {phone ringing} So, I don't want to keep you
 672 too long – do you have an appointment?

673
 674 P1: I don't think so, they'll knock on my door again.

675
 676 K: okay um, I think we've touched on a lot of the things that I'd been thinking about (.) And
 677 there's just so much –

678
 679 P1: Well, we can to be continued if you like, I mean I don't have no problem with that. I mean if
 680 you have other questions and you want to come back

681
 682 K: Yeah, I was thinking that if I'm listening to this that I might think of more questions.

683
 684 P1: Yeah, yeah

685
 686 K: Um, (2) Oh, as far as the physical space of the clinic you kind of touched on that. You know,
 687 it's falling apart and there's old furniture and um (.) I was wondering about, as I was working
 688 here about that half-door there, when you first come in, and being buzzed in and all that, and if
 689 that was always here from the time you started –

690
 691 P1: That's been always here and I ask about that and here's one of the problems that we're
 692 havin' (.) i::s we want to try to limit who comes in and who goes because of confidentiality (.)
 693 u::m also around domestic violence issues (I: Mhm)-if we have a client here and the significant
 694 other followed 'em here

695
 696 K: it's dangerous.

697
 698 P1: it's dangerous. And from that perspective we try to control the flow of who's what, where
 699 that kind of thing

700
 701 K: Yeah because it does have less secure borders or boundaries because it is a community center,
 702 than people are coming in all the time (P1: absolutely, yeah) Have any clients, to your
 703 knowledge, ever said anything about the door?

704
 705 P1: N::one, none (.) uh, that's interesting. that is interesting. Now they'll say "why don't cha
 706 open the do::or!" {demanding, playful tone} You know, stuff like 'gat but nothing – 'cause see,
 707 that gives them a sense of of of security as well. Because there's people comin' and goin' all the
 708 time a::nd you don't know, we can't control a lot of stuff if if everyone is schou, schou,
 709 schou{makes a swishing noise and motions with hand} all over the place.

710
 711 K: That's interesting 'cause I guess I was reflecting on the physical space of this place here and I
 712 was thinking about symbolically what does that door represent, or how it functions. And in a way
 713 I don't know if we can get that deep about it but maybe symbolically it's part of that safe
 714 boundary (P1: safe, it is) that you create here so that it feels less scary and intimidating to get
 715 into some of these issues.

716
 717 P1: Yeah, cause once you walk through there – eh, people can't – you don't want everyone to
 718 have access, so to speak. So it's a safety kind of thing. Now here's the other thing, they don't
 719 mind (.) waiting, now sometimes they get anxious about and will say "let me out of here, what
 720 do you think this is, a prison?!" (I: [LF]) You know that kind of stuff. But also - you know it's
 721 interesting, we have others doors, we have three other doors that they can go out, u::m, we do
 722 fire alarms that way. But it's interesting how this plays out, they come here and they'll all go out
 723 that door.

724
 725 K: Huh, and they know there's another door?

726
 727 P1: There's three doors.

728
 729 K: Is there three?

730
 731 P1: Yeah, there's the kitchen, the hallway Betty office and there's one, right this way.

732
 733 K: Huh, interesting. Is there anything else that –

734
 735 P1: Well, I'm tryin' to think off-hand there were probably a lot of things that I was gonna say
 736 and don't remember off hand what it is. I think the key u::h to this whole thing is, we talked
 737 about this is (.) incorporating (.) a lot of things (.) uh, in the individual, there's more to one
 738 individual we're multifaceted you know, complex individuals um, but if we can keep that simple
 739 we don't have to get real crazy and go off on all of these things but I think we have to take the
 740 person, we take them where they are, you know? acceptance. now the other thing about that is –
 741 it's about also, is acceptance of me. See, I can't accept anyone else, if I don't accept me (I:
 742 Mhm) Okay, there's a little saying which is "you can't give what you don't have" okay? So (.)
 743 u::m if I don't have anything to give (.) then I gotta look into why I'm here. And that's where I
 744 think we were in the past, we had people here who didn't' have anything to give, for whatever
 745 reasons and so it's very difficult if I'm gonna sit down to talk to you about stuff and I don't have
 746 anything to give anybody. I'm bankrupt.

747
 748 K: Yeah, that's why self-care is so important in this field. It's hard work.

749
 750 P1: Pshew, It's everything as far as I'm concerned it starts with self and if you don't got self,
 751 (don't copy that what I just said) if you don't have your self than you can't get anything out, i-i-
 752 it's not gonna work either. And they pick that up, they pick that up real quick. Cause what
 753 happens is that I project myself – (2) (I: well) {time apparently up} to be continued

754 K: I feel like we could talk for hours

755

756 P1: Well, we could {tape recorder is shut off}

APPENDIX E

Interview Transcript: Theresa (P2)

1 Interview Transcription with P2

2

3 Prior to interview beginning subject asks for a explanation/description of my research. We get
4 into a discussion about race relations/discrimination in Pittsburgh. Subject states that Pittsburgh
5 is lagging behind in terms of equality in the workplace/opportunities for advancement for Blacks
6 in Pittsburgh. I reflect something to the effect of “so you feel that Pittsburgh lags behind on this
7 front” Subject responds below...

8 {voice recording device is turned on}

9

10 P2: ...well it's not a feeling about it - it has empirically researched by (Banks?) in his study that
11 Blacks (.) *{P2 is eating lunch during interview, chewing sounds audible while answering*
12 *question}* in Pittsburgh fare worse than Blacks in any other urban areas in comparison, across the
13 nation. So it (.) I can do a an anthropological, you know, um, thing, just looking at my friends
14 those of us who've left Pittsburgh and who did very well other places and who for whatever
15 reasons aging family members and things of that nature come back and lose 30 and \$40,000 a
16 year from our salaries to be employed in this town.

17

18 K: Hmm, now are you from the area originally?

19

20 P2: Yes, I'm not from the 8th district, well you know as a child, yeah (.) but I'm from East
21 City, yes.

22

23 K: So, you've seen that kind of discrimination throughout your life.

24

25 P2: I, think too - yeah very much so - and I also say that if you look at the major hiring practices
26 fo:r UPMC and other places that when it comes to higher echelon jobs where they have
27 designated that they are going to hire an African American or a Black person, that they have
28 developed search committees and I've said this publicly where they say, and I've even talked
29 with VP's and things that say that they're not interested in hiring any Black person in this city (.)
30 So they're going to only bring in Blacks from out of town, as though somehow in this city where
31 we have probably a higher educational background, because we're a college town, they only will
32 take Blacks from out of town for the higher echelon positions.

33

34 K: And, why is that do you think?

35

36 P2: Just some general plantation mentality.

37

38 K: What is it about Blacks in Pittsburgh that would be different from Blacks from out of town?

39

40 P2: It's not about us, it's not on us, it's on the plantation owner's mentality, it's not our
41 mentality.

42

43 K: Right, but I mean the people who are deciding to hire from outside of the city.

44

45 P2: I don't know, there mentality is that they're gonna get something better outside of Pittsburgh

46

47 K: I see, like people who are more educated or more –

48

49 P2: Well, whatever, they can't be more educated because they obviously – more qualified, or I'm
50 not sure what it is that they're looking for. You would really have to ask you know, the
51 plantation owners why they only want to import their slaves but that's the way they operate.

52

53 K: So, very much it's connected with a mentality that's carried over for generations that
54 plantation owner mentality (P2: Right, oh yeah) and it's still (.) even if it's not on the surface,
55 um, that they are consciously saying that's what their ideas are, that they are behaving in a way
56 that shows that //()

57

58 P2: Well, I MEAN THEY HAVE STATED IT during major searches (I: Mhm) When they've
59 been questioned about major searches they say well we decided the search committee, the we
60 don't want - we're bringing in someone and African American for this position and we want
61 someone from out of town (I: Hm) So that's not under the surface (I: yeah) they don't even feel
62 any compulsion not to say those things. They think they have a right to say that.

63

64 K: Mhm, okay, so it's not – it's very explicit

65

66 P2: yes, it's not an undercurrent, it's a practice.

67

68 K: Now, I've gotten that feeling or that idea in my short time being here as well, that that there's
69 been (.) that kind of sentiment has been expressed by staff here that it feels like there is some
70 kind of discrimination within the medical system in terms of which clinics get, um, which money
71 which funding and because this clinic is in a Black community, serving a predominately Black
72 clientele that there is some discrimination as to how much funding is given here. Now does that,
73 is that something that you think as well or is that?

74

75 P2: Well interestingly enough this is not my first encounter as an employee of WPIC, nor my
76 first interaction with the Center. Previously, 26, 27 years ago I worked for WPIC and the only
77 (3), I was just trying to think of how many African Americans were in the (.) O'Hare building
78 but there was always this conclave who were here in the 8th district (.) (I: Mhm) And in those
79 days most of the 8th district team was not as – well, there was among us, a one-upsmanship you
80 know, at the Center -

81

82 K: here

83

84 P2: No, I wasn't an 8th district group person (I: I see) I was an Oakland team person. And then
 85 part of main outpatient, WPIC (I: I see) and I recall thinking that you know, getting that sense
 86 that working at the Center was not a::s (.) prestigious (.) as working on O'Hare (I: Mhm) and um
 87 (2) so I think that that mentality, is not just part of the Center or whites or the medical profession
 88 but I recall as an African American, having the idea, as a young person, that I was a little more
 89 tougher, and prestigious because I was on O'Hare street (I: Mhm) and not here. In this building I
 90 never actually ever, ever came here.

91
 92 K: You never came here.

93
 94 P2: Oh no, I did do some work you know, farthest I would go was {Matilda burrows?} I would
 95 go up there for rounds, but I would never go up to the Center, building.

96
 97 K: You wouldn't want to – you didn't have an interest in coming here (.) at the time.

98
 99 P2: (.) I think in our minds, there was always this question in our minds about whether real
 100 clinical work was going on here, you know. (I: Hm, yeah) I mean some of the staff wasn't as
 101 well educated, our sense was that they weren't as well trained as we were, they didn't have the
 102 same academic backgrounds we had. (2) They were community workers not necessarily
 103 therapists

104
 105 K: Hmm, I see. So there was a distinction, at the time, between community workers and
 106 therapists (P2: Mhm) clinically trained therapists (.) and do you think that that still goes on
 107 today, in general?

108
 109 P2: YEAH, I do think so, I have to give you a kind of anecdotal

110
 111 K: Please, yeah.

112
 113 P2: One of my neighbors works at O'Hare, on O'Hare street and he's so funny, um he like sees
 114 me and says "[WH] *how are you doin' over there, are you oka::y?*" [LF] You know (.) {*more*
 115 *chewing food*} it always cracks me up 'cause he always looks at me with such, um (.) empathy,
 116 like "*are you okay?*"

117
 118 K: Oh, boy

119
 120 P2: so, there's, in his mind - and I don't think he- it used to be offensive but I think he genuinely
 121 does worry, it's like he's worried to see if I'm okay or not, (I: Mhm) how am I faring and that
 122 kind of stuff.

123
 124 K: And how do understand that, what do you think he means?

125
 126 P2: M::m, I think without him re – well, first of all, I mean, there is some reality in the fact that
 127 we do - we are in a place where (.) there is a lot of trauma, u::m, there is a lot of (.) serious
 128 reason for people to be struggling (.) to survive, and the impact of that on their psyche on their

129 mental health it's a very unhealthy environment where, it's not uncommon that I'm gonna see
 130 something on television and comin' here, finding out that it's connected to what's, you know
 131 o::ne (.) one of the patient's sisters died (I: Mhm) or you know, from a gunshot wound o::r come
 132 in and find out well the boy who got shot, that's my nephew, so, that's a lot of trauma. And it
 133 happens on an ongoing basis, u::h, it's funny because I also live in Wilkensburg and I think
 134 that's another traumatized area, but I have to truly tell you that (.) I don't sense and I'm very
 135 enmeshed in that community, I don't sense as much trauma (.) (I: Interesting) on an ongoing
 136 basis as I do in the 8th district so I do think, I don't know, you know, if it pans out (.) if we look
 137 at the crime statistics or not, or I wonder if it has to do with – that might be a nice comparison,
 138 how many miles are we talkin' and because you're goin' 2 miles up, 2 miles down, and 2 miles
 139 across, does that intensify, u::m, you know, everything that's happening in other places, but
 140 because it's such a small place, {makes a swishing sound, “shoo”} it makes it hotter, (I: Mhm)
 141 and harder, I don't know.

142
 143 K: yeah or even the geographic, u:m, relative isolation of the 8th district that it's been sort of cut
 144 off in some ways from (.) just the way that the roads are, the transportation system
 145

146 P2: When I come to work usually I cross all the way across town {takes a sip from her drink}
 147 and the worst roads, the ice, the snow, salt and everything stops at the top of the hill where the
 148 VA is {P2 knocks on the table near microphone adding emphasis to each word, snow, salt, and
 149 Va} and from then on it's like put your car in double low and just slide on down.

150
 151 K: Hm, it's so interesting. You know all of that says so much, really.

152
 153 P2: And it must say so much to the people who live here, I keep saying what is there, is there
 154 some kind of city ordinance, “don't salt the 8th district?” Just that one thing has just made such
 155 an impression on me! (.) (I: Mhm) that as soon as I get past, see you know that's where the two
 156 arteries are they can still go towards the university of East City or the VA and pow! as soon as
 157 you pass that, it's no man's land. It's wi::ld [WH]. As soon as I get to the top of that hill, I have
 158 to put my car in low, I finally figured out how, cause I'm goin' WHO::AA Oh no, what
 159 happened!! But now I know, be prepared, because there's not goin' be any salt on the street. It's
 160 not gonna look like the rest of what you just came through.

161
 162 K: Yeah, it's just uh, overlooked it's ignored, it's neglected.

163
 164 P2: Um, what is the psychodynamics? You know, is there a need for us, do we have a need to
 165 have places that we can point to and say well you know well we're good people but those people
 166 there - oh we're safe. And you hear that so much when you hear these little captions from people
 167 on television who've suffered some kind of trauma in their community and they say something
 168 like, well, {in a lower voice} “you know, we never expected this to happen in this community”
 169 (I: Mhm) Why? because people don't live there or what? and the assumption is that certain
 170 behaviors are attached to certain communities (I: Absolutely) And locations are a critical part of
 171 that. So, you have that coming at you all the time. So, we never expected that- something like
 172 that to happen in this neighborhood, this community.

173

174 K: Yeah, that came up a lot 2 yrs ago, over 2 yrs ago now, at Duquesne there was that shooting
 175 (P2: Yes) And I was working at the counseling center there at the time, or the clinic on campus
 176 we did some of the responding to that, as far as offering more groups and stuff, but I became
 177 very interested in the campuses response to it because Duquesne is a very white university in
 178 general and it happened at a Black Student Union dance and all of the racial stuff just surfaced
 179 like, quickly, and maybe not to the students of color maybe it's not under the surface but I think
 180 it's pushed under the surface most of the time and that issue just brought up all of these, you
 181 know it was that kind of dance and it was those people and it doesn't happen on this kind of
 182 campus usually. It wasn't said in so many words but –

183
 184 P2: But there was a distancing

185
 186 K: Yeah and it was really, um (.) eye opening for me. Just to look at that on our campus

187
 188 P2: Yeah the whole idea that it has within it's mission statement, so much language about
 189 community, about Christian community

190
 191 K: Yeah and there's efforts you know that Duquesne it's near the 8th district, it's sort of part of
 192 the 8th district geographically, it's sort of right there. And so, I think they explicitly have said
 193 that we are making these efforts and we want to be part of the community but underneath it there
 194 are all these, really entrenched, institutionalized, uh, racist ideas and I feel like that, you know it
 195 happens everywhere,

196
 197 P2: You were talking about those neighborhoods or those places (I: Mhm, right) where certain
 198 things aren't expected to happen. Places where these traumas aren't supposed to happen. One of
 199 the things they've been talking about here is a whole conceptualization of whether or not we're
 200 just talking about a post-trauma person here and a post-trauma person here, but maybe we're
 201 talkin' about a traumatized community (.) (I: Mhm) and an area that's under trauma and what
 202 that looks like and what – it's like, if we were in Beirut or something you know, I mean, is there
 203 a certain kind of trauma that people are subjected to (.) you know (2) violence and (2) and
 204 scratching at your survival is a way of life so uncommon to the majority culture (4)

205
 206 K: and that becomes a whole community that is traumatized (.) (P2: Mhm) Yeah, and I've heard
 207 P1 use that term before I think it's very (.) it's an interesting idea, and an important idea, is there
 208 a way in which conceptualized as a community rather than the individuals within the community.

209
 210 P2: Mhm, now, I have to tell you something I have had the experience of living in other places
 211 and being in other places (.) and there's actually no way to explain to a (.) person who's not of
 212 color, how much being of color (.) defines your encounter with the world (.) um (.) because I've
 213 been a lot of places, I can say world (I: Mhm) um, there's no way that I can walk down the street
 214 of Johannesburg and they can know that I'm not South African (.) Um, there's n::o way that I
 215 can walk down the street (.) in Stockholm (.) or London (.) {voice is lower} and Vancouver, you
 216 know these places where it's not apparent that I'm not African and yet I'm not Europe. And so,
 217 there is this particula::r thing that you know u::m, I guess defines us from other people um,
 218 Africans (and the Diaspora?) I remember being in Argentina and these Black ladies who were

219 about this tall {*motions with her hands to about 4 ft off of the ground*} they were Brazilians and
 220 they were like grandmothers {said with some wonderment} and they're lookin' and lookin' like
 221 {makes gasping sound} looking – and I'm in this jewelry store and their looking and looking at
 222 me and they say {makes another gasping noise} {el grande?} and I'm like {makes puzzled look}
 223 and then I realized there was 2 of us, me and a colleague and we were both almost 6 feet tall, and
 224 they thought that was just ama::zing – and they were like, {whispers something inaudible} (I:
 225 Mhm) So, there's this um this sense of being of two nations, because we're not Africans, you
 226 know, we're not 100%, most of us are not 100% African. So what happens is that we're like a
 227 people that are afloat

228

229 K: hmm (.) afloat

230

231 P2: You know we don't really - we have our origins and you know we're like - it was like what
 232 Israel wanted so badly when the Jews decided that they had to have a homeland because they
 233 were Jews in Diaspora, I mean even at the time of Jesus there were 2 million Jews outside of
 234 Jerusalem (I: Mhm) You know so, they were such a scattered people//

235

236 K: oh yeah, wandering

237

238 P2: -they had been! such a scattered, wandering, so they had to br – you know, that's what Israel
 239 represented for them, a base. But I submit that we don't have a base and as a result (.) um, we're
 240 always sojourners' we're always, aliens.

241

242 K: hmm, always “other” in a way

243

244 P2: yes, yes, we're always other. And so how that gets played out, um (2) in the way we're
 245 received, in the way we receive the world, there's a part of what we struggle with here. I do
 246 believe.

247

248 K: And when you say, we struggle with, do you mean you struggle with as a staff, or you
 249 struggle with your clients who come here, or both

250

251 P2: Both, both. I think we struggle with that as a staff, u::m (.) and perhaps we're labeled as the
 252 ones who've been somewhat successful and whatever, you would call that, {voice becomes
 253 softer again} I used to do immigration, refugee resettlement (I: Hm) this is a refugee
 254 resettlement, so when we've been had people that we identified as people who [short LF] as you
 255 know, better or stronger along the process of resettlement so I guess we've been properly
 256 assimilated or we've been assimilated a li::ttle better than others. But, so (.) that's who we are.
 257 We're the ones who figured out how to do it OR else we're the ones who we're so fortunate that
 258 we fall in the manor and come out riding the pony, you know, we're the lucky ones

259

260 K: That's the way you're perceived, you mean?

261

262 P2: No, I'm saying that's how I look at us.

263

264 K: That's how you look at it

265

266 P2: You know, we're the lucky ones but we really – but we can pass along some things of
267 survival, some survival skills some interactive skills, some things like we can give some
268 nurturing, we can put some {sand on some wounds} we can um, be there when there floating,
269 you know almost like an anchor, for the floating one, you know, floats out and floats back, floats
270 out and floats back. And uh (.) sometimes you know we're cheerleaders, you know it's like, I
271 believe you can make it through the weekend without using I believe you can

272

273 K: Mhm, so really, um, advocating// for your clients

274

275 P2: Yes,| yes. I believe you can do that, Marcus does, you know, things systemically, at least, in
276 his arena – now at this point I'm still (3) I'm still struggling with the whole thing, still struggling
277 with the whole thing, and I can easily, because (.) I think we are (.) chameleons, you know, (2)
278 that I can make myself survive wherever I am (.)

279

280 K: And- it sounds like you have been in a lot of different places, very diverse places.

281

282 P2: Mhm, I've lived in King of Prussia where I was the only African American in my whole
283 dang building! Psh. (I: Hm, wow). You know, I knew I was different (.) but I also knew that after
284 a while, they wouldn't notice me as much, (I: Hm) you know.

285

286 K: They wouldn't notice you as being different.

287

288 P2: Mhm, I mean they would notice me as being different, but it wouldn't be so shocking to
289 them. I mean, I'd come out and they'd go, oh, oh, *{makes a motion of someone looking*
290 *uncomfortable, taken off guard, frightened?, trying to wave hello}* hello [silent LF] (I: Hm) (.) or they
291 wouldn't speak at all and I'd train them to speak in the morning and then (.) after a while they
292 wouldn't be so nervous about seeing me and they'd all say, "hi, how are yo::u?" You know, it
293 became okay.

294

295 K: What were you doing there?

296

297 P2: I was working there, living there, so.

298

299 K: okay, what were you doing for work?

300

301 P2: um, at that time I was – I ran the national program for justice for American Baptist churches
302 USA so, that was the headquarters there down in Valley Forge and I lived in King of Prussia, s::o
303 I headed the division that (.) did things like refugee resettlement. And Um (.) investment,
304 minority investments and that kind of stuff. We were part of a team, that wrote the Valdisse
305 principals and things like (I: Hm) that so we were really head of the team, part of the *{voice*
306 *lowers to almost a whisper}*visitation team created for the elections in South Africa negotiate
307 contracts with South Africanand some US entities. So I have a really kind of funny edge on
308 myself, you know?

- 309
 310 K: A funny edge?
 311
 312 P2: Yeah, I mean I don't, um, I see this from a bigger vantage point (I: Mhm) though I have to
 313 say as a little girl, I grew up 'till I was 5 on Burrows Street so I come from this {area?} I have to
 314 struggle to remember that.
 315
 316 K: You have to struggle to remember your roots here? (I: Mhm) (.) Like, it's hard to remember
 317 it, or its'–
 318
 319 P2: U::m (2) I've just been other places longer, so it's harder to- I don't have as many memories
 320 of being here, because I was so young.
 321
 322 K: Mhm, Mhm yeah that's pretty young
 323
 324 P2: so know, I didn't – there are some things, I remember goin' to a {Via wilds?} school, I can't
 325 remember my teachers face but I remember going to that school. I remember you know, walking
 326 in these communities and I don't remember being being frightened at all, but I remember being
 327 different.
 328
 329 K: When was it that you were living here? How long ago was that?
 330
 331 P2: Oh, a long time ago, 50 years ago or more
 332
 333 K: and you don't remember feeling unsafe or anyone telling you to be careful or anything like
 334 that
 335
 336 P2: U::m, Um (.) [h] I know that my mother didn't want to live here, I remember that as a child
 337 that my mother didn't want to live here (.) and she was like pushing my dad (.) we lived in the
 338 projects! to um, move. She wanted to move, she wanted to move, she wanted to move, (um) she
 339 wanted to move, *{said as if she were reenacting what her mother said to her father at the time}*
 340 Um, [WH] what can I say here (5) my mother was a rural girl, s::o (2) I think she had some,
 341 uncomfortableness, with this urban setting (I: Hm, yeah) She hadn't been here very long, maybe
 342 5 years, maybe, somethin' like that, I was a little girl only 5 years old, so she wasn't totally
 343 happy, wasn't totally happy, because, she didn't have any dirt to dig in, or (.)
 344
 345 K: Mhm, it's very urban for a rural person around here.
 346
 347 P2: Yeah, so and then we did get a house where she had a yard and she could dig and we could
 348 run in the grass and so that was her (.) probably her idea of living (I: Mhm) s::o, how much of
 349 the otherness I feel came from that and not from some sense of racism, I don't know (I: Hm)
 350
 351 P2: But I remember her like telling us a story about going to dinner at these people's house who
 352 were white and they served like yellow corn (.) and she was so appalled when she saw it on the
 353 table because she was like [‘h] [WH] “oh my god, they must really be struggling up north!”

354 (I:Hm) 'cause she said she didn't know what to do, she was so embarrassed you know, because
 355 you know, that's what they fed the hogs.

356

357 K: [LF] funny.

358

359 P2: - and the horses they only ate white corn, which was you know, that sweet little – so she
 360 didn't know what to think when she saw (.) feed –

361

362 K: on the table!

363

364 P2: - on the table.

365

366 K: Wow, that's quite an experience!

367

368 P2: (h) YEAH! , I guess so. So, that's why I say to you, I don't know – my major person who I
 369 interacted with was my mother, and I do know there was a estrangeness to this area but I'm not
 370 sure what was the grounds for it, because she was very much estranged in this area because of
 371 the whole urban thing, but I knew that we weren't goin' to stay here long.

372

373 K: Now, it's interesting to me that, you, it sounds like you went away from here for quite some
 374 time, and somehow you've come full circle and you're back in this community, working here,
 375 not living here – but um, (P2: Mhm) it seems like something pulled you back to work here and
 376 I'm wondering what// your thoughts are –

377

378 P2: Um, basically! I came back because of my family and the issues of aging and really them
 379 needing some more support (I: Mhm) to help you know, to help someone survive because we
 380 really didn't want her in a nursing home, so I came back, and my sister came back to keep her
 381 out of a nursing home (I: Mm) u::m, one of the things that I've discovered is that things are just
 382 as antiquated as they were when I left, if not more so. I ended up back here because I couldn't
 383 get my foot in the door where I should be.

384

385 K: Where would that be?

386

387 P2: I should be higher in administration (I: Hm) um, I'm here, pshh *{facial expression looks*
 388 *disgusted, tone is dismissive}* doing this, okay? But if I were a white woman with the experience
 389 that have and the credentials that I have, I wouldn't' be here. It just wouldn't' happen.

390

391 K: So, this is not a chosen place where you would want to be this is sort of, u::h (.) sort of what
 392 was left for you.

393

394 P2: Right, right, right

395

396 K: So (.) it's sort of been a disappointment for you to end up here? I mean, I- I can see you seem
 397 like you have a lot of experience and you feel like you should be in a higher position.

398

399 P2: Oh, I know I should be. But this is a plantation where they don't have to listen to what – they
400 don't have to be equitable

401
402 K: Mhm (.) and is the plantation you are referring to not only the medical system here but the
403 city in general (P2: Mhm, Mhm) so, comin' back here was not what you would have preferred to
404 do. I mean you came back here for family, and to take care of them but it sound like this is not
405 the place where you feel you have the most opportunity

406
407 P2: oh no

408
409 K: - and you've had other um, – now when you went to school was it for psychology or social
410 work, what was your training in?

411
412 P2: Yeah, I my bachelart degree was in psychology. I have uh - I did work in graduate school in
413 social work and then I did a Masters in Divinity and then I did a Masters in Education, and then
414 I'm ABD for my Ph.D.

415
416 K: Really?

417
418 P2: - in education. So, there's no where else where a person with my background would be in a
419 position like this, come on, for real [LF]

420
421 K: So what happened with your Ph.D. – that was in education?

422
423 P2: I just started travelin'

424
425 K: you started travelin'

426
427 P2: I started travelin' I had opportunities, I had choices, I had – a wonderful job came up that
428 was a job of a lifetime and I wasn't gonna not, take it. And, I knew it would probably gonna
429 threaten my ability to finish – I finished my comps and everything, I just didn't have time (I:
430 Mhm) I was too busy promoting big deals all over the place

431
432 K: Mhm, doing the refugee work and-

433
434 P2: Oh my god! I set up the first summit in Kansas City, Kansas for the gangs, I was in LA I did
435 a national film there that was used across the country on the burning of LA. I was building stuff
436 in Florida, and I rebuilt churches that were burned across the U.S. in major projects (we built in
437 major churches) I was on assignment in South Africa (.) and um, Argentina, I was in London,
438 well Conventry outside of London when Diana died, also I was on assignment there.

439
440 K: mm, wow

441
442 P2: yeah, right, so, come on for real (.) let's be honest, do you expect me to be here?
443

444 K: Well, like I said it does seem like you have a lot of experience for -

445

446 P2: Well, that's the way it is, and that's silly, but that's the way it is, that's the real deal, so this is
447 um, *{sighs}* (2) I'm good to the people I understand their ways, I'm ordained, so I'm used to
448 taking care of people it doesn't bother me. I've been ordained for 26 years so I'm one of the
449 front-runners in that area, so. I'm used to what it means to struggle in areas where you're
450 required to have much and you're given back little.

451

452 K: Required to have much and given back little. hm (.) and that applies to your work here as
453 well. (P2: sure) It really does seem like the center here is struggling to provide a very important
454 service, I think, to the community and to give back a lot to the community without really having
455 a lot of those resources (P2: Mhm) um, financially and otherwise. And, so you're work here you
456 feel it's not where you want to be but you do have, you feel like you can work with the clients
457 here and you have - and that's important work?

458

459 P2: Well, sure, I run a soup kitchen in Wilkinsburg, I'm totally committed to doing this kinda
460 work, but I don't want you to think that, I don't want you to come and do your Ph.D. thinking
461 that you're encountering the people who work at this level, for real for real, Earl with his
462 background, Marcus (.) 7 years, the doors of opportunity are not as open to us (.) and so as a
463 result these people get a very high level of care at low costs.

464

465 K: That's really interesting (.) and really makes, as I'm listening to you, I have a sinking feeling,
466 that doesn't, uh -

467

468 P2: So it's on our backs (I: yeah) so someone does pay the price

469

470 K: So you're working - I mean it just seems like a lot to contain, on a daily basis that you're
471 working with people coming in struggling with, like you said, a history of trauma, community
472 trauma, facing discrimination and oppression everyday of different sorts and at the same time
473 you're also, as a staff and as individuals, struggling with some of that yourselves

474

475 P2: The same issues of racism and exploitation, we all know it because we're living it, and we're
476 giving the highest quality of care becau::se we're live it. So right now I make \$40,000 less than I
477 made 10 years ago, just to be here. (I: whoa) So there is a cost and I'm paying it.

478

479 K: It feels like- well, you're paying a cost to work here -

480

481 P2: I'm paying it! Yeah, I'm paying a cost so it's not, I mean they may withdraw, they may keep
482 the money, but the money comes from somewhere, it comes from me, okay. It comes from those
483 of us who come highly trained and work for hardly anything. (I: Mhm) (2)

484

485 P2: I mean, if you understand that perspective

486

487 K: yeah, absolutely, there's so many questions I have related to - I'm just trying to think about uh
488 (.) what I want to ask you about that (.) It's just a really - uh, such a paradox in ways you know

489 (P2: Mhm) um, and I did - it's interesting that you're saying this because like you said I'm in a
 490 fairly removed position I did have some experience working here and seeing what's going on
 491 and dealing with some of the challenges myself which were different coming here as a white
 492 woman, from – you know as a practicum student (P2: Mhm) then they would be in your position
 493 but, you know, I definitely just felt like, um (.) a lot of issues of race and class were constantly
 494 there, coming up.

495
 496 P2: yes

497
 498 K: -and again different for me as a white therapist who they might imagine, clients might
 499 imagine had a privileged background or didn't have the similar experiences

500
 501 P2: But there used to that, their really not that uncomfortable with that

502
 503 K: Yeah, I noticed that, but at the same time um, I felt like it's still in the room somewhere

504
 505 P2: Okay, yeah, yeah, the credibility issues are floating around somewhere

506
 507 K: yeah, or even just in um you know having a client who, I'd go to ask P1 something, about –
 508 you know he needed something that I didn't know about, and he'd leave the room, the session
 509 room because he didn't want me to think that he was stealing my stuff, you know when I wasn't
 510 in there – and he had been in prison so there were a whole other host of issues, but it was always
 511 to me something to consider, what does this have to do with what I represent and because (.) you
 512 know, there is a history!

513
 514 P2: oh, yes

515
 516 K: - I mean I even wondered about that coming in here

517
 518
 519 P2: I'm really sort of amazed because when you think about it you realize you know the level of
 520 care that these people are receiving is not because the institution is supporting it's because
 521 African Americans, with a high level of training are sacrificing to be with them (I: Mhm) that'
 522 what I'm trying to say, it's a major sacrifice, and I talk about it to myself every morning you
 523 know– “*what the hell are you doing?*” you know, “*why are you doing this you can't hardly pay*
 524 *your rent?*” Your one, your one, your 2 week check the whole thing goes to my damn rent (.) so
 525 then how do I make it, I'm like how am I gonna get through the next few weeks for gas, (please
 526 don't make me start having to charge gas 'cause that will really kill me) I mean this is what it
 527 takes to be here

528
 529 K: Yeah, I think what I started before as I have been reading, and was talking about being an
 530 outsider and try to understand, and a little bit from what I learned from talking to people here,
 531 but it does seem like there is such a parallel process between (.) what's gone on in the
 532 community historically, it's been overlooked and neglected, and sort of treated as if almost as –
 533 well, I'll just bulldoze over that community almost act as if it doesn't matter. And you're

534 experiencing that, the clinic is experiencing that, even in the physical condition of the space and
 535 you're experiencing that as a staff person. I feel like there is a parallel process, the same kind of
 536 attitude almost, you're kind of pushed to the side or overlooked or maybe sometimes like you
 537 said purposefully, [LF] it's not such a, I have been thinking of it as something unconscious
 538 almost, and I think a lot of it is, but some of it is conscious, like you said-

539
 540 P2: there's a lot of grand design crap that goes on
 541

542 K: grand design crap? (P2: Mhm) from the top (.)
 543

544 P2: there are people making grand designs about what this place, this city should look like, this
 545 just trickles down (2) it's amazing, it just trickles down *{chewing food}*
 546

547 K: I think it's interesting like you said about Duquesne too, what's on paper as a mission
 548 statement and also at UPMC, and I'm not trying through this project to villainize anyone but just
 549 to open up, your know, well what are these contradictions here?
 550

551 P2: I've never known any African American from outside of Duquesne who's ever put in an
 552 application to Duquesne, who's ever been brought in for an interview. I've never known,
 553

554 K: you mean a student from there you mean?
 555

556 P2: no, when they post positions I've never known anyone who gets called in for an interview.
 557

558 K: hmm, interesting (.) from Duquesne
 559

560 P2: I've never known! it just don't happen!
 561

562 K: Yeah, they definitely have a history of that, I want to say that they are trying to correct it but I
 563 know people I've known who've had bad experiences on campus, racially being
 564 harassed because they're Muslim or for various reasons, it's not and this may be the case in other
 565 universities as well, I don't know, but um, it's really not addressed, it's the way I think it should
 566 be
 567

568 P2: And I think this is a cost, and it's really odd because what I think I'm seeing is if we just
 569 look at- and you should want to take a look at the Bangs report - B-A-N-G-S, that Bangs report
 570 you'll really want to look at that report, you don't want to do this work without looking at that
 571 report, okay?. Because you want to get that down in your gut, I'll tell you what else he said, I
 572 was just in a meeting with him, well a presentation with him about 3 weeks ago, he also said the
 573 East City plan is crap
 574

575 K: The East city plan is crap - what plan is that?
 576

577 P2: That's the one where they kids are gonna get money
 578

579 K: Oh, the Hope, whatever -

580

581 P2: Yeah, East City Hope, Okay, here's what he said there's a problem (.) he said, you gotta look
582 at this (.) Kalamazoo, they explained what they did an analysis of Kalamazoo plan, but the
583 Kalamazoo gives the first money and the East City hope gives the last \$5,000 (I: Hm)

584

585 P2: So in other words, how much does it cost you to go to Duquesne?

586

587 K: Well, because I'm a Ph.D. student, the tuition is covered but it probably would be 30 grand or
588 something like that.

589

590 P2: Okay, so the kid has to come up with the first 25 and then they'll give them 5.

591

592 K: Really? That's interesting 'cause I have heard about it, I just never heard that.

593

594 P2: Well, I was there 'cause we invited him to Wilkinsburg to sit down with us

595

596 K: The person who was -

597

598 P2: Bangs, from University of East City, Graduate School of Social Work and that's what his
599 analysis was, that you know that they're givin the last 5. So you and I don't have to be rocket
600 scientists to figure this out, where are they gonna get the other 25 from?

601

602 K: Right, I mean that's-

603

604 P2: So basically, it's not really gonna help the poor kids out.

605

606 K: Yeah, I mean I thought that was - and this was the plan where they say if you go to the public
607 schools that they'll pay for your education

608

609 P2: {nods}

610

611 K: okay, wow! so that's really a different story then what, at least I had -

612

613 P2: and the UPMC money is going into it, and all that yeah, it's not coming out anywhere near
614 the Kalamazoo, and you'll want to look at the Kalamazoo project which is paying the whole ride
615 and it's only 2 years old- and then you want to look at the Hope and you'll see the big
616 differences even though there saying that (in the study) it's not the same program, heh. (I:
617 Mhm) So, there's your hope for getting out and those are some of the things that I think are
618 really important. 90% of African Americans that I know who get educated and want to make
619 something of their lives, leave East City (.) (I: yeah) and all of my friends who've left are
620 successful (.) and all of my friends who've stayed are poor [LF] you know, if - there's a real
621 issue, you know, it's a real issue

622

623 K: It's really segregated here still, I mean I grew up on Long Island in the suburbs so it wasn't
 624 diverse in my neighborhood but I went to school in the SUNY New Paltz which is close to the
 625 Bronx and so it was a pretty diverse campus. Um and when I came here I definitely felt it, it just
 626 seemed, most places have their segregation, even New York city but people are crammed so
 627 much more together and there's not as much - it does seem like African American communities
 628 are separated here even geographically speaking

630 P2: Mhm, East Hills up on the hill you know, you can corner it off in a minute if they wanted to
 631

632 K: yeah, it was striking to me as someone moving here from the outside, even my first - it's very
 633 interesting to me that I ended up doing this kind of research in the 8th district because of on of
 634 my first experiences here when I came here for interview was that I got in a cab, like a taxi cab,
 635 and was staying in a hotel the one that's right near the arena there near Duquesne and I didn't
 636 know Duquesne was so close so I called a cab and he was driving me there and he said to me,
 637 "don't go to the left there, that's the 8th district district" but to me I thought he said, the hell
 638 district

639
 640 P2: [LF]

641
 642 K: 'cause he kept saying, you know, you might get shot - unless you have a gun -

643
 644 P2: [LF louder and harder]

645
 646 K: - and so I was thinking, you know, my point of reference is New York city, so I thought, it
 647 must be really bad if that's you know - and I thought to myself the hell district, that sounds like a
 648 scary place!

649
 650 P2: [LF]

651
 652 K: the hell district, you know and as I learned more about it - it's not that and just working here
 653 and like you said from the news and the statistics there is a good amount of violence here but I
 654 certainly didn't feel like, you know-

655
 656 P2: (h) we were in hell!

657
 658 K: - yeah, yeah, that's so telling I think in what you're saying that even just perpetuates the idea
 659 just the way people talk about it, about what a violent place - and it really just cuts off any real
 660 interaction because it is that real interaction, I think, that can sometimes dispel those stereotypes

661
 662 P2: That's right!

663
 664 K: So I should probably I mean I should probably write that somewhere that that was my first
 665 experience, that's pretty amazing (P2: Mhm) (.) So I realize {*glances at clock*} we're, ooh, just
 666 about out of time here. Do you have a client coming at 3 o'clock or anything?

667

668 P2: I don't think so, but If they show up

669

670 K: Um, I didn't get to talk to you much about your clinical work, um, with clients –

671

672 P2: Well, you really did.

673

674 K: Well, we did get some, I don't know if there was any specific example or instance of a case
675 that felt particularly challenging to you or (.) I feel like we touched on that without specifically -

676

677 P2: One of the things that really fascinates me, is like, um (.) like I said to me is um (.) I have to
678 work with these people, whose incidents are on television (.) (I: yeah) When I come – you know,
679 get up in the morning and say [WH] “*Oh, my god that's so awful, Oh my god, those poor*
680 *people*” and then I come to work and find out I know them (.) I still can't get over that (.) I don't
681 know why it just it just [‘h,h] (.) I just can't – I'm like [WH] that was you son, that was your
682 daughter, that was - I'm like, “*o::o, ho::ney, how horrible!*” (2)

683

684 K: Yeah it's really, uh, horrific (P2: oh {nods}) for it to be right in front of you like that

685

686 P2: It really is and very exhausting, that's the other thing about the clinical work, um we'll often
687 say, like we'll be in group [‘h] (.) and it'll be so intense (.) that (.) when we come out (.) we'll
688 end up looking at each other and saying “*oh my god, I'm so tired*” (I: Mhm) or you're kinda
689 pumped up for minute and then as soon as the adrenaline goes down, you feel like you're on the
690 ground, ex::hau::sted, EXHAU::STED! and I often hear my colleagues transferring back and
691 forth – Marcus goin' “I'm tired today” {*says in a lower voice, imitating masculine tone*}, and
692 Earl sayin' – “exhausted.” (I: Mhm) I think it has to do with the level of, um, intensity that (.)
693 they bring, our patients, and the level of intensity it requires to meet them. so that you come here
694 like wo::o, WHOA! I'm tired. And I have to think, I do not remember really being this exhausted
695 in any of my other positions.

696

697 K: Interesting

698

699 P2: Okay, and even though, um (.) I've been some places that were physically challenging to me,
700 you know, I mean [h] machine guns in my face and stuff like that, but I don't think that I've ever
701 been this exhausted as I have here. Because you know, I'm lookin at some damn (Eco) soldier
702 and it's like “get that damn gun out my face!” (I: [LF]) [LF] you know, he's like, “MADAM,
703 you must state your business” {*said in lower tone, imitating male, French accent*} and I said,
704 “you know damn well, you know damn well, I'm the woman who bought that damn rifle you got
705 that has a USA emblem on it (.) Okay? That's who I am, the taxpayer who bought that gun,
706 now, get that rifle out of MY FACE!” (.) I slept pretty good that night! Now he::re, I sleep too,
707 but I'm exhausted it's like “o::h my go::d!” after li::stening to so much of the pa::in and the
708 a::gony they go through I sometimes, I am exhau::sted and I hear () is hard work, sometimes
709 to get [WH] them up off of that ground and dust them off, and help them start breathin' in deep
710 again and believin' they can go out there dammnit and they can live and they can make it, they
711 can survi::ve it's just s:o intense. And if you're counseling on a campus you know how
712 sometimes they come in with I'm leaving, I'm going home, or I can't make the next test, and

713 now that- (2) cause I used to be (.) a Chaplin for University of East City and CMU you know, so
 714 (.) you know, I know what's it's like to pump those guys up and that's serious work sometimes
 715 'cause they're really having crisis. [h] I thought that was
 716 just take that, and just I'm not sayin' you're not – I'm just sayin', take how, you know
 717 sometimes you got a kid who just wants to run away or leave or whatever and you're doin'
 718 everything to – just take that and just triple it (2)

719
 720 K: Yeah, it's really hard.

721
 722 P2: [h] It's ha::rd wo::rk (2) so hard that I think that many of us would rather avoid it or deny it.
 723 You know, just kind of be in denial about it

724
 725 K: About how bad it is, yeah.

726
 727 P2: Sometimes I resent it (.) you know I resent it it's so damn hard (2)

728
 729 K: There's so much it seems like just in my brief time being here and I've been working over at
 730 Mercy Behavioral Health too, which you know, also there's a lot, it just feels like there's just s::o
 731 much that feels outside of the realm of even what can be worked on within the realm of
 732 individual therapy//

733
 734 P2: YE::S! Ye::s!

735
 736 K: Il feel like just systemically there's s::o much that feels like (P2: [LF] how could you possibly
 737 provide all that, or possibly address all that?

738
 739 P2: [LF] You CAN'T! (h)If you did there wouldn't be nothing left you would sit down and say
 740 *{gestures with hand}* “well THIS used to be our psychologist!”*{uses high pitched joking,*
 741 *sarcastic tone}* (I: [LF] *{again in a funny tone}* “now she's just melted away!” [LF]

742
 743 K: Yeah!

744
 745 P2: - you would just wither away, completely!

746
 747 K: Yeah absolutely and for you I would imagine there is a different level, I would imagine even
 748 a deeper identification with some of the racial issues like you mentioned that you've struggled
 749 with (.) you know I felt it sometimes as the child of an alcoholic and my brothers' a recovering
 750 addict, and sometimes with the addiction issues it get stirred up a lot – but sometimes that can
 751 make it that much more intense and with you some of the discrimination you've faced and the
 752 feelings you've had about that and being here I imagine that plays into your work as well.

753
 754 P2: Very much so, one of the things I like you know, I have triggers! I have triggers, u::m and
 755 then not only with whites or the white-black issue. Like I have triggers, like I don't like pimps
 756 [LF] I mean (I: [LF]) they're just not my favorite type men, okay? And (.) you know (.) there's
 757 one of 'em that keeps his mouth shut (.) for the most part – but there's one who likes to MESS

758 with me! Okay? It's as though because he's such a wonderful - what would you call it? (2)
 759 {other voices audible in the hallway} he's so good at, you know (.) identifying women, and
 760 analyzin' *{snaps her fingers}* women (I: Mm) That he KNO::WS *{snaps again}* I can't STA::ND
 761 him, okay? But, I like him as a person except for when he'll say something that's s::o da::mn
 762 sexist (.) (I: Mm) and O::H!, I could backhand him, you know? WA::M! and it's like "SHUT
 763 YOUR MOUTH UP!"

764 'Cause I do - (.) (I: Yeah) And he could say some sleazy stuff about women, okay?

765
 766 K: sure, geez.

767
 768 P2: 'till you feel like the hairs stand up on the ba::ck of your neck, all right? It's like, ['h, h]
 769 WHO::OU!

770
 771 K: and how do you manage that, in the moment?

772
 773 P2: you know it's really funny you know I thank god that I've been trained very well, you know
 774 I've been trained very well. Earl told me the other day there was a little edge on my voice when
 775 the guy said well, "I don't have any problems slappin' a bitch!" *{repeats slapping a bitch to*
 776 *herself describing how it felt to her, shaking head in disbelief}* (I: [LF]) () so I was like,
 777 o::ka::y ta::ke 50 deep breaths here [LF], (h)okay? 'Cause that was like off the chart, I mean that
 778 to me, that was just off the cha::rt - "I don't have any problems slappin' a bitch"

779
 780 K: In the middle of a group

781
 782 P2: *{Claps her hands together excitedly}* YES!

783
 784 K: So you kind of you recognize your reaction to it and you back up and take deep breaths?

785
 786 P2: Mhm, it's like this zipper that goes right here *{points to center of body}* that little zipper just
 787 goes, woop! *{gestures towards zipping it up her center}* (.) And before he left he came and
 788 apologized to me and hugged me. (I: Mhm) And, I hugged him, you know, and I said you know
 789 what, we're gonna get past this, and he said [WH] "*I'm so sorry I shouldn't have said that*" But
 790 you know I said I'm glad you felt comfortable enough to be that honest, so we could get that up
 791 and we could get that out. So, but he's not the one who gets me it's another one that triggers me
 792 and knows he triggers me (I: Mhm) and he says, you know, I hear a little anger in your voice and
 793 I say, yeah, you do hear anger in my voice because you're disrespectful and disrespecting me (.)
 794 (I: yeah) and I feel (.) offended by that

795
 796 K: yeah, there has to be room for your experience of him there too.

797
 798 P2: Yes, yes, yes. So, there are certain things and I guess that goes across the border for all of us,
 799 there are triggers (I: Mhm) You know, and I don't like the pimps (.) no!, I like the pimps, I don't
 800 like the pimp talk! (.) (I: Mhm) And when they do that it just feels like, [WH] he did not say that!
 801

802 K: now you said you had really good training, did you get that training when you were in school
803 or did you get that training on the job?

804

805 P2: Um, I think I got really good training at Western Psych. – um, I'll admit most of my success
806 across the country working was a lot of the training that I received early on in my first
807 professional position at Western Psych. I was really trained well. One of the things they did there
808 was in the old Western Psych. colleagues, you worked with an older colleague and um, they
809 really worked with you. And we went back and had clinical meetings about everything and we
810 talked through things and every week I had to take my cases in to talk to Dr. Ballavue (?) my
811 consulting psychiatrist. And we would go through each case and talk about the transference
812 issues –

813

814 K: That's great

815

816 P2: - and so, I got really incredible training right from the start. And then here since I've been
817 back, well - I've always been able to use Bob, you know, Dr. Marin as a consultant. And then
818 since you know I've been here, Earl is a really good source of, m::m, you know, training, (I:
819 Mhm) he's a really good consultant.

820

821 K: Do you feel that you feel supported by the staff who is here for the most part?

822

823 P2: Yes, I- (.) [h] one of the things is that because I come, because 'a who I am (.) you know,
824 who was the poet again who wrote that book, (When and Where I Enter) I am (.) pshh, (3) If I
825 wann – If I wanna know something they're gonna tell me, okay? And, I don't feel threatened by
826 no one 'cause I know so many things that they don't know, and I don't care you're gonna tell
827 me. So I hold my own with these guys –

828

829 K: Are you the only woman here now? I guess there are psych residents or something around,
830 yeah

831

832 P2: Yeah and they come in and out, and Betty comes in and out, but I'm the only woman
833 therapist

834

835 K: And Yvonne left, right?

836

837 P2: And Barbara, yeah, so (.) yeah, they left on the same day (I: wow) I made it quite clear that
838 I'm not gonna give any (pains) and I'm not gonna give any either, okay? 'cause there's
839 somethin' to that

840

841 K: Something to the fact that they left on the same day? (P2: {nods}) Do you feel like you
842 experience some sexism within here?

843

844 P2: Um, it might not be intentional but if I d::o, I just get it cleared up

845

846 K: its' pretty hard to avoid a workplace, at least in my experience, that doesn't have some of that.
 847 Especially as you start to rise – have positions where you have a little bit of power or you know
 848 you have an education
 849

850 P2: And you should surely know that in ministry 26 years ago (.) [h] (2) that every time I sat
 851 down at the table, I was the only woman – you know? It was just disgusting! And not only that,
 852 but they felt threatened to have us at the table then, It was like we were comin' – we were comin'
 853 there to castrate everyone. And it's like, get your head out of your neck! We don't care anything
 854 about that! That's not why we're here! “*Well why do you want to do this?*” {said in a lower,
 855 *masculine voice*} I'm like “WHAT DO YOUR ME::AN why do you want to do this?” So they
 856 were very neurotic! Um, sometimes I can just overlook it, 'cause I beat 'em at it, you know.
 857 They say I couldn't do it and I did. (I: Mhm) So I don't even care anymore about whether they
 858 like it or they don't like it that I'm here or whatever, they get on my nerves. It's like they did
 859 with that paint, it's like psssh, I really don't care, okay? I'm not tryin' to live up in here, do it
 860 handle it, I'm not gonna pick colors, I'm not gonna do this!

861
 862 K: So in your training, um, (.) you felt like you had a lot of good training through Western
 863 Psych. and in your graduate training did you feel like it prepared you for the kind of work you're
 864 doin here now? Did it have sufficient courses in looking at diversity or any of that stuff?
 865

866 P2: No, that really wasn't goin' on when I was in school, back in the what, the 80s and 90s, that
 867 just wasn't - you know, we were really just startin' to talk about this kinda thing, not really
 868 knowing how to articulate it (I: Mhm) um, the discussion about diversi – I left here in '87 – the
 869 real powerful discussions about diversity first began in the business world because you know
 870 economics is what drives the nation and they started realizing that it was really business savvy to
 871 talk about things like diversity. Um –
 872

873 K: interesting, yeah, point
 874

875 P2: in my previous position to (remoo) in Valley Forge, one of the things that I had to do was
 876 – I was – I wrote all the statements, for, you know, statements on economic justice and na na na,
 877 when the delegates get together () Episcopal church has decided to receive gay clergy and
 878 whatever, whatever – that's a process (I: Mhm) and I orchestrated that process for American
 879 Baptist and we were very diverse, so one of the things we had to do was wrestle with this
 880 diversity problem I had to have men and women on the committee, I had to have lay and clergy,
 881 I had to have North, East, South and West represented and I had to have conservative, moderate,
 882 and oh, reformers, all at the table at the same time. So they for::ced me to work diversity because
 883 that was the only way – if I didn't get all of those people at the table and that statement got
 884 presented, I was gonna get () – somebody was gonna get up and walk out, you know, grand
 885 stand, but if I had a representative of a::ll the different positions and then the person got up and
 886 said you know what, I felt that way too but I had to back down or I had to modify because the
 887 greater good is this or that, that's how I learned about diversity, you know, really hands on kind
 888 of way, and we often studied and prepared a statement for like 6 months to a year before it was
 889 presented so we would go to the actual cities and study things. So I said, when I wanted to do
 890 peace work, I took 'em into Boston and they walked the streets Eugene Rivers and the gang

891 people there, and met with the people at 10 point and the governor, and then I flew them from
892 Kansas City, Kansas to meet with the gang people there. Then I flew them to L.A. to this place
893 where they have this daycare that does all this peace stuff so I would create a traveling
894 curriculum an experiential curriculum, that's what taught me, being forced to have to think it
895 through and think of all the angles, that taught me about diversity. (I: Hm, and -) so I guess I'm
896 saying to you, I knew the written work but what it felt like and the angst that it creates to try to
897 do that I learned tryin' to work that, oh trying to work it

898

899 K: That sounds like an amazing experience that you had

900

901 P2: Yeah, I was really blessed, you know

902

903 K; That's really great, Well, I'm sure we could talk, I could talk to you for hours probably but I
904 think we can stop it there

905

906 P2: And if you need more ti- if you get to workin' and think "oh, I need to get something" – call
907 me, we'll set up another () for you and we can try to crank it out

908

909 K; Okay, that's great 'cause I might have – you know as I'm listening to it, I might think, Oh I
910 wanted to ask her that, or um, so – maybe I'll even just call you and ask for clarification

911

912 P2: that would be fine

913

914 K: I really – thanks so much for agreeing to sit down and talk to me I feel like I could talk to you
915 for a long time you just have some much to offer such a long, and such a broad experience

916

917 P2: yeah, thank you

918

919 K: and like I said, I really appreciate you agreeing to - allowing me to benefit from it and my
920 study.

921

922 P2: Well, you're very welcome. You know the guys are gonna have their angle on things and
923 they have good angles but it's nice to have some fresh perspective

924

925 K: Absolutely, yeah

926

927 {voice recorder turned off}

APPENDIX F

Interview Transcript: Michael (P3)

1 Interview transcription: P3

2

3 K: So, u::m (.) so again just thanks for sitting down with me to talk

4

5 P3: You're very welcome

6

7 K: So, you have been here for how long now?

8

9 P3: I have been here for almost 7 years. It will be 7 years in July.

10

11 K: okay, and u::m (.) so I'm just gonna start with some general questions about how you got here
12 and what brought you here, and we'll go from there. And like I said, anything that seems more
13 interesting to you or that you want to elaborate on, just (P3: all right) feel free to do that.

14

15 K: So, how did you come to work here, 7 years ago?

16

17 P3: Well, I attended the social work program at the University of East City, and graduated a::nd
18 u::m, I wanted to work in a community setting. Uh, I wanted to work with an underserved
19 population, I wanted to work with people of color, African Americans, um, so, u:m I talked to
20 m::y um (.) advisor, my field instructor a::nd he suggested that I apply down here. U::m, I did, I
21 got the job and um, you know, sort of, got started pretty quickly. So, I've always been brought
22 up in the helping tradition you give back, you know, each one teach one, that type of philosophy
23 (I: Hm) U::m (.) that you are because of other people, so it's never about you, it's always about
24 the next person and you have a responsibility to make a difference in everybody's life because
25 someone sacrificed for you to be in the position that you're in um, so it's always been about
26 helping people, helping people that are less fortunate than you are, u::m a::nd tryin' to really fill
27 that gap in mental health services when it comes to people of color, or particularly African
28 Americans.

29

30 K: And so you're saying that that was something that was a value, as you were growing up, even
31 before you went to school?

32

33 P3: Mmhm, yes, definitely. Definitely, raised u::m, in the church, um (.) it was always about (.)
34 helping other people, you know when I graduated um, from college, um, you know my dad said
35 to me, "okay, great job, now what are you gonna do?" So [LF within the word] when I graduated
36 from graduated school he said uh – and he's still sayin! I: [LF] "Now, what are you gonna do?
37 (I: [LF]) I mean this is great but don't get comfortable, you have to keep moving you have to
38 keep growin', you have to keep developin' um, because problems don't stop a::nd um, there are
39 a lot of people that sacrificed, and were injured and died, just so you could have this opportunity,
40 s::o, um, don't let it go by the wayside keep movin' keep progressin', keep helpin' people.

41
 42 K: And, now (.) the message you got was specifically– or what you’re most interested in is
 43 specifically helping people of color// or African Americans
 44

45 P3: Well, PEOPLE| people in general but (.) obviously I’m African American so, that is gonna
 46 be near and dear to my heart. But really, not just African Americans but people who need help in
 47 general. I say African-American because, number one, I am African American, and I was
 48 brought up in that tradition but, number two, if you look at it, um all the socioeconomic um
 49 indicators, um African Americans lag very far behind and I think if you look at the history health
 50 care system, u::m, uh, the effort to provide culturally competent, quality care, u::m, has been
 51 u::m less than acceptable at times. So um, understanding that history and knowing that history,
 52 um, definitely there’s a need to really specifically try to help people who have been
 53 disenfranchised. And there’s no one who’s been more disenfranchised than African Americans.
 54

55 K: One of the things that I’m wanting to incorporate in the story I tell about what goes on here, is
 56 the history of this community itself. (P3: okay) You know and (.) one of the things I saw going
 57 on here was that, that, it is a community based care but really goes further than that in really
 58 integrating, (P3: definitely) u::m what is the history of the people here? And I wondered if you
 59 could speak a little bit about how that comes into play in your work here?
 60

61 P3: Okay, So let me be specific do you mean the history of the community, or the history of the
 62 Phoenix House, or
 63

64 K: well, if you could speak to (P3: okay) both and that would be great if you have something to
 65 say about them
 66

67 P3: Okay (.) well one this that’s important to understand is that a lot of the folks in this
 68 community in the 8th district have been historical displaced, okay. A::nd, u::m, you know, urban
 69 urban redevelopment has really meant over the years historically that, you know, Black folks get
 70 moved out big buildings go up, u::m, people lose their homes, they lose their identity, um a::nd
 71 that really is a form of trauma, um and it’s an historical trauma (5:19) u::m, I think one of the
 72 things that is a benefit in the Phoenix House and what we do at the Center is we try to provide
 73 cohesive services within the community. We try to make it a one-stop shop. Now, we can’t be
 74 everything to everybody, but can try. And, I think what we try to do is make people feel
 75 comfortable with the idea that this is their clinic, this is their home, we are here to serve you
 76 u::m, it is about you when you come in here u::m (.) and the whole history of the Phoenix House
 77 is about helping individuals and families improve their lives. Um, because there’s a lot of
 78 poverty in the community you know, there’s a lot of unemployment in the community, um,
 79 there’s a lot of frustration in the community. And, um (.) it plays out (.) in other ways that may
 80 appear to b::e, um, you know, this this is just a bad person, or or people are bein’ irresponsible
 81 but it’s really people are, are actin’ out their pain, (I: Mhm) um, so what we’re tryin’ to do is get
 82 people to understand, that we do understand that a::nd here’s another option. you know, we’re
 83 tryin’ to provide another option, you know, we understand that you’ve been impoverished, a::nd
 84 you’ve been discriminated against a::nd you know, you may have been miseducated or non-
 85 educated, u::m, we understand that you’re locked out of the American dream, you know, um, for

86 you in many ways, it's a nightmare. U::m, so what we're tryin' to do is give you a place, where,
 87 um, you can not only develop in terms of your mental health but also in terms of empowering
 88 individuals socially and culturally, politically, getting them involved in the voting process. You
 89 know, we do voter registration- I mean, we encourage clients to- we have an advocacy group
 90 a::nd they do voter registration. u::m, doin' things like helpin' people to, get into college, you
 91 know, many of our clients are now, goin' on further, you know, u::m (.) so, also I think it's
 92 important to understand that um, it's not just about (.) how you feel but it's about (.) dealing with
 93 the obstacles in your way, because, you can feel wonderful but run into obstacles every five
 94 seconds, so what we try to help people do is to sort of manage those obstacles and um, be able to,
 95 um, realize their full potential, um, through self-esteem and through confidence and through
 96 empowerment and realize that they can make a mistake and that's okay, but they can still
 97 progress, a::nd u::m, the most important perception of who you are is not society's perception
 98 but your own perception. but, you know, that's something that has to be developed because when
 99 it's been crushed, um, it's a tremendous challenge, it is a tremendous challenge.

100

101 K: I can tell as you talk about it that you have, you have such a personal connection to your work
 102 here and uh -

103

104 P3: Oh, I'm very passionate about my work here. Because I understand the ramifications of u::m,
 105 of not having certain things. u::m I understand the ramifications and the consequences of being
 106 locked out, you know what it not only means for the individual but for the individual's family for
 107 the individual's community, um, I understand the connection between a healthy individual in
 108 terms of their mental health um, and someone who's able to be productive and someone who is
 109 able to be there for themselves and be there for others. u::m, I also understand that our clients are
 110 resilient, you know, and we come from a strength-based perspective, a holistic approach, uh, that
 111 means, we don't see them as a problem, we see them as a solution. we see them as having
 112 problems but not as a problem. It's a very important distinction to make because when you see
 113 someone as being the problem than that becomes the focus. You know, let me fix this person (I:
 114 Right, right) as opposed to, let me help this person and there are some things that have gotten
 115 you to this point so let's build on that, let's work on that, and then we can move forward in a
 116 positive way but we don't need to focus on the negative. We know what the issues are, now let's
 117 resolve 'em (I: Mhm).

118

119 K: Now, it sounds like, um, from what you're saying about - you're looking at the person first, as
 120 a person with problems, not the person as a problem

121

122 P3: Exactly.

123

124 K: and um, it also sounds like, from what you were saying before you know, experiences of
 125 discrimination and a long history of oppression, um, in the nation, as well as in the community,
 126 they have a specific kind of history here, um it's sounded like what you were saying is that when
 127 people are acting out, or breaking down, it's looked at as that's a bad person -

128

129 P3: - Mhm, stereotypical.

130

131 K: - that's a problem but it's really, it sounded like you were saying that it's really kind of a
132 manifestation of these social inequalities –
133
134 P3: //Mhm, exactly
135
136 K: -social problems!
137
138 P3: which impact mental health, tremendously
139
140 K: And that's something that um I noticed is a pretty prevalent perception here. And I wonder
141 about, and this is something I wondered about when I worked here too, is this clinic in particular
142 is within a larger psychiatric um, institution that often times conceptualizes problems in a
143 different kind of way, like more so a biological model and I was wondering about how that - if
144 that's something that comes up in your work where you feel like you're juggling those or-? Does
145 that make sense what I said?
146
147 P3: Yeah and what I would say – and that's a good point and you're right – and what I've tried to
148 do over the years i::s, um (.) basically catch the system up, cause one great thing about what we
149 do, I BELIEVE, there is some things that are culturally specific, but I believe, the strength-based
150 perspective, the holistic approach is good treatment across the board. Because what it does is it
151 says okay, I have this circle pattern, and I'm not sayin' that circle pattern has to fit everybody,
152 I'm sayin' the holistic approach means that I'm gonna meet you where you're at, I'm gonna help
153 you where you're at, and, you know, the cultural part of this, is um, “yeah” there are times when
154 we feel misunderstood but I think that we also have an opportunity to advocate and we're able to
155 still do the things that we need to do for our clients because it's still therapy - a good therapist, is
156 a good therapist, is a good therapist – so, you know, you're not a good BLACK therapist, I mean
157 if you're a good therapist, you can help anyone. u::m (.) if you know, I don't - obviously I'm a
158 Black man but I don't see myself as a Black therapist, I do therapy – we do see individuals who
159 are, who are, white here and of other cultures and I approach it in the same way in terms of the
160 mindset (I: Hm) okay, the person is the strength - now the problems may present differently. now
161 that's where you have, the interventions might be different but my mindset is – strength,
162 strength, strength, strength, strength. Um, so it isn't – it's important to make that cultural
163 distinction and your right, the larger system often you kinda get swallowed up in, “what's
164 perceived as, okay, this'll work for everybody across the board and this is what you're supposed
165 to do u::m, but you also have to look at your reality and your own specific programs and that's
166 what we do and I think all programs do that, I hope they do (I: Mhm) u::m (.) because I can't
167 help you, using a standard that historically has been a negative for you. Then it means I'm doing
168 you an injustice.
169
170 K: So, you're really conscious of adapting the therapy – to individualize it (P3: definitely), but
171 taking into account what might be the commonalities and the shared experiences of groups of
172 people (P3: exactly). And do you feel like in graduate school that you were prepared to do this
173 kind of work? Do you feel you had the courses necessary?
174

175 P3: Actually, yes! I have to say yes, and I had some very good internships in graduate school.
 176 But we did a lot of role playing, I had, my professors were very hands on, u::m, I would say yes.
 177 We would break up into groups I mean it wasn't just studying the theories, we actually would do
 178 the therapy. U::m we would play the therapist we would play the role of the client, we would
 179 play the role of the observer, so you got it from all different angles. U::m, interesting too,
 180 because a lot of the people that were my professors, I now have some contact with somewhere,
 181 you know, in terms of, you know, the hospital or – all of them – not all of them, many of them
 182 seem to be in the system you know, in terms of being, you know, a doctor or a social worker.
 183 You know, there's some connection. (I: Mhm) So (.) there, there's familiarity there too.

184
 185 K: Mhm, great. And um you know, in terms of again, just the larger system of the medical
 186 system that you're in, I'm wondering what the relationship between the Phoenix House, or the
 187 Center I should say, not the Phoenix House, and the larger system is.

188
 189 P3: Well, I think, I think it's decent, u::m, h (.) you know the CHALLENGE often is getting
 190 people (.) to understand that yeah, there are - we're the same, because it's mental health
 191 treatment, but we're also different I mean if you - for example, if you have a clinic that only all
 192 men come to (.) you know (.) there're gonna be some issues specific to those men. If you have a
 193 clinic where only all women come to, there are gonna be some issues that are specific to only
 194 women. you know we have children's hospital there's a reason why we call it children's hospital
 195 because we focus on children, okay, and that's okay! and I think it's okay to understand people
 196 in that context. The battle or the challenge often is with dealing with the larger system, in terms
 197 of the relationship, is getting that larger system to understand that, u::m, we're all part of the
 198 same system, but we're all separate from the same system too. So, sometimes, we're kind of out
 199 here, on an island, because I think this is a very unique clinic you can get some examples that are
 200 somewhat similar in terms of how the clinic is made up, in terms the community etcetera, but I
 201 think that this is probably one of the few, truly um, community-based mental health facilities
 202 u::m (.) in, in, in East City, I mean where everything is just, in the heart of the community and
 203 sometimes it is a challenge to get the larger system to understand that, but the good thing is that
 204 we have the autonomy (.) to be able, as long as we follow the guidelines and all those other
 205 things which we do, we have the autonomy to still, um, implement our own program. So, it's
 206 important that they understand but, it's more important that we be able to provide these services
 207 for our clients. So if you don't understand, but I'm still able to provide the services for my client,
 208 um that's okay.

209
 210 K: And uh, so in your experience in other clinics you've worked at this is a very unique kind of
 211 set up.

212
 213 P3: This is extremely unique um. I'm gonna tell you a story. When I first started here the very
 214 first and I will never forget this. The very first day I walked in the door, you know, and
 215 everyone's askin', "are you the new therapist? are you the new therapist?" and I say "yes" you
 216 know, "my name is Marcus Flonoy, nice to meet you" a::nd they say oh, "nice to meet you too,"
 217 a::nd there was a woman that said, and I know to this day I still remember her, she said to me,
 218 she said, "you know, this was our clinic lo::ng before you got here and it'll be our clinic lo::ng
 219 after you're gone" and I said, "okay." AND, AND, and then she said to me, "it's nice to have

220 you.” Now, WHAT I TOOK FROM THAT was, we’re happy that you’re here (.) um, but
 221 understand, this is our house and right now you’re a guest, you know and 7 years later, I’d like to
 222 think that I’m a little bit more than a guest {smiles} but I understood it. and I wasn’t offended by
 223 it, I completely understood it. I’m a stranger to them, initially and I’m a stranger to the clients
 224 initially, a::nd you know, they’re tryin’ to figure out “well, who’s this person comin’ in here?
 225 I’ve been here, and we know the clinic, we want to know who *you* are. You know, we wanna
 226 know who you are,” you know, “we wanna know who you are.” And I respect that.

227

228 K: Mhm, so that was a coworker who said that to you or that was a client?

229

230 P3: Mmn, no that was a client.

231

232 K: Oh that was a client, okay, wow.

233

234 P3: yeah, that was a client, yeah.

235

236 K: in a way that speaks volumes I feel like about (.) a feeling that maybe some clients have about
 237 this being their home base (P3: exactly, exactly). That’s wonderful in a way – that’s great. Yeah
 238 it’s neat. I had another question as you were talking that I can’t quite, u::m (.) so I guess that kind
 239 of leads into another area I wanted to ask you about which is the culture of the center itself and
 240 the relationship between staff and clients and staff with each other. That’s something that really
 241 struck me as I was here, for the short period of time that I was, and I was wondering if you could
 242 say a little bit more about that.

243

244 P3: Okay. One of the good things about the relationships between the staff and the clients is that,
 245 um, even if you don’t have a particular client (.) you know them, you know them by name. And I
 246 think that’s very important because, in a crisis (.) um, even if someone who’s psychotic (.) when
 247 you develop a strong relationship with them outside of the crisis – if the crisis becomes the
 248 nature of the relationship, for example, a parent the only time they say something to their child is
 249 when they’re angry with them or tellin’ something they did wrong, that becomes the nature of
 250 the relationship – so when you’re dealin’ with another individual, you always wanna build the
 251 relationship outside of (I: Hm) the potential crisis because when and if there becomes a crisis,
 252 that relationship will be more solid. If a CLIENT doesn’t particularly like me or the way I’m
 253 doin’ things or you know, we don’t have a good relationship and they have issues, they’re
 254 decompensating, it’s gonna intensify it (.) okay, um, but if we have a strong relationship, then –
 255 and I’ve seen this happen- you know, there is a difference in the way that people respond to you.
 256 So the relationship is strong is very community orientated, it’s about the individual, u::m (.) we
 257 don’t have a lot of issues in here terms of altercations and things like that because we know our
 258 clients, we know when they’re comin’ in we know what they’re upset before they even say
 259 anything. We know when they need to vent, we know when they need to process, u::m, we
 260 understand them, they understand us. We respect them, they respect us. you treat people with
 261 dignity and humanity at all times, you don’t stereotype people, because somebody is different
 262 than you doesn’t mean that they’re a bad person. Because someone’s a little louder, doesn’t
 263 mean they’re gonna get violent, you know, because, u::m, someone, um, may appear to have an
 264 attitude, you don’t know what just happened to them. maybe they should have an attitude you

265 know it's about giving people the benefit of the doubt, it's about respecting and expecting
 266 respect. So, we set expectations, but we also try to meet our own expectations, and that's
 267 important because if I'm puttin' it all on you, then that's not a collaborative relationship, you
 268 know, uh, the treatment is about collaboration, it's not just about me sayin' you must do this, you
 269 need to do this – that's the authoritative model. We're about the collaborative model, the
 270 strength-based model, the holistic approach. That means I'm responsible to a certain extent and
 271 the client is responsible to a certain extent and the nature of your relationship really will entail
 272 how that plays out. So, I think the relationship between the staff and the clients are very good,
 273 and I think the major reason why it is, is because they understand that you know (.) I'm a
 274 therapist and you know, you're a client but I'm no better than you, I don't have this, this – you
 275 know, I don't try to take authority over you. U::m, I'm hear to help, I'm here to understand, I'm
 276 here to build options for you, I'm here to provide options for you um, I have your best interests
 277 at heart. It doesn't mean there won't be times in the relationship when there are disagreements,
 278 but a good therapeutic relationship you talk about that, you know, um, and people feel
 279 empowered when they have choices and when you choose to treat someone like a human being
 280 and with dignity and respect - and often you'd be amazed at how people don't get that in any
 281 area of their life. and you, and you speak to people like they're, u::m (.) valued, u::m, as people,
 282 it makes a difference. So those are the things that we practice and () here.

283
 284 K: Yeah, I could see how that would help to build the relationship, whether it's a cross-cultural,
 285 cross-racial relationship or not. (P3: exactly, exactly). that openness to the other being however
 286 they are and trying to understand that.

287
 288 P3: - and not bein' afraid to say, "what did you mean when you said that?" 'Cause sometimes
 289 people will say things and I consider myself to pretty hip but sometimes you'll get a younger
 290 clientele and they'll use words and I'll think to myself, "can you tell me what that means?"
 291 'Cause I don't know what it means (.) and I'm not afraid and you can't be afraid to put yourself
 292 out there like that and say help me to help you, help me to better understand you. The more I can
 293 understand you, the better I can help you (I: Mhm) and um bein' able to do that I think is a
 294 positive

295
 296 K: yeah, that's really important. I think that's a real strength of your model here and way of
 297 taking up cultural competency in a non (.) what the way to put it? - stereotyping way,
 298

299 P3: Mhm, non-threatening, yeah

300
 301 K: - yeah, it's not like you're gonna study a given a culture and know all about
 302

303 P3: //right, right, right

304
 305 K: what this isl it's really about how each person experiences their (P3: right, right) own reality
 306 and backgroundl

307
 308 P3: 'cause we're not tryin' to tear people down to build people up, we're sayin' you know (.) you
 309 have things goin' for you, we want to improve on those things, you know, we're not tryin' to

310 ch::ange the wa::y you talk, we're not tryin' to change the essence of who you are , we're not
 311 tryin' to – we accept you, and respect you, but what we're sayin' maybe you're doin' some
 312 things that aren't healthy you know, and and and there are reasons for that, you know, we're
 313 tryin' to help you where you're at but we're not tryin' to change, to reconstruct people. You
 314 know, 'cause we don't see the person as bein' faulty, we see their conditions as bein' faulty. We
 315 see their treatment in terms of society often as bein' faulty you know, we see some of the
 316 circumstances in terms of what they've been exposed to as bein' faulty, but we don't see them as
 317 being faulty, and actually they're strong, they're resilient, u::m and in many ways people don't
 318 even know that, I mean you talk to them about everything that they've been through they're so
 319 busy in it that they don't understand, "wow, I went through all that, and I'm still here and I'm
 320 fighting and I'm winning"

321
 322 K: So in some ways you end up bear- just being a witness (P3: right) or bearing witness to the
 323 fact that they're still here and they survived it (P3: right, exactly) and that's so often an issue
 324 with people going through serious trauma that they have to realize that they're still here like
 325 sometimes it can feel like they got lost somewhere along the way and didn't make it through
 326

327 P3: right, right, right

328
 329 K: Do we have time for one more question?

330
 331 P3: Yes, we do.

332
 333 K: U::m, well, I was wondering about, if you could speak a little bit to some of the major
 334 challenges about working here, which you've touched on a little bit, or anything that's an area of
 335 improvement for the work here, or something that could be developed more.

336
 337 P3: um, resources are always a challenge. Um, particularly in a community that has um, multiple
 338 needs, u::m, resources are a big thing in terms of bein' able to provide, not just therapeutic
 339 services 'cause I think we do a good job of that, but other services um, maybe legal counseling,
 340 you know, things like housing programs, u::m, things like u::m, you know, um, employment
 341 opportunities, you know now these things are out there but there's such a need for them we need
 342 more of these things, Um things to not just help people to be comfortable (.) you know, but to
 343 thrive, we want people to thrive you know um, it starts with survival, and then after that we want
 344 people to say, well, now that I survived, now I can take it a step further. Now, I can thrive and a
 345 lot of these things are lacking, these resources are lacking u::m and you know for a variety of
 346 reasons, you know, we're in a war right now and a lot of our funds are being depleted and a lot
 347 of the programs are bein' cut um (.) but the bottom line is people need this type of help, people
 348 need this type of support. And, it's NOT, a hand-out it's a hand-out, I mean this is fundamental
 349 stuff, I mean if you tell someone uh, I'm gonna uh, I'm gonna, I want you to run this marathon
 350 but u::m, but I'm gonna take away one leg and one arm, now, you might be able to run it, you
 351 know, you might be able to run it but I think it's probably gonna be a little bit more challenging
 352 for you. and, so I think just for people to get the basic opportunities um, is key and I say
 353 opportunities, not guaranteed results, but opportunities and I think that's very very important.
 354 'Cause you know we have something in this country called the deserving poor and the

355 undeserving poor, you know, and some people are more, u::m, deserving than others, right, um,
 356 often in a poor impoverished community of color, um, you have a lot of undeserving poor -
 357 that's the perception, you know, but you take similar folks and similar situations somehow
 358 there's a little bit more compassion, a little bit more understanding (I: interesting, yeah) they
 359 know that! And They've been sayin' that for years! Um, and they've been screamin' it and
 360 yellin' it and I think now they have, they have us to be able to advocate for them. So really the
 361 resources are key.

362
 363 K: I'm just curious about that deserving/undeserving poor. What do you feel like goes into that
 364 distinction?

365
 366 P3: Well, I think unfortunately (.) we live in a society where when an issue doesn't impact the
 367 majority, in a big way it doesn't become a bigger issue. I can give you an example- HIV is
 368 probably the biggest example, you know, in the late 80s, HIV was considered to be a disease that
 369 only affected, homosexual males (.) u::m, and then as years went on, we found out - so we said
 370 "okay," so HIV, that's drug users, okay, and then we went on and said it's not, it's affecting
 371 Blacks, um, then women (.) HOWEVER, if you LOOK at it, it really only became this big, big
 372 issue when white males began to die. Now, it was ALWAYS an issue but when it was -
 373 particularly when it was just considered to be a disease you know, suffered by homosexuals and
 374 people who use drugs and also African Americans, cause those are the undeserving *{said in*
 375 *lower voice with emphasis}*. You know I'm not sayin' everyone feels that way, but there's a big
 376 perception of that, a::nd, so I think right now for instance with trauma, all the violence, all the
 377 school violence, we've been sayin' this for years. you know there have been Black kids that have
 378 been traumatized for years, I mean it's great that we're getting this, publicity but this isn't new,
 379 this stuff isn't new. it's just when it hits certain folks than it becomes an overall issue. And that's
 380 sad, it's sad that we kinda, u::m (.) unconsciously and sometimes very consciously, value, certain
 381 life over other life. And, I think if we just look at it as being trauma, period, as we just look at it
 382 as being, whatever the issue is, as crime period, you know you never hear a term like, white-on-
 383 white crime but you always here, Black-on-Black crime. it's crime, it's crime! I mean it doesn't
 384 matter who does it if you commit - it's crime. So I think the consistency, just be consistent with
 385 whatever we're doin' um, and not make those distinctions in term - only when they need to be
 386 made, but there's no need to make a distinction if someone's suffering and in need, they're
 387 suffering and in need. There shouldn't be a distinction to be made. who's suffering you know,
 388 u::m is it someone u::m who's Black or someone who's White or someone who's young or
 389 someone who's poor someone who's a drug user - I mean, we do value human life differently
 390 and that's, that's sad. It really is sad.

391
 392 K: I heard, some sort of - I can't remember where it was, but it was about how murders are
 393 punished - if you murder a black man or a white woman or a black woman that you can actually
 394 see trends in terms of, and hopefully it's getting better, in how much jail time.

395
 396 P3: yeah, sentencing.

397
 398 K: the sentencing exactly, Even with things like that or like the news coverage
 399

400 P3: well, I'm sure you follow news, just recently the young Black boy who was killed about 5-6
401 years ago was shot in the back by State troopers, and they weren't prosecuted but there was just a
402 civil judgment made and it's its it's a child you know, a child, shot in the back for supposedly
403 um, on some level bein' involved with a stolen car. You know, I don't even know if that's true,
404 but that was what was said, but even if it was true – stolen car – death, there's somethin' you
405 know, THERE'S SOMETHIN' THAT'S JUST NOT RIGHT ABOUT THAT that even if the
406 toughest person on crime would have to admit that

407

408 K: And you're trying to kind of work within that here, that that's in the background

409

410 P3: Yeah, oh yeah {said in a lower voice, almost whispered, with emphasis}

411

412 K: - that there is that stigma or even more than that –

413

414 P3: Oh, oh, are you kiddin' me {said in a lower voice, almost whispered, with emphasis}

415 -I see so many clients who have lost sons, you know murdered, it's sad, it's really is sad, and you
416 know a lot of times, all they want is just validation of feelings, you know um, I'm a human
417 being, my son's a human being, um, and that's what we try to provide, we try to be that
418 supportive, supportive individuals

419

420 K: Thank you, I'm sure there are more questions I might have and as I listen to this they might
421 come up, would it be alright if I give you a call just to clarify things

422

423 P3: Definitely, definitely,

424

425 K: But thank you very much I appreciate your time

426

427 {After interview P3 had to see client which was reason for shorter interview however he
428 commented on how he actually had enjoyed the interview and it felt good to talk about his
429 experiences – that they often only have meetings to discuss clients at the clinic but don't
430 typically have a sustained period of time dedicated just to their thoughts.}

APPENDIX G

Interview Transcript: Sam (P4)

1 Interview with P4

2

3 I: Okay, so how long have you been here?

4

5 P4: Uh, since 1995.

6

7 I: Okay and can you tell me a little bit about your background and your training and how you
8 came to work here?

9

10 P4: Sure, um, I'm a psychiatrist, u::h, I'm in East city as a faculty psychiatrist at Western
11 Psychiatric Institute I came here in 1979, uh, to d::o. uh, research, uh in neuropsychiatry actually.
12 and um, I began in geriatric psychiatry specifically uh, to do that um, but in parallel to that I was
13 working as a volunteer u::m. in antinuclear or so called peace movement groups a::nd u::m in the
14 late 1980s as the iron curtain began to drop or as it was being raised, however you want to think
15 about it (I: yeah) there was uh, a movement that I was part of and there was a shift in where the
16 kind of things that people uh, socially minded, politically active were interested in doing that for
17 me led to exploring the so called gang problem as a uh place where as a psychiatrist I thought I
18 might be able to make more of a contribution that I wanted to make in the peace movement. so I
19 explored this for a couple of years and eventually I got connected with a group called gang peace
20 counsel in Western Pennsylvania which had just formed here in 1993 following the first national
21 gang peace summit in Kansas city um and that summer following 91, 92 and I became affiliated
22 with that group and um, as. I started doing some work still as a volunteer um. the idea of being
23 connected with the Black community of East city seemed of interest to me I've always been very
24 socially minded conscientious minded, concerned about uh, issues of social justice and civil
25 rights (I: Mhm) and um, it turned out to fit my clinical obligations, I had to provide some
26 additional outpatient time so I began working here as a staff psychiatrist in 1995 roughly

27

28 I: uh so it sounds like you said it sort of uh, your coming to work here was partially based on
29 your personal interests and values but it also fit into what you had to do professionally

30

31 P4: Well, I had to provide some additional clinical service and I much rather prefer doing it this
32 way then doing outpatient geriatrics

33

34 I: Uh, so you've been here ever since

35

36 P4: Mhm.

37

38 I: And um, what's it been like?

39

40 P4: Wonderful.

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I: Wonderful. Could you say more?

P4: Well, uh, tell me, tell me, what you're interested in.

I: Well, um you like I said I'm sort of interested broadly in community mental health as sort of its own tradition separate from possibility, depending on how people define it but also the more kind of um cultural, race, class, social issues and how those incorporated into clinical work, Now with you my background in in clinical psychology and other people I've interviewed here more so come from a psychological background so it's especially interesting to me to hear how as a psychiatrist if you would refer to yourself as a community psychiatrist or if there's some other term...

P4: Yeah, so at that time I was more a faculty psychiatrist who had this kind of orientation of you know providing a service as part of you know, commitment and concern as part of the country's history

I: What about the history of this area in particular?

P4: Uh, you know it wasn't it didn't really matter to me where it was other than it was convenient, however, um yeah so that wasn't special per se it was just finding something that was accessible [I: okay]

I: I kind of interrupted you were you going somewhere else with that?

P4: Yeah, so I was saying that um, I didn't strongly feel an identity for myself as a community psychiatrist at the time, [I:okay] but from a professional and personal standpoint that has clearly been one of the outcomes of doing this work [I: Mhm] So the end of the story is in part is I'm still here, still doing this. Uh, couple of years ago this will be third year in September, I became the Medical Director of this clinic, I made that shift when there was brought on board an administrator who I thought I would be happy to work with and therefore to make the commitment of accepting the responsibility of doing something I was prepared to do. I think I had been asked if I would become the Medical Director up here before that because we had been without a Medical Director for a couple years...by 2005, um so that was one part of it. So, one professional outcome is I became medical director and I'm still here, but then this has grown into a *larger* uh venture which is very important from a community psychiatry standpoint which is that um, the state of Pennsylvania, the Commonwealth has given to Western Psychiatric Institute also to Lake Erie college of osteopathic medicine and also to the University of Pennsylvania, grants to create centers for public service psychiatry – the same thing that you're talking about, community psychiatry basically [I: Mhm] In order to create opportunities for the commonwealth to be able to track and retain psychiatrists who want to serve communities um, serving in poor urban communities is not the focus, it's much more general than that but that's been another part of it so that's why we have as of September of 2008, a Center for public service psychiatry and I am the associate director of that.

86 I: So through Center what kinds of services are offered:

87

88 P4: So the Center is first charge is to create training opportunities for psychiatrists who want to
89 work in the public sector

90

91 I: and like you said it's not just in poor, urban communities but it's broader than that

92

93 P4: it could be urban or rural [I:okay] there are many counties around the state who have
94 virtually no psychiatrists, physician uh, coverage so training and education is one part it, the
95 other part of it is to serve as a Center embodying this mission this outlook and to find ways to
96 um, engage connect with and support the *many* provider agencies and the many provider
97 professionals who share this concern either because they think it's important or because they are
98 suffering in some way because they cannot provide the service that they want to. This means
99 traveling to X town or Y town or Z town or many other places to meet people as community
100 mental health professionals and getting a sense of what their lives are like and getting a sense of
101 the way they do their work, and um engaging them we are now doing this in the process of
102 changing attitudes, changing practice, generating new ideas, generating support, um,
103 commitment, collaboration, that we hope is going to give the commonwealth and I should say
104 the country more broadly an opportunity to move in this direction.

105

106 I: Mhm, I'm wondering if because there has been this fairly recent interest in supporting these
107 kinds of efforts, was it different before? Was the state of community work, overlooked, not
108 supported

109

110 P4: so let me just if I can do two things here, let me go back to your first question and then we
111 can go back to this part, okay?

112

113 I: Yes, Uh-huh.

114

115 P4: So, since you – uh, to talk a little bit more about being here and this work, I think you're
116 asking me um, how has it been here and what it's like, or what do I do here, the challenges, I'm
117 not sure which part

118

119 I: all of it [LF]

120

121 P4: so it is um, really wonderful work, I totally love doing this, most days I actually really do
122 love doing it and the um, payoff is I see it as providing a clinical service I see it as um making it
123 a little bit more likely that some people get a service or quality of service or opportunity that they
124 wouldn't otherwise get and um, providing leadership and providing collegial opportunities
125 support for students, like yourself, um but especially psychiatry residents because the way it has
126 been I actually haven't had much opportunity or role in working with the non-physician students
127 - other people have done that as you know. So anyway, there is clinical service education again,
128 but um since I guess you're interested in, I'm surmising you're interested in the values, attitudes,
129 motivation part of this work so I would just say briefly that um, I uh, see work within the African
130 American community as a response to racism and social injustice and the human cost of that so I

131 really feel there ha been a systematic process of establishing creating and maintaining the kind of
132 um, sort of distress and disorder that people see as quote, unquote, “urban problems” the
133 problems of you know the African American community the problems of the poor, etcetera. So I
134 do not uh agree with the view that says this is simply a matter of people being poor or simply a
135 matter of people being uneducated or simply a matter of people not wanting to do better for
136 themselves so I really feel that there is a systemic problem here and in order to understand it you
137 have to have that kind of historical and social political position – that’s my position on it.

138

139 I: Yeah, I uh this is a question that I struggle with myself and I’m curious how you deal with it.
140 How do you address that or incorporate that when you’re in the room with someone individually

141

142 P4: working

143

144 I: yeah, um I’m sure there’s not a simply answer, but what are your thoughts on how to keep that
145 presence or awareness and address that in some way

146

147 P4: so part of it is nuts and bolts basics of being a decent person beyond any skill professionally
148 [I: Mhm] so just by brining your humanity your concern your caringness to people with an
149 interest in doing the right thing by what’s best for them – um I think by best for them means
150 what’s best for them in terms of what *they* think is best for them in some broad sense. So we
151 think about it, my co-workers and I as like an empowerment strategy the mission is
152 empowerment um, so the mission is empowerment the mission is doing what is best for them to
153 help people acquire the sense or a stronger sense, I should say a stronger sense of helping people
154 better acquire a sense of hope, a sense of power in their lives, and a sense of community, sense of
155 being a related part of and committed to, supportive of their community. Now their community
156 means this neighborhood my family this city, this part of the city, this county, this world [I: LF]
157 this universe, whatever it is, okay? [I: yeah] so the idea is to see this kind of flexible, so that’s the
158 way I think about it. so the mission here is empowerment and it’s empowering people to
159 strengthen their own sense of power in the community.

160

161 I: so are those values part of what – or the focus on the values part of what differentiates
162 community work from um, traditional kinds of psychiatry – not that those aren’t there but the
163 specific focus on it?

164

165 P4: Well, do you know about the recovery movement in psychiatry?

166

167 I: A little bit, yeah.

168

169 P4: So, um, so the recovery movement in psychiatry is taking the little crystal of recovery from
170 alcoholics anonymous and twelve step programs and uh generalizing that a a strategy as a goal,
171 as a process to sort of guide um all aspects of psychiatry for people who aren’t connected with it
172 and who don’t identify with it, recovery is um is *separate* from what they do, but that reflects the
173 state of psychiatric world and not how the work has to be done. So for me, it doesn’t matter
174 whether I’m here or somewhere else I’m always doing empowerment [I: Mhm] You don’t have
175 to be a psychotherapist to do empowerment [I: oh, absolutely not] um, doing medication checks

176 the right way can have the same outcome, in that sense, *if the world was the way it should be*
177 (according to me) all treatment would be recovery oriented, the public service psychiatry center
178 is really built around the idea that uh, the system will better serve it's ends if all treatment is
179 recovery oriented

180

181 I: recovery oriented meaning including all of the - kinds of like empowerment, being present
182 where that's person is at, all the stuff you mentioned is that what you are referring to?

183

184 P4: yes, so i-it's totally compatible with what we're doing okay? although in practice it would
185 make differences there are certain things that are being done which may not be affordable in a
186 recovery oriented system, there are certain things being done that may not be in the best interest
187 of people um, when you have to decide what's more important, because in the end there is a
188 practicality part of this so the finances are a reality and uh, the politics of money has it that some
189 things get funded and some things don't so in that sense knowing what neurotransmitters are out
190 of alignment in someone with schizophrenia is related to recovery BUT it may not be worth the
191 dollars to pay for that when there are people who can't afford the medications.

192

193 I: to pay for...

194

195 P4: for that research, for that kind of research. It doesn't mean you shouldn't do the research that
196 determines it may be needed knowing that molecule could be the most powerful efficient way to
197 help people have a sense that they are empowered, I'm just saying it's complicated like that.

198

199 I: Yeah, and you bring other dimensions that I've wondered about especially when i was working
200 here, the economic and the political dimension that are also part fo the work and um when you
201 were first talking about affordable I was thinking about clinicians time also, you know that there
202 is also that piece of it – I wonder how that impacts your work if you've noticed that there is more
203 pressure economically especially since you've been doing this for a while, have you noticed any
204 shifts where there is more pressure from insurance companies or focus on productivity or any of
205 that stuff

206

207 P4: sure, we feel that – life is pretty crazy most days of the week. so it takes a lot to kind of stay
208 grounded not be angry, not get frustrated, to feel that despite all that we are doing something that
209 is valuable but I think the way you framed it before is really useful you know how do we bring
210 recovery principals to the footsteps of somebody who walks in your door for help so, it's like an
211 outlook and um then you know you have their values, their skills, that you make use of so that
212 you see that this is what the complaint is about – just like what do we do when we talk to
213 somebody, we try to understand from *their* vantage what the problem is, from *their* vantage what
214 is important, from *their* vantage, what are the obstacles to life looking more like they would like
215 it to look and then we go to work. There's negotiation, clinical skills, psychotherapy skills,
216 whatever, around the alliance building about acquiring a shared definition of the problem about
217 uh, then doing something that is gonna make a difference. So it begins right there – if you walk
218 in my office that's where it starts.

219

220 I: Yeah, and that's uh, again I don't have background in medicine but it makes me wonder you
221 did mention some of the recovery values are not necessarily considered most valuable in the
222 world of psychiatry in general
223

224 P4: Yeah, but I don't think this is a physicians problem – the profession may have a double dose
225 of it but you can have a very non-recovery oriented, non-empowerment oriented professional
226 without being – so you don't have to be a physician to be in that place
227

228 I: Sure, sure, I guess um, I'm just thinking about what does it mean to do what you say you're
229 trying to do with your patients – what does it mean to be living through or being a community
230 psychiatrist here and doing community work and how you're viewed there within the field?
231

232 P4: So the question is how we're viewed. You know, I'm not sure what a useful answer to that
233 would be, so maybe we can come back to it, Katy right? [I: okay, yeah] Uh, it's mostly viewed
234 with indifference um, and lack of awareness [I: Mhm okay] but there are lots of places where this
235 is prevalent, I mean I think there really is a top-down, as well as a bottom up, there really is a
236 top-down movement in this direction. Uh, it's very easy to find within the American Psychiatric
237 Association um, people who have been presidents of organization and lots of other places of
238 people who totally support this outlook so at leadership levels I think there is a lot of support for
239 it – uh, but when it comes to making decisions in your backyard or his backyard that can be a bit
240 more of a problem. Uh, private practice can be recovery oriented but um if you're not involved
241 in serving underserved populations there are certain aspects of the recovery challenge or mission
242 which are not being served by the system – right, so that's a bit of a problem. On the other hand
243 um I don't remember the data but it's substantial that the number of psychiatrists who are
244 working in some sort of community setting now is *very* high now – I think like 40%. [I: Hm,
245 that's interesting] So it's no longer a purely private practice kind of model or ideal, so I think
246 that is changing.
247

248 I: Okay, yeah I think I kind of asked that question because I've read some literature that
249 suggested that community psychology is somewhat marginalized within the field as being less
250 important or less academically rigorous, but you know the field is always changing so it sounds
251 like -
252

253 P4: I mean you could find people who have that view okay, and actually in terms of taking in
254 what I'm telling you – you know I'm not a mainstream kind of person on this kind of thing
255 okay? And also I don't easily get discouraged and I have a lot of experience at this point uh, you
256 know feeling great about things that a lot of people don't really care about and I certainly don't
257 perceive the indifference or the opposition because it really doesn't matter to me, it really
258 doesn't matter to me.
259

260 I: Okay, that's helpful. I'm interested most in your perspective.
261

262 P4: I'm saying to you though to tell you that I'm not a good person to ask about how other
263 people think because I'm not that knowledgeable about it I'm very limited in terms of what I can

264 actually read and study and so on and so forth, and then my outlook I'm so like a mission
265 oriented person that it doesn't phase me.

266

267 I: Yeah, you strike me as you're focused on what you want to do and the importance of your
268 work and so you really you kind of zone the rest of that out it's probably helpful style where
269 there is just so much going on

270

271 P4: However, however, actually so you're making me think – is that really true? For instance I
272 work in a very current traditional department which is very large and is more in certain ways
273 contemporary, transformation oriented recovery orientated and just getting on track with that and
274 I really see as part of my work bringing this outlook to other people who are receptive to it. And
275 I am very good at doing that, okay? and so there's a way in which I am actually very aware of it
276 and it is like the work. I teach residents, this is a teaching program for residents as you know, and
277 they really like coming up here, they gave us the program of the year award people are coming
278 back this year who were here last year so I really see as what I'm doing and what we're doing as
279 getting the message out there – carrying the fire so to say. Do you know about carrying the fire?
280 It's the title of the book of the people who went to the moon for the first time [I: oh, okay] so the
281 person who stayed on the satellite I mean who stayed on the space ship

282

283 I: when it was orbiting yea

284

285 P4: wrote a book about the whole process which he called carrying the fire – I didn't read the
286 book

287

288 I: [LF] it's a good title though

289

290 P4: but I see myself as somebody who carries the fire, so I was raised in a Jewish home and the
291 European holocaust was a formative experience of my childhood and I grew up very frightened
292 and uh, very limited very unsure of myself and (2) um, I eventually learned that the point of my
293 father saying all sorts of terrible things about the Germans and being Nazis and all that stuff that
294 the pay off for all that, for hearing all of that, cause I really didn't go for that, because he was
295 also very idealistic person and thought he was supposed to respect other people and so I kind of,
296 I didn't kind of I *did* put this together for myself – but what my dad was saying that when bad
297 things happen you don't sit around when atrocities are being committed the trick is to get
298 yourself in gear, maybe put yourself at a little bit of risk, maybe a a lot um and um, that's what's
299 important that's how you know what's important... but why was I telling you that?...Oh, about
300 carrying the fire right, so I feel like I've been tuned into where the atrocities are being committed
301 and I think the realities of day to day life for people who are poor especially for the peoples who
302 have been systematically oppressed, okay, in the United States, that is primarily people of
303 African descent *and* Native Americans, they are different than any other immigrant group. There
304 are many places where you find serious poverty, like I said, it's not just a matter of being poor so
305 there' many other places where you find serious poverty but the Native American population um,
306 and the African American population has been systematically oppressed by every level of
307 American life to very present day so I think that's atrocious.

308

309 I: and you were drawn to work with that community with one of those communities anyway
310 partially because of–
311
312 P4: well I worked I did work in the Navaho area – not for such a good reason though, I wanted
313 not to be in the Vietnam War
314
315 I: Okay
316
317 P4: Those are my, those are my *fear* years. So I was a progressive person but uh, now it's kind of
318 different it's kind of different
319
320 I: the image of the flame is really rich – what do you feel like the fire is, what are you carrying?
321
322 P4: you know, It's the uh, feeling the knowledge the conviction that's important, actually there's
323 another dimension I should talk to you about, the spiritual dimension but um– but *fire* is like
324 FIRE IN YOUR BELLY! M'kay, uh, so that's some sort of conviction some sort of intuition that
325 you can make a difference. You know fire is about transformation, remember the alchemists you
326 know transforming lead into gold [I: yeah] so when you see that there are problems that you can
327 make a difference to and that those differences have value you know that's what fire is about.
328
329 I: that's a beautiful image, um, and I can tell that there is so much personally that you bring to
330 your work and your own background...did your family immigrate here?
331
332 P4: Uh, no my grandparents immigrated here, so a lot of Jewish life, Jewish culture
333 it's coherent it's supportive, it's scared, it's paranoid, and it's very competent, so those are the
334 things. But for a long time I felt like I had mostly the fear part of it [LF]
335
336 I: Uh, huh, and then it turned into something else it seems
337
338 P4: Yeah, well I was very interested in psychotherapy and psychoanalysis so that was my way of
339 dealing with my own personal problems [I: Yeah, I can relate to that [LF]] so that was a big part
340 of it so I'm really a psychotherapist at heart, that's another reason why I do things the way I do
341 them. So I feel like a I'm a psychotherapist at heart and I tell that to residents so that they can
342 have a model of docs, psychiatrist who can be kind of mainstream as far as science and
343 psychiatry and still have that connection
344
345 I: have the human side, yeah. I mean its seems fairly recent that psychiatry moved away from
346 that more, that it used to be much more integrated...Well, I don't want to keep you if you have
347 other appointments, I mean I could keep talking to you but
348
349 P4: There's a question for me then that will help me decide. So the purpose of your research is to
350 find out what kinds of things?
351
352 I: Well, it's very uh, open ended um, and I based my research project on what I had experienced
353 here, I had so many questions about what does it mean as a white therapist to be coming and

354 doing this work in the hill district, and how do my clients see me, and what does it mean you
 355 know I talked to Earl a lot about funding this clinic and wondered about it's position within the
 356 rest of the University Medical Center so my interests are varied and the research project- the
 357 question are coming from the data in talking to you and others and and integrating with my own
 358 observations here, I want to tell a story and highlight themes of this work because I feel this
 359 work is so valuable and a lot of past studies were not quite as qualitatively focused and also I'm
 360 wanted to look at the systemic dimension – so long answer

361

362 P4: no, that's perfect. so I'd like to take another minute If I can, do you have time?

363

364 I: Absolutely, I have as long as you'd like to talk to me. I just didn't want to – I know that your
 365 time is valuable

366

367 P4: that's right so, there are 2 or 3 things that cross my mind that I want to share with you, okay?
 368 First of all like perspectives to have on culture and political reality okay um, one which I think
 369 is like a message to get out into the world is that uh, a big part of what we call the white world
 370 and the black world is about history and culture and that the biggest problem with the white
 371 world is to re-identify itself with culture, all right? Specifically what I'm thinking is just this very
 372 simple idea that we don't really know, what our cultural identity is when we call ourselves white,
 373 all right (I: Mhm) and um, there is a historical and subterrean unconscious reason why we don't.
 374 So you know, the general reality is that there is white America and then there are people from
 375 other countries (I: okay). So, Asian American, African Americans (I: right) other *continents* I
 376 should say, okay [1] so there's that kind of background and uh the white world, would perhaps
 377 benefit from just remembering the simple fact that we are European culture in a general sense,
 378 from different countries, etc, but the idea is that there are African Americans, there are Native
 379 Americans, and Asian Americans, etc, so White American is really European America and that is
 380 a progressive and transformative label because um, it takes us a little bit beyond the place of
 381 being the class of privilege and the white oppressor so-so the reason I think why white sticks,
 382 okay and everybody else is from another continent is a little bit of white domination (I shouldn't
 383 have said the word here) but it's part of being the white upper class the white oppressor etc.
 384 okay, so that tissue of like what do you call it what is the problem is related to this because the
 385 tendency WE white folks have to talk about about the problems THEY have is from a very white
 386 perspective, okay (I: Mhm) and so there's another thing, I think the existential people know
 387 about this a little bit so you know about so-called "whiteness studies" (I: Mhm) so I'm talking
 388 about whiteness studies, so whiteness studies, about what it means to be white, okay and the long
 389 and short of it is that if you wanted to change a label that would make a difference, um, I think it
 390 would be really powerful for people to identify with the label of European because that would be
 391 transformative (I: Hm) because moving from being white to European is moving from being
 392 everything that whiteness embodies, um, to being just another culture in this multicultural uh,
 393 rather extraordinary country of ours (I: Mhm). So, that's one thing I wanted to mention okay,
 394 um. and then and then along with that there is the sort of politics of domination and um, the fact
 395 that the white dominant part of our country has been driven especially in relationship to the
 396 [inaudible, African] experience by profit and economics, so it's really important to kind of
 397 explore what the payoff is for being white, what the payoff is for helping other people and as I'm
 398 sure you know, the downside of being white and helping other people is that you unconsciously

399 cast yourself into the position of an imperial controller, a colonist etcetera, and what looks like
 400 being nice and liberal is actually kind of a self-serving way of token, not that being white is bad
 401 but there is that kind of structural problem, anyway, so I think it's really important to kind of nail
 402 that and then within that you know is, who are the white folks who are particularly influential
 403 they tend to be wealthy people and they tend to be men (I: Mhm), so there's the issue of gender
 404 and feminism in there, which I think is really important to consider...so that's one part of it, I
 405 just wanted to say all of that. Um, And then also, so the point is that IS what this kind of work IS
 406 about, okay? So the public psychiatry the community psychiatry outlook is for me okay,
 407 basically an issue of social justice and all these other problems around the structural problems
 408 the historical forces that kind of create and perpetuate a social injustice, it's not just about being
 409 humane and nice [social justice is a trick here]

410
 411 I: It requires a lot of self-reflection, constantly looking back on one's self and how I'm viewing
 412 an interpreting what I'm looking at and how that is informed by my background and my position.
 413 I'm glad that you brought up the issue of whiteness because it was I hesitated a little bit to do this
 414 type of research – going into this urban area doing research into urban areas with African
 415 Americans because diversity is often seen as having to do with the “other” diversity doesn't
 416 mean =

417
 418 P4: =white, that's right

419
 420 I: but I do feel there's so much going on, there so much more that in that, and that reflecting can
 421 be incorporated into it - so I'm really glad that you mentioned all of that it's very important

422
 423 P4: and then there's like an internal part of the clinical work okay, um. u::m. that when you have
 424 people dealing with their own race and cultural identifiers, whatever they are especially here, but
 425 we'll just simplify here “black” and “white” although there is no simple black and no simple
 426 white okay, so that means many things to many people but in any case that means working
 427 through the emotionality and psychology of that and creating working environments in which
 428 that reality is kind of part of the work and that is part of the understanding that it is safe and
 429 valued to dig into it is really difficult in doing that here, going back to the beginning of what
 430 we're doing here, so doing that here, I think, it actually, it has been very – um I fell very um.
 431 really uh, proud, actually about the way in which Earl and I, and other Marcus has been here for
 432 a long time and others, who you might not know, Thelma we're all part of a process which is
 433 extraordinarily healthy and open about. dealing what it means to be who and what we are.

434
 435 I: And you talk with each other and those issues =

436 P4: =we talk about that, yeah. in moving in we talk about ourselves where we are and where we
 437 come from and also how this all plays out with the work with our patients/clients. so that's one
 438 other piece okay, um. so that's a whole story in and of itself which I'm sure you've thought lots
 439 about. So – the other thing I wanted to tell you uh, that I think is really important and you
 440 reminded me about this when you mentioned about being existential, okay. the existential folks
 441 who I hear talk about this seem to be talking about being in the here-and-now with another
 442 person as kind of a phenomenological, experiential truth and that's really important and not
 443 getting lost in you theories and constructs and your reflections on how things came to be the way

444 they are etc. so that's important and I agree with all that. But, um, one thing I feel is uh, the
 445 existential point of view is at risk for missing is uh, the spiritual reality of the present and that's
 446 another dimension that is not existential the way it seems to be I've only read a page or two here
 447 and there the existential psychologists in general may not be orientated to the spiritual
 448 dimension. And my guess is that it has to do with the historical piece of how it came to be and
 449 there is certainly existential people who, at least one person I know from Duquesne who I did
 450 know, who appreciates this and it's a critique he might agree with, but it's totally possible to
 451 integrate an existential and spiritual point of view with each other but t um the existential point
 452 of view seems to me I'm remembering Norman Mahler for example at the moment, seems to me
 453 to shy a little bit away from um, from um morality and ethics from human values and in the
 454 interest of not being judging of other people existential points of view sound to me like there's
 455 no place for having opinions about what is good and bad because there is the implication is that
 456 you can't do that without doing injury to other people's existential realities or some such thing
 457 and uh, I think that's crazy okay? that's actually not true and there's a misunderstanding about
 458 what the current reality is

459

460 I: yeah, that is a criticism I've heard against some of the more post-modern ways of
 461 understanding experience

462

463 P4: so there's are points of view and understanding about what it means to be aware of what's
 464 happening that offers a way to respect all of that but actually go to another level with it. If you
 465 haven't come across Ken Wilbur?

466

467 I: It sounds familiar

468

469 P4: so Ken Wilbur has really to nail this problem and help us see how to move beyond and
 470 through it he's not the only person to know how to do it but his work is essentially around this
 471 question, okay? and um. (3) and the core of knowing how to do that has to do with going back
 472 into yourself and looking more clearly actually in an existential way, phenomenologically about
 473 who and what you are because it turns out it's like a testable hypothesis it turns out that um the
 474 self that has to be respectful of all points of view, is a fiction, it's a construct and um, uh, and
 475 um, in religious traditional and more generally spiritual traditions have been working with that
 476 and um, integrating that into so spiritual practice for me is like the centerpiece, we talked about
 477 carrying the fire okay? so I've become a very deeply spiritual person over the last 15 years and
 478 um, I have discovered a lot of really important things, pleasure and others stuff, by doing that
 479 and it's relevant to this work, that's why I'm telling you this. and I feel that amongst people who
 480 take on ambitions and feel it's important to carry the fire, you'll find this kind of orientation
 481 because it's part and parcel of what it mean to see that you're doing something that has value
 482 beyond the value of your own personal life, alright? so I guess the question is how do you
 483 embody that, how do you realize that alright? so I think that the work here for me, the work of
 484 being here is really part and parcel of having that kind of orientation toward myself and
 485 everybody else. So, when people walk into my office um, when people walk in here I have said a
 486 few times, this is a person who is totally humiliated and ashamed of everything. that he or she
 487 has done, okay. so my orientation is and I have said this on occasion that when you walk into my
 488 office, you are a child of god, okay? so uh, for me when you talk about empowerment that's

489 actually where empowerment comes from. now I'm not talking about believing in god, I actually
490 don't believe in god, okay?

491

492 I: yeah, it doesn't have that ring to it, to me at least

493

494 P4: so when you see that, when you see that, then things become pretty amazing. they become
495 very great, so I like seeing it like that because it does the job for me and I works really well. and,
496 uh it makes a difference alright? but it has to do with like the whole nature of this work. so for
497 many people, and certainly this is true of within the African community that there is an intuition
498 and unconscious knowledge, that kind of transcendent self that transcendent sense of who I am
499 and who you are important is what keeps us going and makes it so that there is no doubt that of
500 course I'm doing this of course it makes sense. except on the days when it doesn't *{smiles}*

501

502 I: [LF] yeah, there's always gotta be those days. so when you see people how often do you see
503 them if you're working with a patient. do you see them like monthly or more often than that?

504

505 P4: yeah I mean for me, uh, officially most people are seen every month etc. but for me it doesn't
506 matter, 15 minutes every month – you're still a child of god every 3 months even 30 minutes it's
507 always relationship building so like so many things that I really try to share with residents is that
508 you shouldn't be confused about what a med check is about and they say well, we only have 15
509 minutes and I try to help them see that that if they really know their stuff – that means they have
510 a whole hour in a year

511

512 I: Mhm, so you just look at it completely differently. Um, I have a question that takes us back to
513 last winter I guess, I was curious about we had holiday party over at the auditorium and you
514 played something

515

516 P4: A child's Christmas in Wales, Dylan Thomas – did you like the story? Had you read it
517 before?

518

519 I: Yeah, and no I hadn't read it. I was just wondering about what led you to want to tell that
520 story?

521

522 P4: Oh, I see. In college I had an English teacher freshmen year of college who made us write an
523 essay about a poem and the poem I chose was a Dylan Thomas poem called Fern hill and I was
524 very much not a poetry reader at the time at the end of the year or something I came across a
525 Dylan Thomas record and I was curious to hear him recite it and it was A Child's Christmas in
526 Whales so I just loved it was wonderful and I decided that maybe when I'm old enough to have
527 grandchildren I'll memorize it and recite it for them. so about 15 years ago or something like
528 that, I started to memorize it and then I started doing it different places, that's how it came about.

529

530 I: neat. well do you have anything else that we haven't talked about

531

532 P4: You've been a good audience

533

534 I: well I really appreciate you talking to me and I have to say that doing these interview I really
535 have enjoyed it.

536

537 P4: I bet, I bet, what you're doing is wonderful.

538

539 I: it's just a matter of organizing it and figuring out what to do with it.

540

541 {tape recorder turned-off}