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"A certain dream" : the political potential for therapy by activist clinical social workers

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Political Potential for Therapy
By Activist Clinical Social
Workers

ABSTRACT

In this study, I explore the integration of clinical and political levels of practice among clinical social workers who self-identify as political activists. Particular attention was paid to treatment issues with clients from oppressed populations, and to the benefits and drawbacks of particular clinical theories for addressing social conditions in the lives of these clients. Paolo Friere's *Pedagogy of the Oppressed* (1970) serves a theoretical backdrop. Specifically, Friere's concept of *conscientization*, the practice of building the capacity for critical consciousness and reflective action, served as a framework for the study.

Eleven social workers were interviewed for this study, which was qualitative and exploratory in nature. All participants were female, and most identified as white, while one participant identified as a person of color. Participants ranged in their clinical social work experience, but all had spent at least two and up to forty years in a clinical position.

Thematic analysis indicated that most participants held a strong commitment to understanding and addressing social conditions in the lives of clients. However, results showed several barriers to a Frierean clinical practice. Participants overall lacked an integrated understanding of oppression and expressed uncertainty about bringing politics into the therapy room. Psychodynamic practice, which was strongly represented among participants, had potential to add to the complex and nuanced understanding of social factors, but lacked the egalitarianism of Friere's ideals. Findings indicate that better integration of clinical and political work is needed to fulfill social work's ethical objective of furthering social justice.

"A CERTAIN DREAM":
THE POLITICAL POTENTIAL FOR THERAPY
BY ACTIVIST CLINICAL SOCIAL WORKERS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER ONE

INTRODUCTION

The purpose of this study is to explore the ways in which clinical social workers who identify as activists integrate political activism into therapy with clients from oppressed populations. Political activism among social workers in general is a relatively unexplored phenomenon in the literature (Ritter, 2007). Still more unexplored is the way in which social workers might integrate their political action into the clinical realm. Numerous authors from a variety of clinical perspectives have written on a theoretical or personal level about their work with clients from oppressed populations, and their efforts to bring racism, sexism, classism and other societal forces into the therapeutic purview (Altman, 2010). What is lacking is a thick explanation of exactly how activists do effectively use clinical theories in this way. In this study, I will use Paolo Friere's model of a critically conscious pedagogy (1970) as a roadmap for how clinicians from various theoretical perspectives might enact clinical activism.

The lack of thick explanation in published social work literature is perhaps unsurprising. Politics has long been considered a fraught topic for therapeutic work, given the long-standing, psychoanalytic ideal of the neutral, blank-slate therapist (Gerber, 2007). On a more pragmatic level, mental health professionals in general have feared explicitly embracing ideals of social justice, thereby risking their place as treatment providers in the modern medical establishment (Aldarondo, 2007).

Despite these misgivings, contemporary society presents a number of challenges to both social workers and their clients that may increase the necessity of keeping politics in the therapy room. Economic inequality and poverty are on the rise, and with them the physical and mental health issues born out of lack of access to resources (Aldarondo, 2007). Since the 1996 welfare reform legislation, the capacity of safety nets to catch those that have fallen through the cracks has dramatically decreased,

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shifting pressure to social workers to manage an increasingly desperate and ill-resourced client population (Lee & Curran, 2003). In the workplace, many social workers must cope with ill-kept facilities, Medicaid/Medicare inefficiencies, and interfacing with troubled public agencies such as public schools. In this way, they encounter the same tangible effects of racism, sexism and other oppressions as their clients do (Altman, 1993; Altman, 2010). Women continue to be disproportionately impacted by domestic violence and to be paid less than male counterparts (Aldarondo, 2007). The recent DOMA (Defense of Marriage Act) challenges rights to marriage for same-sex couples that had gained tentative recognition in some states (Green, 2007). In short, society today is rife with threats and challenges that upset the lives of clients and clinicians alike, becoming a daily reality in therapeutic treatment. In this environment, a study on the incorporation of activism and therapy may be helpful in empowering clinicians who work with clients from oppressed populations.

In considering the needs of oppressed populations and the goal of social justice, this project falls in line with the professional goals and ethics of social work. The NASW, in its Code of Ethics, specifically calls upon all social workers to engage in political action and to work for social justice (1996). This project may broaden the scope of those principals, by bringing them into micro-, as well as macro-, level work. Furthermore, mental health professionals as a whole can be seen as having a "commitment to witness and decrease human suffering, but also to promote human values of equality and justice" (Aldarondo, 2007, p. 5). Clinicians who, in their work, attend not only to emotional and personal growth but to broad social realities will have a greater means of diminishing the suffering of their clients.

CHAPTER TWO

LITERATURE REVIEW

Conscientization and Frierean Theory

To better grasp the possibility of a therapy that would bring political consciousness and activism to the fore, we turn to Paolo Friere's concept of "*conscientization*." Writing from exile after Brazil's 1964 military coup, Friere decried the "unjust world order that engenders violence in the oppressors, which in turn dehumanizes the oppressed" (1970, p. 26). The *Pedagogy of the Oppressed* (1970) is an explication of what the title promises: A means of instruction by and for the people, furthering resistance to this dehumanizing and oppressive world order. Friere's seminal work fires a number of stinging, albeit peripheral, indictments of the professional mental health worker. In a more overarching sense, however, it suggests how a clinician might use therapy in the service of the Frierian project. As Friere would later state himself, as part of a plenary address to the International Federation of Social Workers, "social work practice . . . is inherently and substantively educational – pedagogical. . . . Social workers uncover and make explicit a certain dream about social relations, which is a political dream" (1990, p. 5).

To understand *conscientization*, one must look more closely at how Friere understands the nature of oppression. He understands it to have a much greater impact than hard material deprivation. More perniciously, oppression ultimately gains a quality of inevitability and logic. "Under the sway of magic and myth," he writes, "the oppressed . . . see their suffering, the fruit of exploitation, as the will of God" (1970, p. 43-44). The oppressed come to view their condition as inevitable, unable to see the interplay of seemingly unrelated modes of oppression. They become, in Friere's terms, domesticated. Ownership of personal property – *having,* in Friere's Marxist phraseology – defines the boundary between oppressors or the haves, and the oppressed, or the have-nots. The oppressed view success in terms of their aspiration to

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the material wealth and power of their oppressors, buying into the notion of human vocation as one of ownership and dominance. In this way, Friere sees the oppressed as embracing a dehumanizing view of humanity, becoming unlikely – unable – to resist.

For Friere, resistance to an oppressive system cannot be mustered through straightforward pamphleteering. Friere is highly critical of what he calls the "banking" system of knowledge, in which "knowledge is a gift bestowed by those who consider themselves knowledgeable upon those whom they consider to know nothing" (1970, p. 53). This, he claims, alienates human beings from their capacity for critical thought, thereby transforming them from subjects to object in an act of "violence" (*ibid.,* p. 66). Friere expands here upon Marx's axiom of humanity as defined by its capacity for work. He develops the notion of *praxis*, or action that progresses from, through, and into critical reflection, as definitional of humanity. Any education that claims service to the resistance of oppression must be humanizing. Thus, by definition, it must encourage both the capacity for critical reflection and for action – not simply provide slogans.

Conscientization is the achievement of this humanizing education. Students "develop their power to perceive critically *the way they exist* in the world *with which* and *in which* they find themselves; they come to see the world not as a static reality, but as a reality in process, in transformation" (*ibid.,* p. 64, italics in the original). Teacher and student engage together in critical examination of the world around them, uncovering the mechanisms that underpin supposed inevitabilities of oppression. In participating jointly in the process, teacher and student have access to an ever-increasing arena of action, as well as greater motivation for resistance. When oppressive conditions become artificial, continued subservience becomes de-naturalized as well, and the way is open for "revolutionary futurity" (*ibid.,* 65).

Dialogue, as opposed to lecture, is the paradigmatic mode of such an education. As Friere notes, one cannot simply deposit the capacity for praxis in the mind of the student as a teacher *qua* banker. In this more egalitarian model, the teacher and student together examine lived experience. Friere understands knowledge here in an explicitly radical way. He privileges the knowledge of the oppressed,

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such that "the solution is not to 'integrate' them into the structure of oppression, but to transform that structure so that they can be 'beings for themselves'" (*ibid.,* p. 55).

Friere's critique of the mental health professions arises naturally from his critique of education. He scathingly decries the "paternalistic social action apparatus" (*ibid.,* p. 55) that he sees as governing social services. Though Friere would later declare his solidarity with social work, he remained critical of the professionalization of social work and associated claims to "technical expertise" (1988, p. 6). He sees its emphasis as not merely passively unhelpful but as actively assisting in oppressive domestication, through its emphasis on altering the internal state of the sufferer.

> ". . . the oppressors use the banking concept of education in conjunction with a paternalistic social action apparatus, within which the oppressed receive the euphemistic title of "welfare recipients." They are treated as individual cases, as marginal persons who deviate from the general configuration of a "good, organized and just" society. The oppressed are regarded as *the pathology of the healthy society*, which must therefore adjust these "incompetent and lazy" folk to its own patterns by changing their mentality." (1970, p. 55, emphasis added).

Clinicians could make the obvious argument here that many mental health practitioners take a more compassionate view of their clients than Friere suggests they do. Compassionate individualism, however, meets with refutation from Friere as well. Like the banker-educators, who divide the totality of the world into discrete facts, "dedicated but naïve professionals" in community development emphasize a "*focalized* view of problems rather than seeing them as dimensions of a *totality*" (*ibid.,* p. 122, italics in the original). This argument implies a critique of treatment modalities in which client units are defined as individuals, couples and families, seen in theoretical isolation from their natural context, physically separated from the community during the treatment hour. Friere would see this approach as off the mark. He notes, for example, that rigid, authoritarian parenting styles can only be truly understood as a natural result of a social context of oppression (*ibid.,* p. 135). This isolated focus again results in domestication, as it deprives the oppressed of the holistic and unifying view necessary for their liberation.

Friere also warns of the dangers of the unexamined consciousness of even the best intentioned, holistically minded professional. He describes professional training as "miseducation," where individuals

"have been 'determined from above' by a culture of domination which has constituted them as dual beings" (*ibid.,* p. 139). In this training – as in any traditional educational process - there is an "invasion" (*ibid.,* p. 134), an "antidialogical" (*ibid.,* p. 133) process in which the teachers seek to replace the students' consciousness with one that mimics his or her own. Though Friere did not make this leap, one can easily substitute here the aspiring clinical social worker for the student, and the DSM-IV, the licensing board, the social work institution and/or managed care for the teacher in this dynamic of invasion. Friere objects to any system of knowing that privileges perspectives of the elite and the canonized over that of the liberated common man or woman. For Friere, a knowledge that privileges the few encourages its disciples to devalue the inherent human capacity for critical thinking, reflection and action. This encourages fatalistic acquiescence to the status quo of oppression. Even institutions that ostensibly function to maintain standards of care and protect clients do not fall outside of Friere's criticism. Regardless of intention, any elitist, banking system of education is "simply a product of an oppressive reality" (*ibid.,* p. 135).

In the duality of professional education for social service providers, trainees learn to serve, think and exist as mediators between those at the top of the social ladder and those on the bottom. The duality of the resultant so-called educated individual consists of the subjugated consciousness, overlain by the internalized perspective of the teacher. The professional can thus act in the service of the oppressors. This leads to a dynamic in which those that supposedly serve social welfare in fact act to divorce welfare recipients from their capacity to truly better themselves by resisting the status quo. Friere thus anticipates Paul Kivel's later argument, that social services serves as a buffer between the working class and ruling class, the latter of which funds the work (2006).

Where, then, can the politically-oriented clinician find redemption? Friere did have a role for the educated individual, and lays out a number of requirements for him or her to authentically engage in dialogue with the oppressed. These requirements include love, humility, faith, trust, hope and critical thinking. The terms' simplicity belies the nuanced meaning with which Friere endows them. Love, for

example, entails in *The Pedagogy* not a feeling or a sense of having – even having a relationship to another - but a desire to act for the sake of another's humanization. Later on, Friere more specifically laid out the terms for the so-called progressive social worker, revisiting many of his prescriptions for the progressive educator. These qualities include a commitment to action and to curiosity, a rigorousness that cannot be reduced to loyalty to science, and a deep sense of tolerance (1990). Friere summarizes these traits as a "progressive obsession" (1990, p. 7).

For the purposes of this review, however, it suffices to note one overarching theme in Friere's recommendations for progressives: A belief that action, undertaken with, by and for the people, is not only necessary but is desirable. Friere recognizes that such a belief would be nearly impossible for the professional individual, brought so close to the throne of oppression, to attain. For one thing, this transformation necessarily includes a deep, unflinching examination of one's personal life (1990). "There is only one way for the emerging leaders to achieve authenticity," he writes, "they must 'die,' in order to be reborn through and with the oppressed" (1970, p. 114). Friere, of course, understands this death and resurrection only metaphorically. His work is analogically, rather than literally, messianic in its vision of humanity's redemption. His emphatic language serves to underscore the absolute nature of the transformation that a leader of the people must undergo. As Friere says, "to continuously and consistently practice progressive social work is not enviable" (1990, p.6).

Many theorists have continued to apply Friere's work to theory about clinical practice. They have done so either directly - citing his influence - or indirectly, by taking up the mantle of challenging oppression. A discussion of clinical theories that flow directly from Friere follows in the section on empowerment, ethnopolitical and liberation theories. One can use Friere's work in *Pedagogy of the Oppressed* to assess the potentials of any clinical perspective, however, by assessing the extent to which a particular clinical theory could be enlisted in the service of *conscientization*. Those theories that can engage client and therapist in a process of authentic dialogue on even ground, that facilitate reflection upon the impact of political and cultural structures, and that encourage action on the level of systemic

change – these theories can be recruited to Friere's project. An example of such assessment follows in the remainder of this literature review.

Psychoanalytic Theory

Psychoanalytic theory, also referred to as psychodynamic theory, is an umbrella term covering a vast array of perspectives spanning nearly a century of thought. Despite the range, the theory can be defined in terms of some broad themes. Psychoanalytic theory includes the unconscious – what is excluded from thought because it is dissonant, painful or threatening – as a significant part of mental life. It concerns defenses, intra-psychic conflict, association, and the notion of the determination, rather than coincidence, of all mental phenomena. Believing that the past provides a template for the present, psychoanalytic therapists work to loosen the bonds of that past by creating a transformative interaction or relationship with the client in the present (Shedler, 2006).

Though today psychoanalysis has a reputation as the chosen treatment for the worried well-to-do, the theory has roots in reformism (Aldarondo, 2007). As Freud asserted in "The Future of an Illusion" (1927), "It goes without saying that a civilization which leaves so large a number of its participants unsatisfied and drives them into revolt neither has nor deserves the prospect of a lasting existence" (as cited in Botticelli, 2004, p. 640). The establishment of free psychoanalytic clinics between 1920 and 1935, and the importation of psychoanalytic principles into the progressive education projects of the likes of Anna Freud and Erik Erikson, speak to the early commitment of psychoanalysis to social transformation (Aldorando, 2007; Altman, 2010). Freud had a strong belief in the power of analysis to release the "reasoning abilities in oppressed individuals" (Danto, 2005, as cited in Aldarondo, 2007, p. 7). One does not have to look hard in these examples to see precursors – faint ones, perhaps – of Friere's call to revolution through the vitalization of human beings' critical capacities.

Freud's egalitarianism, however, should not be overstated. In prescribing strategies for treating the poor, he assumed they could not tolerate analytic abstinence, and that material help and direct suggestion would be necessary diluted forms of analysis for the poor (Altman, 2010). For all his vision of

social transformation, he named psychoanalysis's higher aspiration that of transforming "hysterical misery into common unhappiness" (Freud, 1895, as cited by Botticelli, 2004, p. 640). One cannot mistake the cynicism in this phrase, so opposite Friere's principle of loving faith in the oppressed (1970). Moreover, Freud's social vision targeted conditions of material deprivation, ignoring other forms of oppression. Traditional psychoanalytic theory from Freud until the feminist movement took in much of the sexism and homophobia of the time (Lerner, 1988). Considerations of race and racism are almost entirely absent from the discipline up until the present day (Altman, 2010).

Over time psychoanalysis came to occupy a more conservative niche of society. Some authors cite historical factors to explain this shift. The rise of the Nazi regime in Germany put an end to care for the poor through its persecution of both the Jewish individuals making up the ranks of prominent psychoanalysts, and of so-called communist agendas (Altman, 2010). After immigrating to the United States, the McCarthy witch-hunts made many psychoanalysts fearful of attempting to revive any agenda that might seem to smack of socialism (Altman, 2010; Aldorando, 2007). Psychoanalysis was co-opted into a system of increasing medicalization. Over time, profit motives began to confine the lengthy, hard-to-prove modalities of psychoanalysis to the wealthy, who could afford to pay out of pocket (Altman, 2010).

In recent decades, the terrain has again begun to shift, with a number of psychoanalytic theorists attempting to puzzle out how to incorporate a social critique into their clinical work. These efforts began with theorists riding the Second Wave of feminism. These theorists critiqued the standard psychoanalytic model of individual development, in that its focus on castration anxiety and Oedipal arrangements made the development of girl children inherently different, if not downright pathological (Chodorow, 1989; Lerner, 1988). Though the specific nature of these critiques varied, they paved the way for bringing socio-political concerns into the therapy room. Lerner (1988), for example, criticized traditional psychoanalysis's developmental formulation as distorted by the broader social problem of sexism, leading to a devaluation of women in psychoanalysis. In examples of her clinical work, Lerner attends repeatedly

to "the structuring of gender roles and the profound impact of women's subordinate and devalued status" (1988, p. 224). As exemplified in her writing, Lerner's politically oriented stance necessitates that the analyst help women "identify familial and institutional realities that interfere" with a patient's self-actualization (1988, p. 110). Chodorow (1989), in contrast, critiques psychoanalysis – and Lerner's approach – for not making a challenge "to the division of gender and parental roles, to normative notions of sexuality, to normal masculinity and femininity" (p. 235). Her theory thus makes room for critiques of homo- and trans-phobia. Like Lerner, her views point the way to a clinical stance that would see clients in light of social expectations of sexuality and gender expression. When Chodorow later in her career warmed to the idea of a biological basis for women-as-mothers, she also called for analysts to examine "the intrusions of a patriarchal culture" (2004, p. 122) in the lives of clients.

Future theorists would highlight the role of racism and ethno-centrism in therapy, which Lerner, Chodorow and others had ignored in their efforts to attend to sexism. Many of these theorists critiqued the notion of the therapist as blank slate. They argued that the realities of race relations in this country imbue every therapeutic encounter – even with all participants in the same racial category – with certain expectations and feelings (Altman, 2010; Comas-Diaz, 1992; Comas-Diaz & Jacobsen, 1995; Leary, 1997). Thus, as Leary (1997) puts it, "in some treatments, in fact, the talk about race may be the only way to enter into a psychoanalytic encounter, so great are the social challenges of race in contemporary society" (p. 179). The need to discuss race within therapy was twofold. According to Leary, "race [should be] treated as an actuality and as a sociocultural fact, even as it [is] also available for the patient's idiosyncratic scripting of it to serve dynamic agendas" (*ibid.*, p. 186). Race has meaning both as social reality and as a symbol of dynamic processes (Comas-Diaz & Jacobsen, 1995).

Within this overarching schematic, there are a variety of emphases. Leary (1997) focuses on the discussion of race in the therapeutic relationship. Altman's (2010) discussion of race as a focus of therapeutic work occurs in the context of his broader assessement of work in an inner-city context. Though ultimately retaining his micro-level focus, he considers contextual features including agency and

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governmental policies, and other macro-level processes. Altman also branches out into discussing

class/classism. Comas-Diaz takes her work much further than either, calling for a radical restructuring of

the entire foundation of psychotherapy to align with the experiences of marginalized populations (2007).

Her so-called ethnopolitical approach to psychotherapy is discussed in a later section of this literature

review.

The approaches of these theorists involve adding the politics of oppression to the mix of

understanding transference. Other psychoanalytic practitioners have sought a different route to using

therapy as a route to *conscientization*. These practitioners are more overt in their incorporation of

political concerns into therapy, seeing "political energy" (Samuels, 2004, p. 823) as an integral part of the

human psyche, and viewing intense affective experiences in the light of the idea of the personal as

political. In this vein, Dimen (2004) calls for psychoanalysts to ask clients directly about their political

experiences – September 11, for example – in order to find the "huge bursts of feeling over shared public

events" that "democratize the hitherto elitist insight that the personal is political" (p. 862).

The principles of psychoanalysis do lend themselves to a social critique that echoes that of Friere.

Psychoanalysis emphasizes the latent over the manifest. The theory views what is apparent as derivative

or, at times, as an illusion that covers over the true nature of what is hidden. Similarly, Friere's education

is aimed at taking its students from the "limit-situation" of a given historical context, to what is "beyond

these situations – and in contradiction to them," "an *untested feasibility*" (1970, 1982). These terms map

relatively easily onto the analytic conscious and unconscious. As evidence for this, a number of

psychoanalytic theorists have taken up the project of analysis of social problems. Their topics range from

suicide bombings (Altman, 2010), to collective trauma such as genocide (Mack & Redmont, 1989), to

racism (Comas-Diaz & Jacobsen, 1995). All involve uncovering the unifying theme beyond readily

observable events.

The mapping of these two theories is not neat, however, and in some important ways. The divide

lies in each theory's fundamental attribution of conflicts involving domination, power and oppression.

Altman, Chodorow, Lerner, Leary and Comas-Diaz tend to understand issues in the social structure as metaphoric or representative of conflicts originally cast in familial, developmental terms. For example, Chodorow (1989) and Lerner (1988) explain sexism as an outgrowth of infantile relationships with caregivers. Comas-Diaz, in her discussion of the role of race in the transference, uses the example of the "colored-screen" (1992, p. 97) to argue that socially prescribed understandings of race may become mirrors for clients' underlying intra-psychic conflicts around, for example, marginality and self-esteem. Even when broader social problems are topics of discussion, mechanisms understood as originating in the familial context – Klein's manic defense, for example (Altman, 2010) – are *secondarily* applied outward.

Secondly, as Altman puts it, psychoanalytic theory might be inherently questioning of the status quo, but "the direction of the revolution is never pre-ordained" (2010, p. 324). Friere would have had little use for a so-called revolution that did not entail the liberation of the oppressed. As Botticelli notes, politically minded theorists of the psychodynamic stripe rarely venture off the page to material political activism (2004). Some ventures have been made, such as in the form of consultation groups like the St. James Alliance or the Psychotherapists and Counselors for Social Responsibility, which seek to intervene as therapeutically minded professionals in the world of policy making (Samuels, 2004). Yet even the founder of these organizations holds to the view that psychoanalytic thinkers can easily join with anti-change, reactionary elements in society (Samuels, 2004). Friere, in contrast, declares that "reflection – true reflection – leads to action" (1970, p. 48), and action always on behalf of the oppressed.

In sum, practicing psychoanalytically would not necessarily, in and of itself, imbue the practitioner with Friere's variety of critical consiousness *qua* praxis. Yet the theory might prove a powerful tool for so-inclined thinkers to vitalize their political action in service of anti-oppression work. It may lead to *conscientization* through a questioning of what is hidden.

Family Therapy: A Systems Approach

Family therapy gained its position as a legitimate area of mental health in the 1950s and 60s (Aldarondo, 2007), only a handful of years after psychoanalyst survivors of the Second World War

emerged onto the American scene. Family therapists sought greater attention to interpersonal dynamics as constitutive of human experience, partly as a reaction against psychoanalysis's narrow emphasis on intra-psychic issues (McGoldrick & Hardy, 2008) in the years before relational theory gained recognition. Theorists were influenced in part by the development of cybernetics in the 1940s. They began to think of human behavior as a system that "use[s] self-regulating feedback mechanisms to maintain balance and constancy" (Goldenberg & Goldenberg, 2008, p. 18). Individual symptoms were seen as expressing problems within the family group (Hoffman, 1981).

Early family theory had underlined familial structure as the catalyst for conflict and a target for change. Practitioners examined communication between family members, looking for feedback loops, hierarchies, alliances, triangles and other patterns of interaction (Hoffman, 1981). The neurosis, intra-psychic conflict and weak ego of traditional psychoanalysis was transformed, into "maneuvers in a desperate struggle" (Hoffman, 1981, p. 22) to maintain relationships in a family plagued by faulty structural issues. Family therapists would ultimately divide in their chosen focus. Structurally oriented therapists were concerned with questions of family homeostasis, or the structures that evolve as the family resisted or adapted to change. Family therapists who thought about families as systems, on the other hand, understood structure as naturally shifting, emphasizing "not stability and homeostasis but the idea of discontinuous change" (*ibid*., p. 157). Family therapy would eventually balloon into a broad range of theoretical perspectives (Goldenberg & Goldenberg, 2008), including narrative, empowerment and ethnopolitical theories. These are discussed in later sections of this literature review.

For the purposes of this section, the discussion will be confined to the structural and systemic theories discussed above. These came from a "first order cybernetics" perspective (Goldenberg & Goldenberg, 2008, p. 17). In this perspective, the family structure or system could be treated as an objective entity, which could be observed, assessed and treated from the outside by an objective observer. For the purposes of this literature review, theorists in this section will be referred to as "family systems theorists." In contrast, therapists working from a stance of "second order cybernetics" (*ibid.*, p. 23) would

instead view the therapist as a participant in the family system, recursively impacted by the system as he or she creates her own impact. Narrative theory, an outgrowth of the second-order cybernetics perspective (Goldenberg & Goldenberg, 2008), is discussed in the following section of this literature review.

Within the non-constructivist world of first-order cybernetics, family therapists were, at the outset, imbued with a social justice reformist spirit and an appreciation of poverty, oppression and other social issues. This took a backseat to professional interests as family therapists sought a seat in the mental health establishment. Family therapy in the 1970s took the nuclear family as its focus (Aldarondo, 2007). At this point, family therapy as a field was dominated by white, middle-class, heterosexual men, who told the story of families from their demographic perspective. They generally failed to include in their assessment any unequal share of power between family members based on gender or other characteristics (McGoldrick & Hardy, 2008). Women were frequently held accountable for the psychological development of children, with the mother, for example, held as the parent whose behavior could generate schizophrenia in children (Hoffman, 1981).

Critique soon erupted. Theorists argued against the focus on the nuclear family, claiming that the family itself existed within broader societal systems such as the courts, schools, the economy, or history and social structures in general (McGoldrick & Hardy, 2008). Feminist voices emerged in the 1970s, with women ultimately taking a predominance of the leadership positions in the American Therapy Family Academy in the 1980s. A strong, but small voice of critique from the position of people of color emerged in the 1960s. By the 1990s, cultural competency had become a watchword at family therapy workshops. In addition, changes in family makeup in the US, due to immigration, a relaxation of prohibitions against inter-racial dating, increased lifespan, higher divorce rates, and the gay-rights movement, demanded a reconsideration of typical phases in the family life-cycle (Goldenberg & Goldenberg, 2008). Voices of dissent against the dominant discourse of family therapy encountered significant resistance and limited recognition (McGoldrick & Hardy, 2008). Nonetheless, feminist and

multi-cultural critiques have generated a body of writing and research that provide ample fodder for clinicians seeking a Frierean take on work with clients from oppressed populations.

Whatever the nature of the critique of traditional family therapy - feminist, multi-cultural, class-conscious, anti-homophobic - practitioners who use family therapy with an eye to issues of oppression share a number of features in their work. First of all, such practitioners concern themselves with learning about the contexts of their clients. What this entails depends on the client's identity. Thus, for example, a clinician working with first-generation Americans would necessarily learn about the laws, social expectations and monetary demands governing their clients' lives (Falicov, 2008), as well as about the process of migration as it impacts family structure (Sluzki, 2008). Curiosity about context necessarily leads into an exploration of histories and mechanisms of oppression. A clinician working with African-American survivors of Hurricane Katrina would attend to the ways in which a keen desire for "homeplace" served as a survival skill for a people afflicted by forced migration and de-humanization in public spaces (Boyd-Franklin, 2008, p. 349). Attending to context, theorists suggest, opens up avenues for treatment as well as for assessment. Clients are encouraged to draw their own folk wisdom and culturally endowed survival skills into the therapeutic mix (Akinyela, 2008; Moore Hines, 2008).

The attention to context has great significance for those who would apply Friere's pedagogy to clinical settings. Attention to the cultural contexts of clients recalls Friere's distaste for the "cultural invasion" that occurs when "an educational or political action program fails to respect the particular view of the world held by the people" (1970, p. 76). Curiosity about context demands a willingness to dialogue (Laszloffy, 2008; Boyd-Franklin, 2008; Sluzki, 2008), while dialogue forms the cornerstone of Friere's *Pedagogy*. Theorists place emphasis on "breaking the silence," getting to a point beyond "talk for talk's sake" (Hardy, 2008, p. 81), the intensity here pointing to the depth of exploration and transformation involved in the dialogue. Others call for a dialogue of re-humanization (Fraenkel & Carmichael, 2008). Friere's vision of dialogue as a situation of solidarity, trust and faith between teacher and student (1970) shares much with these theorists' vision of systemic family therapy.

Progressive family systems theorists also advocate for self-examination on the part of the clinician. Like Friere's progressive educator, who seeks to understand his or her "own involvement in reality, within a historical situation" (1970, p. 49), the progressive family systems therapist undertakes a critical introspection into his or her social location (Mock, 2008). Explicitly identifying one's place in a network of social dynamics and hierarchies challenges the very notion of therapeutic neutrality (Dolan-Del Vecchio, 2008; Hardy & Laszloffy, 2008). As Dolan-Del Vecchio writes, "A therapist who assumes a 'neutral' stance . . . actually endorses the oppressive social patterns, including sexism, racism, and homophobia, that contribute to the structure of all relationships in our society" (2008, p. 252). In other words, a therapist who fails to take seriously the inescapability of oppression, who considers him or her-self an outsider to that dynamic, only reinforces oppression through silence. Hardy and McGoldrick lay heavy criticism on the failure of traditional therapy to attend to the features of oppressors, rendering the privileged blind (2008). At the same time, they argue that "we are all connected to each other, the abuser, the victim of abuse, and the one who stands by in silence" (2008, 13). Friere likewise levies fierce condemnation on the oppressor class for their failure to recognize the violent realities imposed by domination, even as he notes that all members of the hierarchy "bear the marks of oppression" (1970, p. 40). Both Friere's educator and the progressive family therapist must acknowledge their position in history in order to transcend it, finding the underlying connection between oppressor and oppressed.

Friere ultimately parts theoretical ways with the likes of Hardy and McGoldrick. For one thing, there are notable differences their conceptions of social location. Friere, with his Marxist roots, understands social location in univalent terms: it pertains to class position (1970). Progressive family systems theorists, on the other hand, understand social location as consisting of a shifting web of relationships to one's class, gender, nationality, race and other demographic qualities (Mock, 2008). The distinction is not merely one of quantity of factors. In conceiving of his leader of revolution, Friere imagined one who could relinquish the aims of the privileged - maintaining power - and turn oneself over to the cause of the oppressed (1970). For progressive family systems theorists, the narrative of social

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location is fraught with complication; one stands simultaneously in many different positions on many different ladders. The power of an African-American, middle-class, gay man will be greater than that of a homeless, straight, Irish-American woman in some contexts - but then again, not so in others. Numerous personal accounts written by progressive family systems theorists attest to the complexity of the calculation of power, and suggest that privilege and subjugation may collide within individual identities (Domokos-Cheng Ham, 2008; McGoldrick, 2008; Pinderhuges, 2008).

As a related point, Friere and progressive family systems theorists imagine very different aims for dialogue, even as the respectful, trusting atmosphere of dialogue, and its concentration on societal and historical realities, remains constant. One could imagine conversations in family therapy about class, race, migration or other such factors as consciousness-raising, particularly if these are the first such conversations that clients have had. Yet family systems theorists remain focused not so much on building class-consciousness but on building the therapeutic relationship (Hardy, 2008; Fraenkel & Carmichael, 2008). Hardy (2008), for example, hopes for a dialogue in therapy in which "stained and strained relationships can move from polarization to engagement" (p. 83). Hardy, like other theorists of his stripe, imagines dialogue as potentially ameliorating across boundaries of privilege and oppression. This would be accomplished not through providing "safety" to privileged participants but through honest and open challenge, leading to more authentic relationships (Hardy & McGoldrick, 2008). For Friere, dialogue matters as a means of building unity among the oppressed. The dialogue serves not to build relationships but to develop critical faculties, in the form of "problem-posing education" (1970, p. 65). The dialogue deepens students' identities as members of an oppressed class; in this way, "sooner or later the oppressed will . . . discover that as long as they are divided they will always be easy prey for manipulation and domination" (*ibid.*, p. 126).

One glimpses here vastly different hoped for results of dialogue. Hardy, McGoldrick and others look forward a world where the humanity of all is recognized through pluralism and reconciliation (Hardy & McGoldrick, 2008). *Conscientization* - building a critical consciousness in the form of solidarity with

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those that share one's oppressed status - is less a focus than is loosening the hold that social location

places on relationship building. Friere, on the other hand, calls for the overthrow of the dominant class by

the masses (1970).

Despite these differences, family systems theory, even in its non-progressive form, contains

several elements that render it potentially sympathetic to Frierean theory. Understanding individuals as

produced by family systems is a step - albeit a large one - away from Friere's Marxist take on the

economic order as productive of human behavior. Both accounts weigh the system, and its "evolved set

of rules, . . . assigned and ascribed rules for its members, . . . organized power structure" (Goldenberger &

Goldenberger, 2008), more heavily than the intra-psychic characteristics of participants. However, even

progressive forms of family systems theory do not account for the internalization of systemic rules. This

notion appears in Friere's work when he describes the so-called domestication of the oppressed (Friere,

1970). Narrative therapy, described below, would take on the task of understanding the ways in which

the operating principles of systems could become constitutive of the very self-concepts of individuals.

Narrative Therapy

Narrative therapy grew out of several developments in therapeutic practice during recent decades,

some pragmatic, some philosophical. Since narrative therapy developed chiefly through the writing and

work of therapists, in this section I refer interchangeably to "narrative therapists" and "narrative

theorists." The increased affinity of psychoanalysis with the medical establishment and its emphasis on

elite, expert training had fueled the creation of alternative, more accessible training institutions. Narrative

therapy found its origins here, among practitioners of a more family-oriented therapeutic model (Beels,

2009). In addition, important developments in philosophy and literary theory, in particular that of Michel

Foucault, had begun to critique the very idea of knowledge, seeing all so-called truth as a production of

social relationships of power (Foucault, 1977). Others, such as Bateson and Geertz, re-defined the role

of communication and story-telling in the creation of psyches and cultures (White & Epston, 1990). Re-

thinking knowledge and language laid the foundations for a sea change in how therapists could think

about therapy (Beels, 2009; Gergen, 2009; White & Epston, 1990).

Creators and practitioners of narrative therapy sought to redefine the very nature of the therapeutic project. White and Epston (1990), the pioneers of narrative therapy, understood the to-be-solved problems of therapeutic work in a very different way than their psycho-dynamically minded colleagues:

> . . . when persons experience problems for which they seek therapy, (a) the narratives in which they are storying their experience and/or in which they are having their experience storied by others do not sufficiently represent their lived experience and (b), in these circumstances, there will be significant and vital aspects of their lived experience that contradict these dominant narratives (p. 40).

Psychodynamic therapists view their work as excavating underneath the readily perceived and described into unconscious or early pre-verbal experiences. In sharp contrast, narrative therapists find their terrain in precisely the most readily understood: in the very words people used to describe themselves. They follow the example of Foucault. Knowledge, he argues, is a constituted entity, constructed through social interaction, in of itself productive of social outcomes. People organize themselves by what they understand as the truth (Beels, 2009). In other words, what one understands to be possible determines how one orders the past, contextualizes the present, and, in turn, predicts the future (Gergen, 1991). Language and relationships, rather than the unconscious and intra-psychic drama, become primary.

In this vein, the role of the narrative therapist is to provide that collaborative social interaction that can bring the client to more vitalizing, re-generating narratives. The therapist's role shifts from "clairvoyant" to "co-participant in the construction of new realities" (Gergen, 1991, p. 251), or to the "participant-observer and participant-facilitator of the therapeutic conversation" (Anderson & Galooshian, 1992, p. 27). Narrative theorists provide a variety of suggestions for filling this role. White and Epston (1990), for example, recommend sharing and even co-authoring notes from a session with a client. Others suggest a lowered, tentative tone of voice (Hoffman, 1992). Still others advocate for the use of a reflecting team, which allows clients to view therapists in their conversations about treatment just as

therapists view clients in their conversations (Gergen, 2009). Each of these tactics provides a way for the therapist to step aside to encourage the client to step forward. The title of an essay on narrative therapy by Anderson and Galooshian, some of the foremost practitioners in the field, says it all: the client is the expert (1992).

In this egalitarianism, one can see clear echoes of Friere's teacher-student relationship. The therapist-as-collaborator fits easily into Friere's idea of the teacher-as-co-student. One might easily mistake Friere's call for humility in his educators as the watchword for narrative practice: "A the point of encounter there are neither utter ignoramuses nor perfect sages; there are only people attempting, together, to learn more than they know now" (1970, p. 71). The object of learning for Friere is *conscientization*, for narrative therapists, an alternative story, yet both emphasize the acquisition of autonomous power by the student or client. Even the object of examination is similar. Just as the narrative therapist encourages clients to challenge the accustomed ways in which they story their lives, the Frierean pedagogue views the "here and now" of accepted reality (Friere, 1970, p. 66) as the medium for study.

The crossover between Friere and narrative therapy is not merely coincidental. Friere draws on the work of Franz Fanon, who, like Foucault, developed his theory in the incubator of post-World War Two French academia and Marxist theory (Fanon, 1963). Friere's emphasis on the interface of knowledge and power (1970) reflects these theoretical roots. For Friere, as for narrative therapists, dialogue is not merely commentary upon and reflective of tangible reality – it *constructs* reality. As Friere puts it, "for people, 'here' signifies merely a physical space, but also a historical space" (1970, p. 80) – as narrative therapists might put it, a *storied* space. Narrative therapists understand the problem as equal to the story of the problem. They share Friere's sensitivity to how human beings' ordering of reality can set up barriers to concrete action.

With their roots in Foucauldian theory, the pioneers of narrative therapy could perhaps not help but turn their attention to narratives affecting clients on a societal level. Theorists and practitioners of

narrative therapy followed Foucault in challenging society's dominant discourses (White & Epston, 1990), such as those which center around "such values as being thin, financially successful, heterosexual, or superior to others" (Gergen, 2009, p. 299). White and Epston write that "challenging the 'truths'" described by norms and expectations of society "helps them [clients] refuse the objectification or 'thingification' of themselves and their bodies through knowledge" (1990, p. 30). One could easily mistake the sentence for a restatement of Friere's call for resistance against "necrophilic" ideas and "instruments of domestication" (1970, p. 47), ideas of the oppressor that turn the oppressed into objects rather than humans.

Friere, of course, calls for active resistance to oppression as a necessary component of his pedagogy. Dialogue alone - however much the setting or speakers might carry the "enormous symbolic weight of the cultural surrounds" (Gergen, 2009, p. 275) - failed by Friere's measures to truly revolt against tangibly oppressive circumstances. Early therapists in the narrative field did include action in their therapeutic work. Harlene Anderson, for example, organized a group of homeless women to come together as a community of mutual aid, shared resources and re-humanization (Gergen, 2009). Michael and Cheryl White worked with Aboriginal communities in New Zealand to help them collectively respond to deaths-in-custody of members of their community while in the hands of police (Beels, 2009). David Epston organized the Anti-Anorexia League, encouraging survivors to view themselves as "veterans of a conflict" in an arena of cultural images; Alan Jenkins focused his work on resisting domestic violence (Beels, 2009). In all of these examples, the emphasis lies in encouraging vitalizing relationships and story-telling, the bread and butter of a narrative approach. Using such tools in a group context ultimately enabled formerly disempowered individuals to act for themselves, rediscovering what Friere would see as their human capacity for decision-making and acting upon the world.

For all the broad areas of overlap between Frierean pedagogy and narrative therapy, there are gaps between the two. First and most fundamentally, Friere and the theorists of narrative therapy differ in their understandings of power relations in seemingly subtle – but ultimately dramatic – ways. Narrative

therapists understand discourse as primarily constitutive of power, and thus take discourse as their

primary site for mustering resistance to oppressive power regimes (Lock, Epston, Maisel & de Faria,

2005). The earlier-mentioned organizing projects of narrative theorists might easily have led to concrete

aims – a decrease in mortality, for example, for Aborigines in police custody; or an increase in protection

for survivors of domestic violence. Yet in each of the examples of community organizing by narrative

therapists, concrete changes took a backseat to the goal of creating a "manifesto" or performance

(Gergen, 2009, p. 301), or "articulating" subjugation to "unseen technologies" (Lock, Epston, Maisel &

de Faria, 2005, p. 324). Because power relations are constructed through discourse, the position goes,

subversive speech does indeed constitute a revolution. Gergen sums up this sentiment when he defines

therapists as "social activists," because "their assumptions and practices enter society in such a way that

meanings are altered or sustained" (2009, p. 278). Gergen does go on to recommend that therapists

broaden their activism to include attention to tangible inequities (2009), but this recommendation,

elaborated in a single paragraph, has the tone of a peripheral remark. As long as people have learned to

speak for themselves, the argument seems to go, power relations have been altered.

To take the point further, narrative therapists may be seen not only as offering alternative *modes*

of revolutionary action, but alternative *aims.* Narrative therapy rests, as stated, on the power of

relationship. One can understand speech, communication, and language of all sorts, as the constitutive

feature of relationship. If relationship is primary, then instead of Friere's violent revolution – which, he

argues, humanizes and redeems the oppressors – narrative therapists value restorative justice (Kamya &

Trimble, 2002).

One might understand Friere as sympathizing with the views of Gergen and his colleagues when

he writes, "Critical reflection is also action" (1970, p. 108). Ultimately, however, Friere casts the role of

language in a fundamentally distinct manner from narrative therapists, and consequently differs in his

understanding of power. Friere emphasizes language in its relationship to action, not as action in itself.

Thus, he claims that human beings find their humanity in their ability to "set objectives," to "infuse their

transformation of nature with any significance beyond itself" (1970, p. 78), to make decisions, and to infuse "the world with their creative presence by means of the transformations they effect on it" (*ibid*, p. 79). Language plays a role in all of these behaviors, in the form of thinking out or stating intentions, or imbuing real objects with transcendent symbolic value. In all its roles, however, language serves as a means of galvanizing, organizing or perpetuating action. Friere also speaks of the necessity for "a convergence of what is said and what is done . . . It is much easier to talk than to do" (1990, p. 6). Language here is explicitly demarcated from action. For Friere, re-authoring a story, as narrative therapists do, would have relatively little value unless the story had the power to push its audience or authors to action in the real world. Given this understanding of language, Friere would disagree with narrative therapists in their understanding of speech acts as revolutionary.

The second gap between Frierean and narrative theory lies in their understandings of power relations, and concerns their targets for resistance. Friere places far more emphasis than do narrative therapists on building a shared, class-based resistance to fight oppression. He writes emphatically of the power of "unification of the people" to threaten the "hegemony" of the minority of oppressors (1970, p. 122). When Friere discusses issues of alcoholism (*ibid.*, p. 98), school failure (*ibid.*, p. 123), or child abuse (*ibid.*, p. 127), he does so with a view to how these seemingly microcosmic issues reflect and derive from an economic system defined by personal property and socioeconomic hierarchies. The role of *conscientization*, therefore, is to bring these particular, individual problems into focus as part of a broader social thematic.

Narrative theorists, in contrast, do not consider an analysis of macro-level social forces, especially economic ones, as essential to helping their clients resist oppressive power. In their focus on unique outcomes and on deconstructing individual narratives in all their particularity, narrative therapy encourages a persistently microcosmic view. White and Epston, for example, discuss resistance as a form of relationship to "the problem and its requirements" (1990, p. 63). Power is implicit in the notion of requirements here, yet the power is that held by schizophrenia over a client, or anorexia over a family, to

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cite some of White and Epston's examples (1990). The resistance that narrative therapists nurture, therefore, is that which a client can muster alone. Resisting anorexia, for example, does not necessarily involve attending to media representations of women, allocations of power and resources in the media industry, or a long or broad view of sexual politics. The power, in this formulation, does not lie in these political, social or economic factors but rather in the way in which the client has defined anorexia itself (Lock, Epston, Maisel & de Faria, 2005). While this formulation has the advantage of accessibility for clinicians working in micro-contexts, it has some pitfalls as far as *conscientization* is concerned. In emphasizing deconstructing categories and the shifting nature of narratives, narrative theory threatens to undermine the very basis of a more Frierean type of resistance: the notion of class-action (Botticelli, 2004).

Lastly, narrative theorists and Friere differ in their choice of a target for resistance. Narrative theory is replete with deconstructions of therapeutic authority. Its critique of therapeutic practice covers the diagnostic categories of the DSM (Gergen, 2009), the psychopharmacological industry (Gergen, 1990), treatment for so-called schizophrenics (White & Epston, 1990) and anorectics (Lock, Epston, Maisel & de Faria, 2005), and the very act of diagnosis and treatment itself (Hoffman, 1992). In setting their sights on the therapeutic establishment – even on their own authority – narrative therapists do seem to be following Friere's injunction that the teacher of the people must abrogate his or her authority (Friere, 1970). Yet Friere saw this abrogation as a means to revolutionary activity, rather than an end in itself; teachers and social services professionals served in the employ of the oppressors but did not wholly belong to that class themselves. Given their distinctive understandings of power, it makes sense that Friere and narrative theorists would find such distinct targets for resistance. If power relations are diffuse and perpetuated through the production of knowledge and privileged expertise, mental health professionals are as good targets as any. If, however, the real power stems only in part from words, and more from actual economic arrangements, therapists must deconstruct their position only in order to understand their relation to the oppressor class – and then join the masses.

Liberation Psychology, Empowerment, and Ethnopolitical Approaches

Even the most politically attuned takes on clinical theories synch imperfectly with Friere's approach of *praxis* and *concretization.* A handful of theoreticians have resolved this mis-attunement of theory by bringing Frierean pedagogy directly into a clinical context. The theoretical approaches included in this broad grouping include empowerment theory, ethnopolitical psychology, and liberation psychology. Though they vary in specific ways, all of these theories take Frierean pedagogy as one of their main theoretical influences. The following section offers an overview of these approaches, and an account of their alliance with Frierean political theory and their use of concepts of *conscientization* and *praxis.*

Ignacio Martin-Baró's liberation psychology was the first to grow out of the philosophical groundwork laid by the *Pedagogy of the Oppressed.* Martin-Baró lived in the same environment of social unrest and dictatorship in Latin America as had Friere. His theory developed in parallel with that of Marie Langer, a European ex-patriate to Latin America in the decades following the rise of the Third Reich and the Spanish Civil War. Langer had been heavily critical of Freudian psychoanalysis from a Marxist and feminist perspective. She argued that Freud had failed to place his particular society in historical context and had therefore naturalized certain oppressive social conditions. After settling in Nicaragua, Langer had developed a form of brief group therapy that proposed a corrective experience for those afflicted by traditional, capitalist, patriarchal social orders (Altman, 2010). Martin-Baró's approach would be far more collaborative and non-directive than Langer's, but he agreed with her that to separate the personal from the political was to collude with the status quo (Altman, 2010).

Martin-Baró can perhaps be seen as applying Friere's so-called analysis of the limit situation (Friere, 1970) to the principles of psychology. The comparison here can especially be seen in his critique of empirical and positivistic stances, in which he argues that "[they] necessarily [ignore] everything prohibited by the existing reality . . . winds up consecrating the existing order as natural" (Martin-Baró, 1994, as cited in Altman, 2010, p. 52). Martin-Baró decried a psychology that he saw as individualistic,

homeostatic - ie, committed to resolving rupture and therefore looking negatively on revolution - and hedonistic - ie, focused on maximizing pleasure and happiness. Such a psychology only naturalized the internalization of pathology that was the hallmark of life under oppressive rule (Sloan, 2002). In its place, he proposed a theory and practice of psychology "from the place of a tenant farmer on a hacienda . . . someone who lives in the town dump . . . a woman who sells goods in the market" (1984, p. 28; as cited by Altman, 2010, p. 53). Included in his liberation psychology was a prescription for revolution in all structures "underlying the marginalizing and pacifying order that bases the well-being of the few on the oppressive exploitation of the many" (Martin-Baró, cited in Sloan, 2002, p. 355). Martin-Baró devoted his own life to the cause of liberation in El Salvador, and was eventually assassinated in 1989 (Sloan, 2002).

Before this, Friere's influence, as well as Martin-Baró's, had spread and been taken up by several theoreticians in United States. Empowerment theory emerged in the United States through the endeavors of clinicians such as Rhea Almeida, who set up her Institute for Family Services in 1981 (Almeida, Dolan-Del Vecchio & Parker, 2007). The creators of empowerment theory sought to generate strategies for placing praxis and critical consciousness at the forefront of therapeutic endeavors (Almeida, Dolan-Del Vecchio & Parker, 2007; Gutierrez, Parsons & Opal Cox, 1998; Gutierrez & Lewis, 1999). Theoreticians originally sought to attend to the experiences of women and people of color, and remained concerned with oppressed populations as their focus widened to include the homeless, people with disabilities, lesbian and gay individuals, and other oppressed groups (Gutierrez, Parsons & Opal Cox, 1998). Recognizing the impacts of oppression, and looking forward to a goal of social justice, is a central concern of empowerment-oriented clinicians (Gutierrez & Lewis, 1999). Thus, empowerment theory goes a step beyond Friere, who concerned his *Pedagogy* mainly with the plight of the poor in a class conflict dynamic (Friere, 1970).

Clinicians working from an empowerment perspective sought *conscientization*, or critical consciousness, for their clients, "an authentic essence apart from the stereotypes and expectations . . .

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knowing what one is doing and why" (GlenMaye, 1998, p. 36). They sought to put clients' presenting

problems on hold in order to bring them into a greater understanding of the political, social and historical

forces behind individual and familial conflict. Thus, for example, consideration of incest and domestic

violence in an African-American family would be contextualized within a broader history of slavery,

racist oppression, and sexism (Almeida, Dolan-Del Vecchio & Parker, 2007). Gutierrez and Lewis (1999)

outlined their critical consciousness in these terms: "A collective orientation to social change, feelings of

discontent with the relative distribution of power . . . a rejection of the legitimacy of power disparities

between groups that includes blaming the system for outcomes, and an identification with shared group

values and interests" (p. 7). This definition of critical consciousness strongly echoes that of Friere, who

saw the oppressed as gaining critical capacity in tandem with an increasing sense of doubt, disconnect and

discontent with the existing world order (Friere, 1970).

As evident from the quote above, Gutierrez, Lewis and other empowerment theorists (Almeida,

Dolan-Del Vecchio & Parker, 2007) took a determinedly collectivist orientation. They argue, like

Martin-Baró, that the individualistic tack of mainstream psychology reinforced the internalization of

oppressive self-identifications (Gutierrez & Lewis, 1999). Others critique the very notion of the privacy,

claiming that "confidentiality is too frequently used as a way to preserve patriarchal control . . . [It]

evolved out of a system defined by men for men" (Almeida, Dolan-Del Vecchio & Parker, 2007, p. 184).

Empowerment clinicians utilize a range of techniques including the recruitment of extended family

members and religious leaders into therapy (Gutierrez & Lewis, 1999), sponsors (Almeida, Dolan-Del

Vecchio & Parker, 2007), multi-family groups (Almeida, Dolan-Del Vecchio & Parker, 2007; Gutierrez

& Lewis, 1999**,** or group work and mutual aid groups (Andrus & Ruhlin, 1998; Okazawa-Rey, 1998).

One of these strategies - the use of culture circles in the Cultural Context Model, in which clients join in

homo-social spaces to share in the process of growth - explicitly derives from Friere (Almeida, Dolan-Del

Vecchio & Parker, 2007). Friere calls for groups of peasants to collectively engage in "thematic

investigation", a method to "introduce women and men to a critical form of thinking about their world"

(1970, p. 85).

For empowerment theorists, a collectivist orientation acts to unleash new potential for power. Empowerment theorists regard power as a neutral force in and of itself, distinguishing its exercise in "*power over* others in destructive ways and the creative use of *power* exercised in association *with* others that liberates and empowers" (Rees, 1998, p. 132). Collective action offers a prime example of *power with,* as clients become joined with others who share similar problems and difficulties and can pool resources, decrease stigmatization, and act in concert (Almeida, Dolan-Del Vecchio & Parker, 2007). As Friere noted, unity enables "the oppressed, by perceiving their adhesion, to opt to transform an unjust reality" (1970, p.155). The principle of *power with* has significant implications for the empowerment theory practitioner, who functions as "an enabler, organizer, consultant or compatriot," interacting with clients in a way "characterized by genuineness, mutual respect, open communication, and informality" (Gutierrez & Lewis, 1999, p. 20). One could easily take this description as a re-casting of Friere's faithful, loving teacher and leader of the oppressed.

In addition, collective action offers a check on patterns of dominance that may often be invisible or painful to surrender. A group, for example, can support a male client in taking on a role of increased household chores and decreased control over family finances (Almeida, Dolan-Del Vecchio & Parker, 2007). Empowerment theorists advocate firmly for mechanisms to hold the privileged accountable, arguing that "one cannot have empowerment without accountability" (Almeida, Dolan-Del Vecchio & Parker, 2007, p. 195). While Friere certainly proposes liberation as a means for human beings to become more self-conscious in the motivations, his focus hardly lies in the accountability of students. One might see this as an outgrowth of Friere's narrowly economic focus, in contrast to empowerment theory's critique of sexism, racism, homophobia, and other forms of oppressive ideology.

Power-with builds up towards the ultimate component of empowerment theory, that of reflective action, or *praxis* (Gutierrez, Parsons & Cox, 1998), a direct link to Friere's concept of meaningful action on behalf of liberation (Friere, 1970). Writers on empowerment theory invariably include

recommendations or examples of concrete, externally directed change efforts that can be undertaken as a joint effort of clients and workers. Some change efforts involve the provision of concrete services, such as Community Voice Mail for homeless people in Seattle (Andrus & Ruhlin, 1998). Others involve education, such as the use of consciousness raising groups to provide support to lesbians and gays (DeLois, 1998). Still others target oppressive aspects of the social or political structure, such as legislation that would increase support for kin-foster parents sponsored by Grandparents Who Care, a group of grandparents of color (Okazawa-Rey, 1998). While critical consciousness-raising aims to re-humanize clients from oppressed populations, empowerment theorists view this as only the starting point for intervention in the political and material world (Gutierrez, Parsons & Opal Cox, 1998). The need for action echoes Friere's words: "The man or woman who emerges [from liberation] is a new person . . . no longer oppressor or oppressed, but human in the *process of achieving* freedom" (1970, p. 31, emphasis added).

Power with does appear to line up neatly with Friere's notions of the re-humanization and liberation that occurs when oppressed people realize their potential for action. The movement from a feeling of inevitability and impossibility to a sense of choice does entail a greater sense of scope for action. However, Friere would likely have been suspicious of empowerment theorists' attempt to re-think power as a non-scarce, accessible resource. He would have perhaps accused empowerment theorists of "pure impatience" that "forgets that in history, one does what is possible and not what one would like to do" (1990, p. 9). Certainly, Friere might argue, groups of the oppressed have more power than non-critically conscious individuals, but there are important and immutable differences in the amount of power that such groups have in comparison to the dominant elite. As he notes, "understanding the limits of social work practice . . . ideological, cultural, political and historical" (1990, p. 9) is critical to progressive social work, perhaps because failing to do so is to fail to seriously take into consideration the nature of oppression and the actions needed to rectify it.

Lillian Comas-Diaz's ethnopolitical psychology (2007) offers one of the more recent takes on

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empowerment theory and a more explicitly Frierean clinical perspective. Following the example of empowerment theorists, Comas-Diaz explicitly cites Friere as an inspiration; she also names Martin-Baró's liberation psychology as a cornerstone for her theory of practice (Comas-Diaz, 2007). Like empowerment theorists, she concentrates her efforts on oppressed populations, specifically, people of color (Comas-Diaz, 1992; Comas-Diaz, 2007). Comas-Diaz sees "developing critical analysis and engaging in a transforming practice" - what she understands as critical consciousness - as one of the central goals of ethnopolitical psychology (Comas-Diaz, 2007, p. 94). Critical analysis of political and social structures plays a role in her recommended assessment of clients of color. Thus, she outlines the etiology and progression of Postcolonization Stress Disorder, ethnocultural allodynia - "a disturbance of people of color's ability to judge perceived ethnocultural and racial insults and subsequently discern defiant and maladaptive responses from adaptive ones" (Comas-Diaz, 2007, p. 96) - and trauma due to racial terrorism (Comas-Diaz, 2007). In creating terminology for these disorders, Comas-Diaz creates a language for discussing the impacts of racial and colonial oppression in the therapeutic context.

Comas-Diaz integrates liberation psychology and empowerment ideas with what she calls an "ethnic indigenous psychological perspective" (Comas-Diaz, 2007, p. 93). By this, she intends a paradigm shift in the ethical, epistemic and methodological assumptions of psychological practice. Comas-Diaz argues that mainstream psychology was founded on assumptions of universality that arise from "cultural myopia at best, cultural imperialism at worst" (Comas-Diaz, 1992, p. 90). Truly providing space and a voice for people of color would necessitate a departure from the monoculture of colonizing, capitalistic Western psychology, and a revaluation of so-called indigenous perspectives (Comas-Diaz, 2007). In that space, psychotherapy could come to include perspectives of interdependence rather than independence, of spirituality as opposed to hyper-rationality, and of physicality as opposed to oriented towards the mind. On the one hand, Comas-Diaz views such shifts as enabling the deeper healing of people of color from wounds of devaluation inflicted upon their communal practices, a "reconnecting with their roots by calling back their spirit" (Comas-Diaz, 2007, p. 102). At the same time, Comas-Diaz

imagines a time in which "psychotherapy of people of color will become psychotherapy of all people" (Comas-Diaz, 1992, p. 93).

Perhaps out of connection to her own roots in psychodynamic theory, Comas-Diaz does not appear to rely heavily on group work as a modality as do her empowerment theorist counterparts. Comas-Diaz emphasizes the use of strategies that validate and reinforce the cultural identities of clients, such as the use of religious healers, or the application of Dichos Therapy with Latino clients (Comas-Diaz, 2007), more than she does political action. There are, however, profound similarities between the two. Comas-Diaz calls for practitioners to use any and all modalities of treatment, modified appropriately for clients' racial and ethnic backgrounds, including psychodynamic, interpersonal, systemic, cognitive-behavioral and Eye Movement Desensitization Reprocessing (Comas-Diaz, 2007). Similarly, Gutierrez and Lewis (1999) note that "social work practitioners working from an empowerment perspective are likely to have an eclectic approach" that flexibly adapts to the needs and preferences of the client (p. 58). Comas-Diaz also calls for a collaborative relationship of client and therapist to counterbalance pervasive dynamics of repression and violence against people of color (2007).

Empowerment, liberation and ethnopolitical theories all suggest slightly different takes on bringing Frierean *conscientization* into clinical practice. The development of these theories as a whole illustrates how much the range of options for activist therapists has grown beyond that of Freud's lukewarm call action, to transform "hysterical misery into common unhappiness" (Freud, 1895, as cited by Botticelli, 2004, p. 640). There is a wealth of writing on the theoretical alignment of various clinical perspectives with political action and consciousness-raising. This writing, however, has not touched on how clinical social workers take on an activist identify for themselves.

Political Activity Among Social Workers

The actual level of political engagement among social workers remains a relatively un-researched topic (Andrews, 1998; Ritter, 2007). In studies that have been conducted, researchers found that while social workers are seen as more likely to be politically active than the general population and at least as

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active as other professions (Andrews, 1998; Domanski, 1998; Hamilton & Fauri, 2001; Ritter, 2007; Salcido & Seck, 1992; Wolk, 1981). Political activity among NASW members, based on the results of several studies surveying different NASW chapters, seems to have decreased during the 1980s (Reeser & Epstein, 1987) and increased again by the early 1990s (Ezell, 1993).

While on average social workers could be characterized as politically active, the types and amount of political activity that social workers engage in varies widely. Most political activities are undertaken by a small number of highly committed social workers, while a larger number maintain only minimal involvement (Ezell, 1994; Wolk, 1981). While social workers vote at a higher rate than the general population, and most social workers vote, for many political action stops there (Hamilton & Fauri, 2001; Ritter, 2007). Further investment tended to take the form of advocacy (Domanski, 1998; Ritter, 2007), personally contacting legislators (Hamilton & Fauri, 2001; Ritter, 2007), or having an organizational membership (Wolk, 1981). Only a small percent tend to engage in campaign work or meet with legislators (Domanski, 1998; Hamilton & Fauri, 2001; Ritter, 2007; Salcido & Seck, 1992; Wolk, 1981). A still smaller percentage of social workers have given political testimony (Hamilton & Fauri, 2001; Ritter, 2007; Wolk, 1981) or participated in organized demonstrations (Domanski, 1998; Hamilton & Fauri, 2001; Ritter, 2007; Salcido & Seck, 1992). Social workers were more likely to approve of advocacy than campaigns, and campaigns than demonstrations, as tools for political change (Ezell, 1994; Reeser & Epstein, 1987).

Researchers have presented a variety of explanations for the range of political actions among politically engaged social workers. Social workers are less likely to engage in activities that required greater investments of time and energy or more initiative (Domanski, 1998). They are more likely to engage if they are in the NASW or a part of a politically oriented group (Hamilton & Fauri, 2001; Ritter, 2008), are employed in macro-level positions (Wolk, 1981) or experienced more political discussion in their family of origin (Hamilton & Fauri, 2001). These findings may be indicative of a broader need for a sense of competence as a precursor for political engagement (Andrews 1998, Domanski, 1998; Hamilton

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& Fauri, 2001; Ritter, 2008; Wolk, 1981). Affiliation with politically oriented groups also correlates with greater political engagement (Ritter, 2008), perhaps because social service workers are more likely to engage in action in a group context (Andrews, 1998).

Demographic factors among social workers may also determine the extent of political engagement, though researchers do not always agree about the direction and amount of influence exerted by each factor. In some studies, black social workers appear to be slightly more politically active than white social workers (Wolk, 1981) and personal experience plays a role in motivating political action against oppression (Ezell, 1994); in other studies, that split appears more significant (Andrews, 1998). Income level plays a determining role in some studies, with higher income social workers doing more political action than lower-income social workers (Wolk, 1981); in others, not so (Hamilton & Fauri, 2001). Some researchers have found that social workers engage when they have been in the profession longer (Wolk, 1981), while others find no relationship, instead arguing age as a determining factor (Hamilton & Fauri, 2001). One researcher argues that only urban location determines political action (Ritter, 2008).

The level of disagreement between researchers' findings may pertain to the lack of common samples. Several of the studies sampled NASW members (Reeser & Epstein, 1987; Wolk, 1981), surveyed NASW chapters as a whole (Salcido & Seck, 1992), or surveyed members of other professional organizations (Domanski, 1998). Researchers that sampled both NASW members and non-members showed that membership in the NASW to be a significant predictor of political action (Hamilton & Fauri, 2001), leading to a significant sample bias in studies with only NASW members. A dearth of research meant gaps of years between different studies. Only some studies were conducted on a nationwide basis (Domanski, 1998; Ritter, 2007; Salcido & Seck, 1992). It is difficult to know whether results from studies based in New York City (Hamilton & Fauri, 2001; Reeser & Epstein, 1987) and Michigan (Wolk, 1981) can truly be compared or utilized together, or with nationwide studies, in review – particularly given aforementioned researchers that identify geography as a crucial factor in determining levels of political

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engagement among social workers. Finally, almost all participants received a survey in the mail or in person, and were required to fill it out on their own (Andrews, 1998; Domanski, 1998; Hamilton & Fauri, 2001; Reeser & Epstein, 1987; Salcido & Seck, 1992; Wolk, 1981.) This could easily lead to a powerful self-selection force at play in the sample. Those that mailed in the surveys may have been more likely to care about political action in general. Studies may thus provide more a picture of what politically motivated social workers are like, than the prevalence of political activity among social workers as a whole.

Studies also differed in the measurements used. Almost all studies measuring political activity among individual social workers used voting as an item on their scale, ranked equally with all other items (Andrews, 1998; Domanski, 1998; Hamilton & Fauri, 2001; Ritter, 2007). Only one researcher did not include voting when measuring individual social workers (Wolk, 1981), while others, surveying NASW chapters as a whole, also did not include voting (Salcido & Seck, 1992). Several researchers did not weight items according to frequency with which the activities indicated in the items were undertaken (Andrews, 1998; Domanski, 1998). No researchers weighted items according to the amount of time and energy spent on each task. Some researchers also used measurements that failed to account for whether activities were sporadically undertaken, continuous, or occurred in the past. These researchers simply asked whether social workers (or NASW chapters) had undertaken specific political activities within a particularly time frame (Andrews, 1998; Domanski, 1998; Hamilton & Fauri, 2001; Salcido & Seck, 1992). Only one set of researchers used open-ended items (Salcido & Seck, 1992).

Still another weakness of these studies is that most researchers do not ask social workers to identify the aims of their political action. One pair of researchers found that while a significant proportion of NASW members in the 1980s engaged in political action, most of these activities were oriented towards professional goals (Salcido & Seck, 1992). Salcido and Seck noted that "it is ironic that involvement in protest activities and voter registration is minimal, because these activities can be used to empower the poor, minorities and social services clients" (1992, p. 564). In contrast, a researcher in the

early 1980s attempted to examine specifically client-centered political action, and still ranked sampled social workers as more likely than not to be active or highly active politically (Wolk, 1981).

Research is sparse, as well, that questions the underlying political views that might give shape to political action. In one study conducted in Israel, researchers found that policy practice among social service workers is highly correlated with progressive views, such as the attribution of poverty to structural factors, or favoring a redistributive economic system (Weiss-Gal & Gal, 2008). The findings may not be applicable to social workers in the US: A study by Reeser and Epstein found a 13% decrease in the number of respondents self-reporting political participation between 1968 and 1984, perhaps a reflection of the changing values of the time. This corresponded with an increase in the number of respondents identifying structural factors as the cause of poverty (1987). The applicability of both of these studies is questionable, given the dated nature of one and the cultural location of the other.

Finally, and most importantly for the purposes of conducting this research study, none of this research concerns the particular clinical perspective that guide social workers to political action. Researchers mentioned above focused on macro-level social work without consideration of its influence on, or derivation from, clinical, micro-level social work. The question of how specific brands of clinical thinking might guide social workers to political action – either themselves or with clients – remains unexamined. Finally, and most importantly for this study, all of these studies show what social workers do apart from their clinical work. The integration of the political into the clinical remains unexamined.

Conclusion

Research on political activity among social workers has neglected to explore the ways in which political activism among social workers might find its expression in clinical work. While various authors in different schools of clinical theory have suggested various strategies for integrating political and clinical levels of practice, no one has yet explored the enactment of those strategies on the ground. In the course of this study, I will seek to answer the following questions: How do clinical social workers integrate different clinical theories and perspectives with a sense of political consciousness? How do

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various theories and perspectives influence how clinical social workers think about oppressed populations? How do those theories influence the clinical social worker's self-perception as an agent of political change? Through qualitative interviews of clinical social workers who are also activists, I will begin to explore the pragmatics of bringing activism and consciousness raising to bear upon work in the therapy room.

CHAPTER THREE

METHODOLOGY

The purpose of this study was to investigate how activist clinical social workers who work with clients from oppressed populations integrate their political and clinical work. My questions focused on the integration of social and political concerns into clinical work with clients from oppressed populations, and the mutual influence of clinical and activist realms of experience. My attention focused particularly on the theoretical approaches clinicians took in their therapeutic work, and the ways in which these approaches fostered or limited attention to social and political forces in clients' lives.

Since these questions have not been addressed before, I took an exploratory model in conducting this research. In-depth, semi-structured interviews were conducted with eleven clinicians or former clinicians who self-identified as activists. Findings were then analyzed qualitatively.

Sample

I used a combination of purposive and snowball sampling for this study. I contacted specific individuals who either appeared to fit study criteria, or who might know individuals who fit the study criteria. Inclusion criteria for the study included the following: (1) Participants must be LICSWs or must be LICSW eligible; (2) participants must work at least half time in a clinical capacity, or have been working half-time in this capacity for at least 10 years, and at least one year within the last five; (3) participants must self-identify as political activists. I used snowball sampling to obtain further contacts from recruited participants.

Strong attempts were made in conducting this study to recruit a diverse sample with regard to age, race and professional background. In particular, several efforts at purposive sampling were used to attempt to recruit participants of color. I contacted several organizations that included a high percentage

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of social workers of color. I also contacted several potential subjects who fit study criteria and identified as people of color. Finally, in my snowball sampling with recruited clients, I explicitly asked whether participants knew of any potential recruits who identified as people of color.

Recruitment efforts were made to recruit twelve participants for the study. In the end, I interviewed 11 participants. All of the participants identified as female. All but two of the participants (n=9) identified as Caucasian; one identified as South Asian, and one identified as "post-racial." In terms of ethnic identity, four participants identified as Jewish, two as Eastern-European, three as Western European, one as Indian and one simply as "White."

Participants varied widely in terms of their professional experiences. Participants had been employed in social work for anywhere from 2.5 years to 45 years since obtaining an MSW, with a mean time of 20.25 years and a median time of 19.5 years. One participant could not be included in these calculations, as she had worked a total of 12 years but did not specify whether this was before or after obtaining her MSW. A large minority of participants (n=5) worked only in private practice, while another large-minority (n=4) worked full-time jobs in non-private practice settings such as hospital outpatient mental health services, non-profits, neo- and peri-natal care units, public schools and pediatric care settings. A small number (n=2) split time between both private and non-private practice settings. Finally, one participant worked half-time in private practice only, and another had worked previously in college counseling centers but was no longer working in a therapeutic capacity. All participants had done clinical work in non-private practice settings, including DSS, hospital inpatient units, home-based services, schools, non-profits and community health centers.

Finally, participants varied widely in terms of their political work. Most participants (n=9) had become involved in political activism as college undergraduates, two as children and one as a graduate student. Participants had been involved in movements including economic human rights, affordable housing, environmental justice, racial justice, women's liberation, anti-homophobia and anti-transphobia, disability rights and awareness, pro-peace, prison reform and international-based movements (such as

Cuban solidarity or the movement against the Khmer Rouge in Cambodia). Participants also ranged widely in the nature of their past or present political involvement. They had founded organizations, written articles or letters, run anti-racism trainings or curriculums, served on public commissions or in public office, campaigned for politicians, organized conferences, organized communities, attended rallies and donated money.

Data Collection

The Smith College School for Social Work Human Subjects Review Committee approved this study (see Appendix A). Participants were provided with the informed consent form either at the time of the face-to-face interview, or by email as an attachment before the scheduled interview.

Data collection was conducted through semi-structured interviews that ranged between 50 minutes and two hours, depending on the time available for the participant and the participants' answers to the questions. Participants were asked a total of 6 questions about their clinical and political work and theoretical orientation. In addition, they were asked demographic questions regarding their racial identity, gender identity,, and length and type of professional and political work (see Appendix B for questionnaire).

Interviews were conducted in person when possible. If not, they occurred over Skype, and if not possible over the phone. All interviews were audio recorded with consent from the participants, and later transcribed. On two occasions, audio recording failed to work and interviews were transcribed in shorthand during the interview hour, and then expanded after the interview's conclusion.

All audio recordings and transcriptions were stored in password protected databases and were coded by number, not by name. All identifying information and specific vignettes were disguised. Informed consent forms were reviewed by participants before participation (see Appendix C). Participants were advised that participation was voluntary and could be discontinued at any time, and that they could withdraw from the study before April 1, 2011. Copies of signed informed consent forms were kept in a locked filing cabinet. Copies of signed informed consent forms and coded transcription will be

kept in protected databases or files as required by law for the next three years as required by Federal law.

Data Analysis

Transcribed interviews were analyzed thematically and manually. After transcription, responses were grouped by question. Each question was then read multiple times, the first two times without making notation. After two preliminary readings, each question was read with attention to identifying as broad a range of themes as possible. Once this initial coding was complete, the question was re-read in order to group identified themes and reduce the identified themes to a smaller number. With several re-readings, 4-8 themes were identified per question and all participants grouped according to at least one theme per question. Attention was paid in analysis to responses that fell outside of or explicitly countered particular themes.

CHAPTER FOUR

FINDINGS

Introduction

The purpose of this study was to investigate the integration of political and clinical work among clinical social workers working with clients from oppressed populations. Using the lens of Paolo Friere's *Pedagogy of the Oppressed,* I asked a number of questions aimed at gauging the extent to which activist clinicians found ways of achieving *conscientization* – political consciousness raising – for themselves or their clients. A limited amount of research has been done into the political engagement of social workers, and all of it on a quantitative level. Only theoretical work has been published regarding the integration of political or social issues into the therapeutic context. This research thus furthers our understanding of how social workers on the ground might use or think about their clinical and political work in concert.

This chapter presents data from eleven activist clinical social workers across the United States. Demographic information was gathered, including participants' race, gender identity, length and type of professional clinical work, and length and type of political or social justice work. This information was presented in Chapter 3, Methodology. The following chapter presents the findings gathered from the remaining interview questions. Interview questions were organized around the following themes: Clinicians' views on their clinical population in relation to the concept of oppression; clinical theoretical orientation; clinicians' ability and desire to use therapy, via this theoretical orientation, as a vehicle for *conscientization*; and the mutual impact of therapy and political work.

Client Characteristics

For the purposes of this study, "oppressed populations" were defined as people who are women, people of color, new Americans, low-income people, elders, differently-abled people, or members of the

GLBTQ community. Using the study definition, all participants worked with at least some members of an oppressed population.

As might be expected, the proportion of clients from oppressed populations in clinicians' overall caseloads varied to some extent based upon work setting. Of the clinicians working primarily in public or non-profit settings, such as schools, hospitals, or public counseling centers, four out of five described their caseload as primarily consisting of people of color and people in poverty. Participants working in private practice universally described their caseload as majority White, including participants who did private practice work as an adjunct to full-time public or non-profit sector work. Moreover, while all private practice participants in the study reported that they made an effort to take a broad number of insurances – two accepted Medicaid/Medicare - all described their caseload as majority middle-class. The proportion of GLBTQ clients in participants' caseloads did not follow this pattern. Four out of five public or non-profit based clinicians reported that they treated few or no identified GLBTQ clients. In contrast, all of those in private practice described their caseload as containing at least a few identified GLBTQ clients, while three reported these clients as a significant proportion of their caseload. Finally, only public or non-profit sector clinicians described recent immigrants as a major component of their caseload.

The proportion of female to male clients in participants' clinical population was one variable that did not appear dependent upon the public versus private nature of the clinical setting. Both clinicians who worked in public settings with primarily with elementary school-aged children stated that male students formed the bulk of their therapeutic referrals. Several clinicians worked in public settings that by definition catered to all or mostly women, such as a women's college counseling center and a pre-, peri- and neo-natal hospital unit. Of the clinicians working with adult clients in outpatient settings, four – one from a hospital-based clinic, the others in private practice – described their caseload as primarily female. Three others, all in private practice settings, did not disclose the makeup of their caseload in terms of this characteristic.

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Participants varied with regard to which characteristics of clients they included or excluded in their descriptions of their caseloads. All but one participant identified their clients based on racial background. The exception expressed significant hesitation about so-identifying her patients: "I don't really think about my caseload in terms of race. It's just not how I think about it."

Most participants did not describe their clients in terms of physical ability, though three did describe the presence of a mental illness as a factor that related to oppression. One commented specifically upon physical disability, relating it explicitly to oppression.

> I see people with all kinds of disabilities . . . for people with mobility impairments I actually see them at another office. . . . But technically, under the ADA – this is a very sticky wicket in social work, so it might be worth getting into – technically you can't refuse to see someone in private practice just because your office isn't accessible. . . . So if somebody calls and says, "I understand you work with poly- people and trans-gendered people and I'm trans- and I'm poly- but I also use a wheelchair," under the law, I can't say to him, "Well, my building's not accessible. I should make a good faith attempt to find a way to see that person.

Findings

Question One: "Would You Describe Any of Your Clients as Being a Part of an Oppressed Population? Why or Why Not?"

After being asked to characterize their clinical population, all participants were explicitly asked this question. Depending upon the thoroughness and the content with which participants responded, they were either asked or not asked a series of follow-up questions. These questions included questions about specific categories of clients that participants had not included in their identification of clients from oppressed populations. Depending upon how participants had characterized their clinical population, participants were sometimes asked whether they considered women, LGBTQ individuals, or individuals with disabilities as members of oppressed populations. If answers were vague or confusing to the interviewer, clients were asked to provide case examples.

Almost all of the participants (n=9) responded affirmatively to this question. For two, tackling the issue of oppression with clients amounted to a professional mission. Of those who answered "no" (n=2), one participant went on to describe a particular client "who I do really think is oppressed . . . To

the extent that I think of that framework, I think of it most with her." Despite the almost unanimous nature of participants' responses, participants varied widely in their explanations of the nature of oppression for their clients.

Material conditions. Slightly more than half (n=6) participants referenced the concrete conditions of clients lives in explaining the nature of oppression. One participant explained her definition of her clients as part of an oppressed population as "because of where they are economically resource wise, a lot of them are on fixed income, a lot of them live in poor areas of the city." Another described her clients as "oppressed in terms of their very limited financial resources and limited education, so class wise." Within the theme of concrete conditions, participants referenced their client's incomes and savings, communities, and access to adequate work and educational opportunities.

Within this theme, participants differed in their understandings of how much weight to give concrete conditions, and how to understand the intersection of class with race, gender and sexual orientation. For one participant, the question of concrete resources such as education, income and community safety was primary in viewing a client as part of an oppressed population. The interviewer questions are noted in italics.

> So I would say that the woman who I work with who are middle class, I really don't think of them as oppressed. Because if they're middle class and they've gone to college and they have families backing them there in the background - but I have one woman who has absolutely no financial backing from her family, and she's really struggling. So I think economically, the woman who I've seen, some of them are really struggling,
> *And do you think about your GLBTQ clients as being a part of an oppressed population?*
> I think it depends on the person. It depends on how . . . How much has the coming out process been a process that's challenging for them, and put them out of, in a place of - I think some people are able to go through that process and come out more on top, depending on how they've grown up and what kind of support they've had from their family, and probably their own inner sense of themselves. . . . Some of the gay women that I've worked with, I would say yes, in a small way, but also that - that they've all gone to college, had decent jobs, had family support, so I would say it's in the background not the foreground.

Though this participant does identify an "inner sense of themselves" as a significant factor in deciding whether or not a client copes with oppression, ultimately the deciding factors are material. Her lesbian clients who have education, employment, and "family support" thus do not fit into the category of

clients from oppressed populations. Furthermore, though this participant does mention "women of color" as particularly fitting, in her mind, the label of clients from oppressed populations, she explains this in terms of material resources.

> Because their lives are so organized around the fact that they don't have any privileges. They don't have any financial cushion . . . Because they haven't had the advantages of going to college often, the women of color that I've seen. Because they live in communities in which there's violence.

Other participants took account of material circumstances as one of many factors contributing to oppression. For one participant, the presence of economic advantages could not fully counteract the effects of non-economic forms of oppression.

> [I think of them as oppressed] because of the conditions and experiences of their lives. Um - I mean I think, I'm thinking about - it happens that not all of the lesbians that I see are middle class but a number of them are. But it doesn't - it's interesting because class is protective of them in some ways, but also, it has not protected them.

Participants in this thematic group also disagreed about whether or not clients' oppression could be determined by systemic injuries or inequities. Systems, in this context, signifies governmental or institutional policies about taxation, welfare and social services provision. Only a few of the participants who mentioned concrete conditions as determinative of oppression mentioned systems (n=2). One participant, describing a client whom she thought of as oppressed, noted the fixed nature of welfare income and the lack of resources for the poor and disabled. Another emphasized systemic inequities in her response.

> All, pretty much all of my clients are socio-economically disadvantaged. Oh my god, I was thinking again about the systemic inequities of the school system. . . . We just don't even have music. There's no music. We had it 5 years ago when I first started but now it's all been cut. . . . So they are at least now building us a new school facility which I guess is nice but I mean, it was supposed to be built about ten years ago. . . . But I guess I just - I get really fired up about it because it's really sucks. . . . [In my private practice I have a low-income client] who was shot last year and now she's partially paralyzed, and it's been an eye-opener to me about how the system, how difficult it is to navigate the system. . . . I think for wealthier people, the experience is very different . . . And I just see how hard it is to work, just for the bureaucracy, just to apply for social security and disability when she has a major, severe, obvious disability.

Another participant, though referencing economic disadvantages in explaining the nature of

oppression, explicitly did not include systemic inequities in her explanation.

> I don't know that I would call it an act of discrimination but I'm always watching to make sure their medical treatment is fair and informed. Sometimes a woman asks for a procedure like a tubal ligation and doesn't get it and it's really just cause of the system, it's not an act of discrimination . . . I should add one thing - many of the women speak only Spanish and - it really bothers me that the staff, many of them, don't make the effort to use the interpreter phone. So they speak to them very loudly and in very obnoxious ways, and I have yet to be able to influence that, but that's a way that I don't know that I would call it oppressed, but disadvantaged, by not having full access to information.

Discrimination as oppression. The words of this participant point towards the second theme in responses to this question: A reference to discrimination, or negative attitudes of others, as defining of oppression. Participants in this group (n=3) described oppression as an act performed by an oppressor, who's actions arose from prejudicial or negative thoughts about the oppressed person. The participant above, for example, went on to note that "there are acts of oppression," such as discriminating attitudes, or legislation leading to deportation. Another participant described racist and ageist oppression in terms of the attitudes of the oppressor:

> Pretty much all of my clients are some sort of racial minority group. So I definitely think that they, pretty much all face discrimination based on that. They all experience different forms of racism. And then as children - I mean, I think it's a little problematic characterizing children as an oppressed group. . . But at the same time, I get really angry when I see how kids voices are just totally discounted.

Both of these participants described discriminatory attitudes as partially constitutive of oppression, having listed concrete conditions as well. The third participant in this thematic group noted discrimination as the defining feature of oppression. She did not characterize women, people of color, or LGBTQ individuals as oppressed, but made an exception for one client. Though she mentions this client's poverty, she does so in order to outline the ways in which others perceive this client.

> There's another woman I see who I do really think is oppressed, who, if you saw her on the street - if I saw her on the street, I would think, "Bag lady," and, you know, have a lot of negative associations that go along with that. . . . I think a lot about her and how - what presentation she makes and how that puts people off and how hard that is. I mean, she's overweight, her hair's kind of stringy, she has a lot of medical problems and poverty, that really create a lot of obstacles in life for her.

Internalization. As a third theme, five participants referenced internalization of certain attitudes

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as a crucial factor in determining whether or not clients came from oppressed populations. For two of the

participants, internalization was a primary factor in her understanding of oppression:

> One of my missions with people is to help them with dealing with oppression, not to internalize that, you know, and to recognize that a lot of the negative feelings that they are having are the result of social problems and not to internalize that, you know, and see themselves as not worthy or less than or somehow not responsible - but to put it where it belongs.

> One of the questions that I use privately, I don't always share it with my clients - to me oppression is when you go to the back of the bus because you think that's where you belong. To me oppression is being flattered when a guy holds the door for you, not that he shouldn't, and sometimes even I am pleased because my arms are loaded or whatever. But helping clients to confront what they believe about themselves that's limiting.

> Others cited internalization as secondary to, or alongside, concrete material concerns. One

participant, who had noted role of class conditions as determinative of oppression, described GLBTQ

folks, people of color, and working class and poor folks as "having internalized certain ideas about

themselves . . . People internalize certain attitudes that are very much part of the culture, even for example

they are middle class, I think it's a way in which they [are oppressed by] a kind of objectification."

Another noted the impact on mental health of economic and systemic deprivation:

> A lot of people come to me with mental health concerns, probably 10% with bona fide mental health concerns. But then it's hard to tell - is it depression and anxiety from a lifetime of living in violence and very situational? Or is it organic, and they would've gotten it anyway?

Women – oppressed or no? A fourth theme arose around the issue of whether or not

participants categorized women as an oppressed population. A central question for the participants

pondering this issue was whether or not interpersonal or intimate violence was oppressive. For four

participants, the connection was clear. One participant, working on "gender violence", described women

as belonging to one of many "marginalized identities." Another noted domestic violence, which she

described as a concern mainly for women, as one of the factors playing into oppression. A third

participant, when asked to explain why she categorized some of her clients as belonging to oppressed

populations, stated. "Well, patently, women are." Finally, in the words of the fourth participant in this

thematic group, "Certainly, there are issues of oppression in personal relationships. Many of them have

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struggled with or been affected by verbal or physical or sexual abuse."

Two other participants, in contrast, though identifying some of their clients from oppressed populations, contradicted the views of the participants in the paragraph above. One noted that she only considered non-white, non-middle-class women to be oppressed. Another, though accepting the idea that women belonged to oppressed populations, rejected the link between interpersonal violence and trauma.

> I guess I don't think of them for the most part as [from oppressed populations]. Except that all of them have been women, they've all been trauma survivors. . . . I don't exactly characterize interpersonal violence as a category of oppression even though obviously it's a terrible thing.

Legacy. Most of the participants described oppression as the product of a number of these themes, some combination of material deprivation, discrimination, internalization of oppressive attitudes, and being subject to interpersonal violence. Only one participant integrated all of these factors, describing oppression with the word "legacy."

> From such an early age, there's all these, there's both family systems, there's family dynamics that are obviously impacted by racism and intergenerational trauma, and then there's what happens to these kids when the go out in the world and what they pick up in terms of how people deal with them because they're young black males, that creates this pathway from cradle to prison. . . . I mean, [with toddlers and pre-school age children I think it especially looks like aggression when you're predisposed – when, a, you don't have developmental information about the fact that it's, like, actually pretty normal for, like three year olds to have meltdowns and freak out and throw stuff, and b, when the cultural overlay is, um, black men are gonna grow up to be violent aggressors, and he's just startin' early, kinda thing . . . So that overlay, I just saw it again and again and again and again. . . . [And] aggression in early childhood is so often related to experiences of domestic violence that the family [has had]. Usually mom, usually because mom is the one presenting the concerns, but either parent has had, either in the context of intimate relationships, but I also think in the context of experiences with the police.

Clients are not oppressed. For the two participants who, at least initially, stated that they did not view any of their clients as part of an oppressed population, the desire to not categorize clients was a shared view. The following quote illustrates that theme:

> It's just not a category that comes to mind. I don't tend to think of my clients in any particular category. I mean, it's easy enough to say I see some gay people. But I don't even think of women as - I mean, I'm certainly aware of the issues that women face in their lives, but I don't tend to think of them as an oppressed group. I guess my focus sort of tends to always be on unique individuals.

As the second participant in this group stated, "I just think of it as, everybody comes in with the

facts of their life, and who they are in terms of gender, race and orientation is just one of the facts

of their life that I take into consideration, like a mental condition or a physical condition or

something else." The latter participant also rejected the word "oppression" as carrying with it

connotations that she did not want to reference: "It has this victim tinge that I feel uncomfortable

with - I'm more about empowerment than victimization."

Question Two: "What Theories Do You Use in Your Clinical Work?"

All participants were asked this question explicitly during the interview, as well as a number of

follow-up questions. In the case that participants identified specific theories, follow-up questions focused

on the particular ways in which participants incorporated those theories into their assessment model,

therapeutic style, or treatment goals. Participants who identified multiple theories were asked about the

basis for choosing between them in treatment. If participants did not specify a theory, follow-up

questions explored how participants defined the roles of the therapist, factors important to assessment,

and the success with their clients. The following section presents a distribution of theories that

participants identified, followed by thematic analysis of participants' answers across theoretical lines.

Theories. Though participants cited almost every major clinical theory in answering this

question, their answers, in terms of the particular theories identified, can be divided into two broad

groups. The majority of participants (n=7) identified themselves as, at least in part, psychodynamic in

orientation. Within this grouping, participants referenced Freudian, attachment, object-relations and

relational theory, as well as self-psychology. Three participants described themselves as, clinically

speaking, purely psychodynamic in outlook. Others referenced at least one additional theory that they

integrated into their practice. These included narrative theory (n=1), Gestalt (n=1), body-based practice

such as sensory motor or somatic psychotherapy (n=2), and cognitive-behavioral therapy (n=2). In

general, and in keeping with the major tenets of psychodynamic theory, all participants in this group

posited clients' intra-psychic dynamics as highly significant, and traced the development of those

dynamics to early experiences.

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The second group of participants (n=4) can be generally characterized as present-oriented. Most of these participants (n=3) described an eclectic approach. One cited DBT, CBT and feminist theory; another used feminist, empowerment and Frierean theory. The third cited CBT specifically - "though not in the methodological way it's presented in books, that's much too confining" - and described an emphasis on "reconciliation for alienated family members" that could be seen as a Bowenian version of family systems theory. The fourth participant in this group did not specify any particular theory, and her response could not be easily categorized. The excerpt below provides an overview of her response.

> I think it's about the relationship and what I do is really listen well. . . . I once read this rather nice description that said that therapy consists of listening to people and helping make sense of what they are feeling. So that's my primary orientation. . . . What I struggle with is between staying with the feelings and doing cognitive things, and making practical suggestions.

While these theories range widely in the prescribed modes of clinical assessment and intervention, all of the participants in this group described themselves as more focused on the present than the past. The past provided useful material for learning what intervention would be successful, or the necessary context in order to make behavioral or other interventions. The following quotes illustrate that emphasis.

> I'm focusing on the present, pretty much, as much as I can. I'll use the past pretty much to educate folks, you know, to understand why they do what they do, what's worked, what hasn't, and where we can go from there. I try my best to focus on how do we get through this moment, how do we get to an answer, and look forward to what we want to accomplish.

> There's lots of other things going on in the environment, but I have to zero in on, I'm here, let's tell me what's going on with you and see what I can do. And in a very short amount of time I'm able to find out about her life, whether she has support, what it is that is stressing her.

A third respondent stated, "I don't begin with a complete history, I sort of do that over time, as needed. . . . I don't feel like I need a whole lot of detail, but enough to kind of make enough of a picture for it to be useful. Finally, another respondent stated, "I see myself as pretty present-oriented, and I go back into the past to help me understand."

"Untying the knots". Despite the apparently ready grouping of responses into psychodynamic and present-focused orientations, a number of themes emerged across these lines. The first theme is

reflected in the words above that title this section, spoken by one of the present-oriented participants who fits into this thematic group. That participant spoke of her hope that her clients would, after therapy with her, "see more options - a lot of times the door seems closed and it turns out there's a way to go through another door." For her, the knots derived from "previous life experiences."

Altogether, five participants - two of the present-oriented participants, three of them psychodynamic - saw the goal of therapy as that of giving clients greater flexibility in their lives. In the words of one participant, she hoped to "unlock" clients emotionally; another spoke of alleviating client's "judgmentalism" and promoting a greater sense of permission about one's own actions. The two participants below continued with the idea of the participant quoted in the title of this section. These participants hoped to help clients find greater freedom by loosening the grip of the past upon the present. As one participant stated, "What I sort of identify as goals, is to have somebody have more freedom to make choices in their lives in the face of the present rather than the past." Another responded:

> I do think people get entrenched in ways of behaving and seeing the world that really cause them problems and pain. . . . My goal is to help people feel comfortable with themselves and be able to envision making changes, not only sort of internally but also in their lives.

Strengths-focus. More than half of participants (n=6) described their approach as emphasizing strengths and solutions rather than problems or pathologies. Three participants in this group were present-oriented in their approach. One described a strengths-focus as part and parcel of this focus on the present, "looking at building a life worth living, something she can build an identity out of, rather than all the things she lost." Another took an emphasis on strengths from empowerment and feminist theory:

> Or someone who says that she's not capable of doing something, I might refer to something she's already accomplished, and how it took courage or whatever to accomplish whatever she's done, and might she use the same strengths to do this other thing. And that kind of questions women look up and smile, because women are taught to undervalue their abilities . . . Whatever internalized oppressions I see they have, I'm trying to contradict it, and remind her of her strengths.

Three of the participants in this thematic group were psychodynamic in orientation. One

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described her strengths-focus in attachment terms, as looking for the "angels in the nursery," or endogenous positive associations and memories that could grow new relationships. Another drew upon somatic therapy, describing a process of "resourcing, helping people connect with really positive internal experiences . . . that should be a foundation to address some of the more difficult stuff."

Finally, one present-oriented and one psychodynamic therapist each described their strengths-focus as a counterbalance to the tendency of traditional psychotherapists to pathologize clients.

> The kinds of theorists I've liked and been attracted to are ones who are really well aware of that, and who write and speak about their work with a kind of humility and a kind of respect for human capacities for growth, as opposed to pathologizing people.

> I'm not really interested in thinking about things so much in terms of pathologies, but trying to understand the way in which people's reactions to things and thinking about things and relationships with people are, you know, an attempt to . . . have a sense of self in the setting of a culture which I think makes that impossible.

Client as equal. The third theme across the two groups of participants was that of a non-hierarchical client-therapist relationship (n=5). Not all participants who described a strengths-orientation also described a non-hierarchical relationship with their clients. This group was more heavily weighted with present-oriented participants (n=3). The three participants from the present-oriented group described their non-hierarchical relationships in less limited terms. One participant rejected even the hierarchy assumed in a student-teacher relationship, stating, "I would like to see myself as a partner, someone that doesn't stand over people. When I teach I talk about the distinction between being an advocate and being an ally, so I try to be more of the latter."

The other two participants described their relationships with their clients as almost a reversal of hierarchy. They used terms like "expert" and "boss" to describe their clients' role as having not equal but rather more power in the therapist-client relationship.
As one participant stated, "I go in with the assumption that she's the expert on her life, and she's probably survived a number of things, and probably has the capacity to continue to improve her life." Another stated,

I might say something about "You're gonna be the boss" or "I want your feedback about what's helpful, what isn't, we're doing this together" . . . to make them feel that we're, you know, that they are in charge, that they can trust me, that I have their best interests at heart, and that I'm not someone who has all the answers, or a prescription.

The two psychodynamically oriented participants who did fall into this thematic gave only circumscribed credence to the idea of the client as expert. As one reported, "I'm interested in ideas of transference and counter transference, but relational people sort of think of things in terms of what both people are bringing into the room. Not to say that both people have an equal responsibility for what's being brought into the room." The participant in the above quote describes a relationship of equality, in that transference and counter-transference are weighted similarly, producing a joint product. However, the therapist continues to play a more authoritative role in having greater responsibility for understanding and working with the transference. This participant described her psychoanalytic tendencies as counterbalanced, but not eliminated, by a Gestalt perspective that is less "imperialistic." She stated, "On the one side [Gestalt] there's this rigorous discipline against assuming anything, and not being sort of psychiatrically imperialistic. On the other side is a psychodynamic approach, where we have a *whole* lot of assumptions, in fact convictions . . . So it's this fabulous dialectic."

The more-hierarchical nature of the psychodynamic therapist's relationship with clients was echoed in another participant's response to this question. This participant's response did not fall into the thematic category of "client as equal." Instead, she offered a near-refutation of the idea.

I kind of get uncomfortable when I hear about more touchy-feely kinds of therapies, or people kind of love their therapist, or boundaries are fuzzy. I think for really powerful, intense work, really clear boundaries are important, so that people know that - if they know the fifty minutes is respected, then they can let out as much intensity and affect as they need to . . . They know I'm going to maintain that boundary. I think they may resent it sometimes and be angry about it, but that's okay, that's part of the concept.

Thinking socio-culturally. A majority of participant's responses (n=8) fell into the fourth theme, which was that of thinking socio-culturally, as well as intra-psychically and in terms of family, when assessing and treating clients. Participants in this thematic group considered variables such as race, national origin, language, class or interactions with social systems - or some combination of the above -

as central to their understandings of their clients. Five psychodynamically oriented therapists and three present-oriented therapists fell into this thematic category.

For two of the present-oriented participants who fit into this theme, socio-cultural factors were another piece of information to gather. They weighted these factors equally, and alongside, factors such as history of family of origin, history of substance abuse, and intra-psychic issues. For example, one respondent reported, "I always want to, you know, get a sense of . . . Relationships with parents, family dynamics, socio-economic situation, um, of the family, and the culture." Another stated, "Generally I think systematically, I think of where they've been and what they've been through, whether that's welfare or the patient system or a horrible trauma history or growing up in foster care."

The third present-oriented participant used her understanding not only as a factor alongside other factors in assessment. She also used an assessment of political, economic and other factors as a way to understand familial and internal dynamics. In using the word "superficial" to describe a non-socio-culturally informed intervention, this participant notes that for her, socio-cultural factors were the critical piece to microcosmic success.

> I'm usually thinking about the political, economic, social context that she comes from, and when it's appropriate, I will mention, I will validate that, as part of explaining to her what I suggest. In other words, with someone who has been in a relationship where there's been violence and it's a person from El Salvador and Guatemala . . . . Historically the women have received the aggression based on the men, the men's painful experience, so I will ask her where she came from and whether they were a part of that, how she was impacted by that part of the war experience. . . . Otherwise I could do a more superficial job, but it may not - it may not have much of an effect on her life.

For two psychodynamic participants, assessing socio-cultural factors were critical to understand the client's ways of making meaning. One psychodynamic therapist described cultural factors as important determinants in the nature of her relationship with clients, one piece of being accurately attuned. She asserted, "But you know - issues of culture are measured in terms of the group's beliefs about time, space, nature and authority. And so you have to be sensitive to what people's expectations of authority are." Another found it important to explore

how the client made sense of his or her own socio-cultural, economic and racial position.

Additionally, she saw this meaning-making system as one of the significant factors in

understanding clients' families of origin. She stated, "I look very much at, maybe more than

other people, you know, to understand how they understand their class situation, what, um, what

questions of race and sexuality and all of those things, and how they were sort of understood and

dealt with in their family of origin."

The final two participants in this thematic group combined the approaches of those above. In

other words, they assessed the meaning-making a client and client's family had to understand how socio-

cultural factors influenced relationship dynamics internally and within relationships. These participants

wove their understandings of the impacts of racism, classism and other forms of oppression into their

understanding of dynamics particular to specific individuals and families.

> What she's dealing with is her loss of status as a potentially straight person, by choosing to marry a woman instead of a man, experiencing a loss of status in her family of origin. She's experiencing rejection and discomfort from her parents . . . dealing with going from the dominant identity to a targeted identity. But her mother is white and you know married an African-American man and was basically disowned by her family as a result of it. And her mother is really much less empathetic towards my client than her father is. . . . We talk a lot about what's motivating her mother's behavior, and what if anything my client can do to cope with it or to help her mother move in a better direction. And I do think a lot of it has to do with maybe that her mother values men more than women.

The second participant stated the following.

> So I was aware I wasn't going to use a white standard, a European Western standard around what was appropriate, and diagnose someone or talk to someone about someone being enmeshed with their family . . . I didn't think about [a female client] just as a woman, I thought about . . .how her ethnicity impacted the meaning making she may have. Did she have a word in her language that she could use to describe what was happening to her? Was there ways in which economics played a part in someone deciding to stay with the perpetrator of violence?

As noted above, this group was more weighted with psychodynamically oriented participants than

present-oriented participants. Several of the psychodynamic participants noted, in their responses to the

question, the tendency for many to view psychodynamic theory as Western-centric. These two

participants defended the application of psychodynamic theory to clients from a wide variety of socio-

cultural circumstances. For one, the malleability of psychodynamic theory was obvious.

> And people say, oh that's inimical [to use psychodynamic theory], how could you - but no, I believe that people in every culture have basically similar defense mechanisms. There are different, different cultures emphasize different things, some are more repressive, some are more hysteroid, some are more, you know. But I think the fundamental structures of psychodynamic work, understanding how defenses work, understanding projection, understanding issues of identity.

The other described psychodynamic theory as limited, but nonetheless useful. Like the participant above, this participant valued psychodynamic theory for the insights it offered into clients' internal worlds.

> I'm not one of those folks who are like, "Oh, like, psychodynamic theory doesn't work." In terms of like, thinking about their inner world, thinking about their early experiences, making sense, helping them make sense of, um, their past experiences, thinking about transference, counter transference - I feel like those concepts are really useful. Thinking about what defenses they used in my work. It was really like pulling out particular things. . . . I think people can throw the baby out with the bathwater.

> **Progressive politics**. Closely connected to this theme of looking at socio-cultural factors,

slightly more than half of participants (n=6) cited their progressive politics as integral to their theoretical

orientation in clinical settings. This theme could be seen as connected to the theme of assessing clients

from a socio-cultural lens, as six of those in the previous thematic category appeared in this one. This

group was also largely psychodynamic; only two participants in this category were present-oriented.

Some participants in this group cited their connection to particular progressive theoretical and

social movements. One present oriented participant described her clinical approach as "feminist."

Another, a psychodynamically oriented clinician, listed a number of theories, including feminism, as a

part of her clinical style.

> [The theory] I felt most comfortable with . . . was self-psychology. But then other theories, like, um, feminist theory is so broad - but I feel like you can't do gender violence work without thinking about various feminist theories. Particularly under that, women of color feminism . . . The idea of intersectionality . . . Postmodern theory, critical race theory, Paolo Friere . . .

For one present-oriented participant, anti-racism work was a critical piece of her clinical theoretical

perspective.

> I realized that part of my effectiveness is that I've done my own unlearning racism work, and I have had to work on my own attitudes about, say, women giving birth after using drugs for nine

months, you know, any judgments that might come up . . . I've worked - particularly on the race part - I've worked on my own attitudes. . . . I had to get over my fear of being wrong, or coming from liberal guilt, or other aspects of liberalism have always been a challenge.

Several of the psychodynamic participants in this category described their progressive political orientation as part of an alteration or modification of traditional psychodynamic theory. For two participants, progressivism was an aside or boundary on the role of theory in their clinical work. One participant contrasted theoretical with worldly awareness, stating, "I think I was partly drawn to [relational theory] because they were very influenced by feminism . . . They take theory very seriously but also see theory as very much related to what's going on in the world." Another contrasted her political and clinical orientation, stating, "My basic roots are psychodynamic, so I have - it's kind of like, for the purposes of your investigation, a sandwich of psychodynamic understanding with a progressive political orientation." Another participant noted the difficulty - or at least rarity - of aligning an activist or leftist perspective with a psychodynamic one.

> But I must say, clinically that really is the strongest way in which I think about people, is psychodynamically. I also do think about them from the perspective of social issues. I would say . . . Politically, most of my colleagues do not come from where I come from, were not activists, do not have the same politics or the same political background as I do.

One participant not in this thematic group, in her response to this question, appeared to reject the notion of incorporating a political progressive bent into her clinical orientation. Though she also spoke of her anti-racism work in her response to the question about clinical theories, this participant viewed leftist politics *per se* as something to be treated gingerly.

> In terms of political theories, you know, I think there's a part of me that still resists being completely, totally, left-wing liberal. I'm afraid of anarchy. . . . Well, you know, do I think capitalism hurts people? Yeah, I do. But I grew up very well-off and I think there's a part of me that feels like it's still kind of working for me . . . I've realized that my political identities have a big effect on my life experience and in therapy, I really try to work with those to help people have a healthier relationship to whatever their political identities are.

Going with the gut. The themes listed above create a complex web of considerations participants appear to be weighing in constructing their clinical orientation. However, more than half of participants reported making many of their clinical decisions based on instinct. All present-oriented

participants fit into this group, but even two psychodynamically oriented participants who easily named their theoretical lenses were. The following quotes reflect the theme of using one's gut, instincts or intuition to generate a clinical approach with different clients. One participant stated, "I just kind of go with my gut, just what people need, not a formula." Another reported, "I don't consciously draw on theories . . . I'm drawing on instincts I have." According to a third, "Once you start, you can't be like, 'Well, now I'm using object relations' . . . When you do it, it's kinda messy." Finally, a fourth respondent stated, "It leaps out at you when you're sitting with a person. Something comes up inside of you, either feelings or very strong thoughts or insights - I don't know."

Conclusion. In responding to questioning about their theoretical clinical orientation, participants could be divided into two groups. One, the larger, consisted of at least partially psychodynamically oriented clinicians. The other contained clinicians who did not describe themselves as psychodynamic but rather as present-oriented. Though a number of themes overlapped across the two groups, there were some differences in distribution, as noted below.

Of the psychodynamically inclined participants, a majority considered socio-cultural factors as crucial to assessment. Slightly more than half held a politically progressive standpoint as a part of their clinical perspective. Slightly less than half could be categorized as strengths-based, or as focused on "unlocking" clients or releasing emotional constriction. Only a small number of them - two out of seven - described a non-hierarchical relationship with clients as part of their approach. A similarly small number described "instinct" or "gut" feelings as a tool for making clinical decisions.

The majority of present-oriented therapists were strengths-oriented, sought a non-hierarchical relationship with their clients, and saw socio-cultural factors as critical in their assessments and interventions. Half of them cited political progressivism as part of their clinical orientation. All of them described "gut" feeling or "instinct" as a basis for clinical decision making.

Question Three: "In What Ways Does Your Clinical Work Move Your Clients Towards Greater Control Over the External, Social Circumstances of Their Lives?"

This question was intended to explore the ways in which participants saw clients' possessing greater agency in the external world, particularly in terms of political and social position, as an outcome of therapy. It also concerned the extent to which participants saw consciousness raising as a goal of therapy. Follow-up questions included: In what ways do you see your clinical work as helping clients to understand the impact of policies or social forces on their lives? In what ways do you move your clients towards greater political or social consciousness? Do you see your clients becoming more empowered during the course of your work with them? Why or why not? Attention was paid in phrasing these questions to participants' answers to prior questions about the nature of oppression and their theoretical approach. For example, a participant who identified object relations as her orientation, and racism as a major force of oppression in clients' lives, might be asked: In what ways does object-relations theory help you move clients towards combating the role of racism in their lives?

Connecting clients to the community. More than half of participants (n=7) saw their therapy as focused on connecting clients with their community. One participant noted the problem of families being "isolated," and identified one of her main roles as "helping families to build more of a net around themselves so that when things get funky or they need help they have a few more places to go." This participant ran groups, accompanied parents to schools, identified meaningful social contacts, and provided education on social safety nets such as TANF. Another participant stated that, "I'm always on the lookout for an instance where I feel that getting involved with some larger group that's working on some issue would contribute to my general goal of making them feel more empowered." Another participant focused on social support even when conducting one-stop, brief interventions with clients, suggesting the power of her focus on connecting clients to community.

> I'm always trying to reduce isolation . . . The more she's involved with her community the better. And we have parenting centers in different cities, and I'm always recommending that people go to those centers . . . Because I start from the assumption that when she goes, and sees other

opportunities, she meets people, she'll find other things - someone who knows English so she can learn it and look for a job - whatever it is. The informal networking that women do.

Several others encouraged clients to connect with those of similar backgrounds or political views as a means of alleviating distress. One participant, in reference to working with LGBTQ clients, described the frustrations facing these clients on a social and structural level. She recommended to these clients that they "find other people dealing with the same problem, to affiliate, to develop support networks, or to read other people's stories of how they worked through some of the struggles." Another recommended to women recovering from gender violence that they try "meeting other folks - even sometimes I think that being a part of a group, being part of a gender violence group is a political act." One participant questioned the individualistic focus of some therapists when working with clients with disabilities. This participant saw group connection as a way to counter the pervasive and oppressive nature of disability phobia.

> One of my questions was, 'Did you ever talk with the client, does your client know anybody else with a disability?' Because the mainstream approach to disability is that it's your private, tragic predicament. The fact that it's defined culturally, that it may not, that your life may not be tragic at all, it's not up to anyone else to ascribe tragedy to you.

Finally, some participants encouraged explicitly political or social actions. One participant who worked in hospital-based mental health reported that whenever possible, she offered clients the opportunity to serve on the patient advisory panel at the hospital. She stated, "I guess for some of them it's given them a sense of power, or at least that they are being heard." This participant also invited clients to participate in anti-poverty speak-outs that she had helped to organize around the city. Another connected clients with other individuals with connections to various political activities or demonstrations.

> I would say, "There's this thing going on, maybe you should be a part of it.". . . . I connected them to resources, but I didn't say, "Come with me to this rally." I didn't do that in that context. But I might connect them with someone else that could take them.

One participant countered this theme. When asked about helping clients think about the role of poverty in their lives, she stated, "Actually what I think about more is the social safety network and the role that plays in people's lives and how some people do become dependent on it - it sort of saps their will

to do anything." Though at another point in the interview, this participant had identified expanding social networks as a goal of therapy, here she describes public social supports as a locus of *weakness* for clients, rather than empowerment as did the other participants in this thematic group.

Teaching skills. Some participants (n=4) reported that they used therapy as an opportunity to teach skills for political and social advocacy. These participants did not do this as a matter of course, but rather selectively, with specific individuals or categories of clients. For example, two participants taught advocacy skills to children in order to help them in school settings, and in general as people who experienced oppression. One participant, who at another point in the interview identified children as part of an oppressed group, stated that "The times when I feel most like [therapy is] helping people to be more empowered and have more control are the times when I can help kids advocate for themselves." For one participant, teaching children advocacy skills was one way to counteract the racism that children of color encounter in the school system.

> Thinking about kids as people who need to be both advocated for and develop, be beginning to develop their own advocacy skills . . . In my mind it starts so, so, so terrifyingly early . . . These tiny little peanuts, they can begin to be seen by the school and by their families as really being that bad. And that's so loaded with all this cultural stuff.

The two other participants in this group described ways in which they would help specific clients advocate for themselves within the political system or the community. However, they described doing so on a limited basis, rather than as a rule. One noted that "selectively, I might suggest" actions such as "contacting the board in their city that had to do with housing." One participant noted that before any reference to advocacy, "I'm constantly sort of scanning and screening in my head about what the transference issues, implications are." If the participant felt it would be helpful, she said, she would point the way to courses of action.

> If they're talking about crack dealers in the apartment upstairs, and if they're afraid people are going to be shooting at their apartment . . . and they have children, I might say, "Do you know your city councilor?" Or, "Do you think other people in the neighborhood are concerned?" And in that subtle way, that's kind of raising the view of the client from just, "I'm scared and there's nothing I can do about these crack dealers in my house," and raising their sites to the horizon a little more.

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Both of these participants used words such as "subtle" or "suggest" to describe these interventions, highlighting the tentativeness with which they would approach them.

   Talking about oppression. About half of participants (n=6) specifically mentioned talking about oppression and social conditions as a component of their work. For these participants, such conversations were an important part of addressing clients' issues, as well as a means of empowering clients. In one participant's words, working effectively meant "validating her [the client's] experience, putting it in a social, economic, political context with her, and letting her know that there are things she can do to make it better, so it's holding out that hope." One used conversations about oppression when working with African-American boys referred for "aggression" to help families respond more moderately and effectively: "I would explicitly talk about, you know, 'I'm wondering, I'm thinking about, his race, his skin color - and how that all fits.'" One participant incorporated consciousness-raising into group work.

> We talked about issues of community violence, issues of racism and discrimination, like police brutality, and how these things affect and contribute to community violence. It was nice because it helped the kids to look at, what was individual factors that contribute to violence, what are family factors, what are community factors. And then what are individual solutions, what are family solutions, what are community solutions. Trying to have it not be all about like, well, I'm going to try not to get in fights. That's important too, but you have to acknowledge that it's about more than that.

One participant described talking about oppression as not only helpful, but - with some clients - necessary.

> I do see myself as maybe having some kind of impact, just in the conversations we can have. Being able to talk to people about oppression, and really listening to what they have to say. . . . I got a guy who was shot in the ear, and everyone assumes it was gang violence, but it's really just that he was getting groceries in the wrong part of town and got caught in a shootout. But he's a big African-American guy, so when he goes to the hospital to get treatment, everyone assumes he's a thug, even though he's really this sweet guy. So *I have to* talk to him about what that looks like. *[Emphasis added.]*

Two participants in this group described conversations about oppression as an important part of building a therapeutic alliance. Another one described "a sense of respect . . . Legitimation and a certain kind of recognition" as empowering qualities of the therapeutic relationship. In describing how she

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conveyed these qualities, this participant stated, "when I think people are being exploited, I try to support

their own sense of being exploited and say, yes, I think there are conditions that are exploitative that you

are up against." One participant related a story of one client with whom, because of the client's family

history of racist oppression, she felt it was important to take time to talk about racism and its impacts.

She stated, "With African-American clients, I will explore with them and convey, in some way, my views

. . . [that] throughout their lives they are constantly encountering a society that is racially biased."

One participant, who did not fall into this group, gave a response that appeared to counter this

theme. This participant described a client in whose treatment she noted some issues of oppression. She

described a client who had been left without money or property after the death of a long-term male

partner with whom she had not been married. She noted the role that social factors had played in this

situation, stating, "I really am struck by the difference between women who have a husband and security

based on that, and women who don't . . . Back to Jane Austen and the status that accrues from being a

married woman." Yet when asked whether she connected this social factor to her client's situation, and

how she addressed the issue with her client, this participant responded: "I think it was bad luck."

Mental health is the first step. Slightly less than half of participants (n=3) noted that through

improvement in their mental health needs, clients became more equipped to take their environment. In

the words of one participant:

> If I have someone coming to me for anxiety, and to reduce their reactivity we work on different
> skills at communication - and they improve that, and they get better at dealing with people, will
> they get better at fighting the system elsewhere? Sure.

Participants also pointed out that the aftereffects of untreated trauma left clients ill-equipped to engage in

political or social action. Another participant noted taking care of personal mental health needs was a

central concern for raising political consciousness and empowerment:

> I know there's a theory that we sort of let enough steam off, like that we being social workers are
> a buffer zone where we let enough of people's steam that work with us that the pressure doesn't
> build up to revolution. But I have to say that, at least in the case of people that have been through
> a lot of trauma, I don't feel like trauma necessarily leads people to become activists. . . . [Effects
> of trauma] lead people to drug addiction, and they lead people to, you know, things that are

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injuring themselves or others, they lead to community violence, which leads to more community violence. My experience is that for most people who've experienced trauma, that takes up all their energy.

One participant went further, arguing that unmet internal needs formed part of the basis for oppressive social changes. She stated that, "[There] are very important external things that need to happen . . . But I think that [internal change] has a big impact; when enough people have made those internal changes, external changes will happen."

Consciousness-raising and political action lead to mental health. For most of the participants (n=8), either raising a client's political or social consciousness, or connecting the client to the community, were one means of achieving the overall therapeutic aim of improved mental health. One described coaching clients in advocacy or connecting them with groups as part of the "general goal of making them feel empowered." Another saw these opportunities as helpful to clients for the following reasons:

> I guess for some of them it's given them a sense of power, or at least that they are being heard. . . . Also a sense that they are being helpful . . . Speaking out for the masses. A few patients it's given them a sense of structure.

One participant described going to a rally, donating to a political cause, or joining a political action group as "a form of self-care."

For one participant in particular, connecting clients with the community was a natural outgrowth of her therapeutic approach. This participant worked in an attachment framework, doing dyadic interventions between parents and children.

> So if you think about ambivalent, like an ambivalent attachment style, like sort of being unsure whether you can or cannot reliably get what you need from their caregiver. I think most of these families would be pretty ambivalent about whether they can or cannot get what they need from their communities. . . . In that sense part of the intervention of connecting them is repairing . . . Assisting in a process where their external supports can come to be seen as less threatening and more supportive. Which is exactly attachment, right?

An important subset within this thematic group was those participants who saw consciousness-raising as important to counteract harmful internalized beliefs that clients had developed in response to negative cultural ideas. One participant noted that "I'm trying to contradict" internalized oppression in

order to "remind her of her strengths." Another described helping people to resist being "locked into ways of thinking and reacting," connected at least in part to the "thingification" that occurred in capitalism and what she presented as other oppressive social structures. A third stated that "I'm trying to give greater context to something they're upset about where, again, people so often, there's so much . . . self-blame, narrow vision." Still another stated that "I really wanted to take it outside themselves, so folks who are depressed because they can't find a job . . . You have to remind them about the community they live in, lack of resources, the economy." Another used a group on violence to talk with children about the reasons for violent behavior, and acknowledge the limits of individual interventions in violence.

Another participant saw countering internalizations as her main strategy for helping clients to gain greater control over external circumstances of their lives. This participant had noted internalization as the mechanism through which oppression occurs.

> It's really moving them toward recognizing their actions and their role in the world. I must say, a couple of times a week . . . "People don't come to therapy," I will say to the client, "Because of what someone else is doing. People end up here because *you're* unsatisfied with your own operations. So let's look at the operations that you might think are limiting you. . . . One of the questions I use privately - I don't always share it with my clients - to me oppression is when you go to the back of the bus because you think that's where you belong . . . But helping clients to confront what they believe about themselves that's limiting, is I think the core.

All of the above participants saw critical consciousness raising or connecting clients to community as an important aspect of their therapeutic work. For one participant not in this group, however, looking externally meant a departure from the main goals of therapy. This participant stated that "There are times when I might point out that something might not necessarily come from them but might come out of a social situation." She stated, however, that "I tread that path lightly."

> I feel like to the extent that someone is coping, like if somebody is coming to therapy just to improve their coping ability, I would be more likely to help them see the cultural, and social and economic forces. Versus somebody who's really coming, and willing and able to do the deeper work, I'm probably less likely to bring that up.

This participant viewed an external focus as outside of the main emphasis of therapy.

Empowerment as sustenance. Three participants described their desire for clients' political

consciousness or empowerment as a personal hope or source of gratification - a sort of professional sustenance. Their responses indicated that they saw this desire as one distinct from the therapeutic needs or wants of the client. One participant described a story of a young man who began interrogating his white privilege. She reported, "So I kept the focus on him, but I have to confess, I was incredibly pleased to see somebody, it's like a window was thrown open and suddenly the daylight could come in." Another participant described her feelings of satisfaction at seeing a client become more energized to do activism.

> You know, I had a really, really cool experience a client in my private practice who I had just terminated with recently, and she told me in our last session that she felt like the work we had done together had really freed up a lot of her energy, and she was feeling a lot more draw to get really engaged around social issues. . . . So it was really powerful to hear that because our work, because she wasn't then so caught up in having to deal with this internal stuff, that she then had some energy to put into activism.

For the third participant in this thematic group, having a client who would be willing to engage in activism was in the realm of a hopeful fantasy. She said, "It would be a very satisfying case if I got somebody, perhaps young and with energy and bright, it would be, it would be a satisfying case if I could really turn somebody into an activist."

Caution. For all of the above examples of enthusiasm about moving clients towards greater consciousness and control of their external world, caution was a major theme in participants' responses (n=9). As discussed in sections above, participants would use words such as "selectively," "subtle," or "suggest" to describe the ways in which they would point clients towards empowerment or increased consciousness.

Two participants saw clients as unable to necessarily engage in this sort of empowerment work because of immediate survival needs. One participant stated, regarding consciousness-raising, "I would not get to that part of the treatment until very far into treatment with the family, their basic needs - until they had stabilized."

> I can't go too far because there are lots of beliefs he has that are sort of protective factors for me. . . . Like he wants to believe that the government really wants to protect people. And he lives in a neighborhood where there are shootings every week - he needs to believe that people are doing this to themselves because of drugs, and the cops are doing the best they can, and if people would

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just listen, things would be better. And I'm like, um, who brought the drugs to the neighborhood, who brought the gun, you see what the cops are doing. But I can't say too much. It rocks his world too much.

For this participant, as well as for others, the issue of helping clients primarily with survival connected with a concern about clients' potential for efficacy or energy. This participant stated, "I don't know if anything comes of it. I feel like I'm planting seeds to get them to look at things differently. . . . but I hesitate to get too political with folks." Another stated, "I have to restrain myself from getting too eager . . . I'm sort of realistically aware that for them to write a letter to an elected official would be a big deal."

Other participants hesitated to turn the conversation political for fear of depriving the client of the ability to guide the treatment. One participant, having described some ways she might suggest for clients to become more empowered, stated:

> Then it's up to them. Pathways to healing are so very personal, I can't even know if it's - they are still the expert, and they have to choose what's best for them . . . Even if they're choosing to be disempowered in certain ways it's because there's still more work to do.

Another participant, when asked about political consciousness-raising, stated, "I'm worried about that because I think in a sense that can be imposing my agenda." Another, when asked about guiding clients towards greater external control, stated, "I think it depended on what people wanted." A fourth participant noted that she hesitated to bring up topics that the clients' themselves did not explicitly bring up. She stated, "If they come to me and they're really struggling with certain portions of their lives, I follow their lead."

Limits. Finally, about half of participants (n=6) noted the limits of the therapeutic setting - in terms of either agency or theory - as something that limited their ability to help clients reach empowerment. One participant commented on the limitations of individual clinical work as a whole. Though she had described a number of efforts she made in clinical settings to empower or raise the consciousness of clients, she distinguished this work from her role as a clinician: "Do I see social work as actually helping people through clinical practice, no. . . . I don't really see [the work I do around oppression] as part of therapy." Another participant echoed her words with the following description of

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the limits of therapy. In response to the question of how her work helped clients achieve greater control

over social factors in their lives, she stated:

> I don't ever feel like my work is ever counter to the goal of helping them to feel more
> empowered, but there's times when it feels like the focus on the individual is potentially counter-
> productive to some of the social needs. . . . I try to bring that [analysis of social factors] in, but
> you can only do that so much within the context of individual therapy.

One participant described limits in terms of her personal style and theoretical orientation. She

stated, in response to the original question of this section, "I don't think so. . . . The psychodynamic,

psychoanalytic perspective is so much of what I bring to the day-to-day work with people . . . I can just go

with the individual."

Setting was also important to some participants. One participant stated:

> [My old job] did a better job of coaching clinicians to think and talk about race and issues of
> oppression than the health center that I'm at now does. And I think that impacts - it shouldn't but
> it does impact my strategies for addressing it with families.

 Another noted the ways in which the private practice setting limited her potential for taking certain

empowerment actions. She noted that were she in an agency doing "broad-based" community social

work, "I'd probably talk about, and among other things be talking about getting people registered [to

vote], but I haven't done a lot of that work and I haven't been doing that kind of thinking." A third

participant described the potential limitations of therapeutic settings in the context of talking about the

benefits of her own clinical context: "This one building was the community center conglomerate. I don't

know if that would happen in a counseling center. I think it's easier to do activism and be political when

you're a part of these political organizations."

Conclusion. This section presented an analysis of themes in participants' responses to questions

about the role of empowerment and consciousness-raising practices in their therapeutic work. As the

discussion above indicates, participants described connecting clients with their communities, teaching

skills for advocacy or activism, and talking about oppression as their major strategies. They noted the

relationship between empowerment and consciousness raising and mental health, both by presenting

mental health as a cause of empowerment and the reverse. Some participants also related empowerment and consciousness-raising to their own professional satisfaction. However, a significant number of participants described a sense of caution about turning conversations in therapy to political or social considerations. As the final theme indicates, some participants also responded to this question with a discussion of the limits of therapy. The following section explores these limits more fully.

Question Four: "In What Way Does Your Approach in Clinical Work Limit Your Ability to Help Clients Gain Control of the External Conditions of Their Lives?"

All participants were asked this question, with attention to a variety of factors. If participants had identified a particular theory, treatment modality, or goals that guided their clinical work, this question was re-worded to include reference to those particularities. If participants had identified particular areas of focus in the external conditions of clients lives – economic deprivation, for example, or discriminatory attitudes towards people with visible physical disabilities – the question was also re-worded to reflect those as well. Thus, for example, a participant who had identified herself as working from an attachment oriented perspective and who had talked about the impact of various forms of oppression on family functioning was asked: "Do you ever notice a social or political factor that has an intense impact on the family you are working with, and realize that you cannot address this using an attachment perspective?" Follow-up questions explored areas not addressed by participants' original answers. Participants' responses yielded a number of themes.

Individual focus. More than half of participants (n=7) described an individual focus in their work that detracted from addressing external, political or social conditions in clients' lives. In the words of one participant, "They get a professional focused on their own growth and development and whatever. But, so that, the role, you know, limits me." Another noted that while teaching skills of political activism might in fact be helpful, "it doesn't mesh with treatment, like the goals of employment, or losing sleep, or not being active with the baby's father."

While these participants took the individual focus as simply a definitional limit of their role as

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therapists, two others described the focus as an aspect of therapy that they actively resisted. One

participant noted the split between individual and community as a failure of the community as a whole.

This participant first noted that "there's a lot of pathologizing that happens" in the traditional,

psychodynamic individual orientation. She then stated:

> I guess I've recently just been feeling very strongly that the community healing element is really left out of our training. I say our training but really our understanding. In the field. And I know that for example, like we were taught some, in my program we had a class on advocacy . . . I just don't feel like it was really integrated into clinical work. It felt like this separate thing, and it always felt like, well, if I were a community organizer I would do this, but I'm not so I won't. And now I'm wondering if that split between individual and community is part of a larger social split, this lack of connection, but that's more philosophical.

For this participant, the lack of attention to community problems in the lives of clients meant a relative

inability to act in clients' best interests, i.e., through organizing. Another participant noted that focusing

on the individual failed to address social conditions that perpetuate individual problems.

> Again the same truck driver comes to mind who really was incredibly sensitive guy . . . Helping him value something that in his family of origin he was really treated terribly because of his sensitivity, and deep feelings, and interest . . . what's hard is I think you can as a therapist work with someone and have your own, you know, have this perspective that I have be a part of what forms our interactions, and then, he went back into this really macho world every day. . . . I really do believe conditions in the world need to change for people - for these parts of people to be supported.

Another two participants described tactics they used to actively resist the individualized

parameters of the therapy setting. One stated that she worked to connect clients to the community: "I

wasn't like, let's just sit here, and talk about your relationship with your mom. That's just not who I am."

Another described encouraging clients to partner with others to solve problems such as unsafe housing

conditions. She stated, "[I work on] raising their sights to the horizon a little more and realizing that

they're in a community, they're not alone . . . I do frequently end up saying to people, 'Well that's part of

our species, is we solve things in groups.'" This participant was highly critical of approaches to

oppressed populations that treated oppressed clients as troubled individuals.

> It was very - the fact that the therapist conducted this analysis and this therapy without ever, without knowing enough to confront the client's disability self-hatred and the client's internalized oppression, without thinking of saying, "This is part of the human experience, there are other

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people like you around, have you ever seen a movie with a disabled person, have you ever" . . . It was all done in a hyper-individualistic fashion . . . her inability to recognize that this case was occurring in a context, and I'll pick my words carefully - supremely crippled that case.

Two participants did not describe the individual focus of therapy as a limit *per se.* However, in their response to this question, both gave examples of an individualized orientation as something that they sought. These participants also contrasted the individual goals with the goals of addressing external or environmental conditions.

I see people who have been very limited by their psychological issues . . . maybe has something to do with social issues, but very much the ways in which they grow up.   But I guess what I don't think about so much is the ways in which their parents were influenced.

Another described a failure of medical care faced by one of her poor clients.

You have to wonder at a certain point, do really all of these bad things happen all the time, to this woman, or does she somehow present herself to the world in a way that invites it, I don't know. I'd certainly have to look at both sides.

This participant then went on to describe an example of an inter-racial marriage in a way that favored consideration of individual concerns over examination of social issues at stake.

And it was very she's married to a Jewish man, her husband's culture is very similar to mine. But we talked a lot about the differences in the cultures and their families, and how that affects their marriage - there were a lot of marital issues. It was a great case. And she - well, this is not about a social factor I guess - she'd been significantly abused by her mother and had never dealt with it . . . Race was just one of the factors that um, affects her, I mean not only was she married to a Jewish man but a Jewish man who was kind academic, his family was academic royalty. And all the - I mean she could have been white and that would have been an issue in his family and how she was treated in their circle.

Though she acknowledges the role of racism, she ultimately names the focus of her work as her client's family and early history.

Theory – rigidly applied. More than half of participants (n=7) described their clinical theoretical orientation as itself limiting. All of those in this group belonged to the group of psychodynamically oriented therapists identified in the subsection of findings on the second question of the interview. Thus, all of those in this group described limitations with traditional psychoanalytic theory. One participant critiqued psychoanalytic theory, describing it as unable to account for social or political factors.

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I suppose if I was hard core, and there are few people around now who really are, I would just keep probing for Oedipal and aggressive and blah blah blah, and ignore, um, things that are sort of more in the realm of ego psychology and sort of more interpersonal stuff . . . Psychodynamic theory is so Euro-centric and so wrapped up in itself, that I don't think it has the adequate tools.

Another participant stated, "There's a lot of complexity there. And it's kind of easier to be in the psychodynamic trap."

With the exception of the latter participant, all participants in this thematic group described ways in which they did not follow the traditional proscriptions of psychodynamic theory. One participant stated, "So much of the time in therapy . . . it's an interaction in the moment, so whatever theory I've sort of learned and been suffused by is very much just a part of me." The participant stated this in the context of discussing how she brought her Marxist and feminist roots into her therapeutic practice, suggesting a fluidity, or looseness, in her application of theory. Another participant described using psychodynamic theory to help her understand where and when empowerment efforts would be more effective, describing her as "my own ideas about that that seem to work for me." A third contrasted "my theory" with that of traditional psychoanalysis. A fourth described serving as an advocate for a client despite the stringencies of "traditional attachment theory" stating, "I sort of philosophically believe in meeting people where they're at and this is where she's at, and that feels like it overrides - not overrides but becomes the guiding force." One participant described her efforts to actively resist her training in psychodynamic theory:

I had to train myself to actively work against my micro-level training . . . I'm sure the first couple of cases were really micro. And then I was like, okay, something doesn't feel right, I have to step outside myself, this is not how I operate in the world, I can't be this artificial being - how can I be my whole authentic self in this clinical, or this social work space?

Finally, one participant in this group specifically critiqued one aspect of psychodynamic theory, the injunction to be a blank slate for clients' projections. This participant pointed out how the approach of therapeutic neutrality was in fact anything but, in that it served to help oppression occur in silence.

I've just more and more recently strongly been coming to this feeling and this belief that neutrality means siding with the oppressor . . . The oppressor just wants you to be silent and let things happen . . . When we as a therapist are just kind of a blank screen, really what that does is

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it allows the system to continue being as it is . . . My African-American clients who talks a lot about race with me, during the election, the last election, he asked me, he was like, "Did you vote for that black president?" . . . I wasn't sure if I should answer right away . . . And he said, "You voted for the White president?" And so right away my not answering was seen as, like, oh, you did just side with the status quo, which in this case he was seeing as the White person . . . not that it would have necessarily been better if I'd been like, "Yeah, I voted for Obama." That doesn't necessarily make me not a racist or whatever, but just made me think about that.

The client's limits. The majority of participants (n=8) reported feeling reluctance or caution to help clients address external conditions in their lives because of the clients' own limitations. For one participant, these limitations were situational. She stated, "Sometimes I probably encourage her regarding employment possibilities at a time when she's not interested in talking about it, or maybe I give more information than some people are really wanting at the time." This participant saw her clients during the hours and days following labor on a neo-natal unit, and described this timing as not conducive to consciousness-raising or encouraging political activism. However, this participant reported elsewhere in the interview that consciousness-raising was a critical part of her interventions with clients.

Five participants expressed concerns that efforts at helping clients to feel more agency in the external world would harm the therapeutic relationship, or be clinically contraindicated. One described a situation in which the goals of building secure attachment with a client felt at odds with the goals of serving as a housing advocate. Another stated that before encouraging the client towards any mobilization, "I'm constantly sort of scanning and screening in my head about what the transference issues, implications are, about the implications for this particular patient's defensive style." A third stated, "I see what people are coming for help with, they're not coming for help to become more politically engaged, or activists, or to hear my political opinions or anything like that." The response of one final participant pointed towards the difficulties of negotiating this issue. She stated, "[I intervene] when it would feel empowering and not disempowering. But how do I decide which is which? I don't know."

The three final participants in this group questioned the capacities of their clients to engage in consciousness-raising or activism work. One stated, "I may judge that I mean, guess, that they are not

ready or that the timing might not be right." Another described toning down her therapeutic expectations

for a client who was struggling with constant financial crisis and homelessness. She stated, "That was as

far as I got with her because that was as far as we got. But I think I was supporting her by being really

interested in who she was, and validating." This participant explained this as "a hierarchy of needs," in

that "dealing with base economic reality" could interfere with looking deeper. A third participant

explained:

> But nobody comes to our clinic to be a community organizer. People are pretty much in crisis, in
> this mental health clinic, they're dealing with fairly low-level Maslow hierarchy stuff. They're
> barely getting through the day when I first get them.

Setting. More than half of participants (n=7) described the setting in which they practiced

therapy or received supervision as critically important in determining how much social or political issues

could be addressed in therapy. Two participants described their workplace as facilitating addressing

external conditions in the lives of clients. One reported, "my current role, in my current role, my role is

flexible, so I function as a clinician and therapist but I also function as an advocate . . . It's pretty

awesome." Another described how working in "a hotbed of resources" helped her to avoid a rigidly

individualistic focus.

For the others in this group, however, setting proved a primarily limiting factor. The setting of

training and supervision proved critical to three participants in this thematic group, one of whom has been

quoted above as currently working in a more conducive setting. This participant described her graduate

training as a "bubble". Another described a lack of attention to the impact of oppression on clients'

mental health in during both psychoanalytic and somatic training, stating, "Whenever I tried to bring

[racial trauma] up, I got really vague responses, and was really frustrated with that aspect of the training."

Another described a lack of role models who would help her learn to challenge traditional psychodynamic

therapy's individual focus, despite her willingness to expand her repertoire.

> I don't have many models of people in my life who integrate both, who integrate the
> psychodynamic and the political. Like, most of the social workers that I know, they have redone
> their kitchen. Like I'd go to trainings with these people and I'd go to lunch and they'd be like,

"Oh, I just redid my kitchen." I felt so alienated . . . There's a part of me that's a radical that doesn't identify with them.

This participant went on to describe psychoanalytic therapy as a "privilege," occurring with a particular limitation of focus, cost and time that would prohibit actively working with oppressed clients to address their social condition. Two other participants also described their current workplace as limiting their ability to engage in consciousness-raising or other externally oriented conversations with clients. One participant, also in private practice as was the participant above, stated, "If I were in, sort of an agency more rooted in an oppressed community and involved in the myriad ways in which such agencies can be involved, maybe I'd feel it more appropriate to, to get into political sorts of things." Another, who worked in a publicly funded position in a neonatal unit, described the limitations of such an agency.

> I wish I had more time, I wish there was a third social worker and we each had less people . . . As social workers we are not respected enough for our knowledge, but we - because - we have a very high risk patient population, so there's more that we get pulled into, like we're affected by the fact that there's so many high risk patients, but there's ten nurses and two social workers, but the majority need social workers. It's a lack of staffing and understanding of the importance of the social workers. We're essential but we're not given any credit.

For this participant, both the lack of voice given to public social workers and the high caseloads meant limitations in her ability to go deeper.

Question Five: "How Has Your Clinical Work Impacted Your Political Work (strategies, causes)?"

During this section of the interview, participants were asked how their clinical work impacted their political work. This broad, overarching question was followed by a number of follow-up questions. These included: How does your clinical work change your opinions of or investment in political causes? How do you think about your political work in terms of your profession as a social worker? How has your clinical work impacted your use of strategies in the political realm?

Communication and group work. The majority of the participants (n=7) described their clinical experience as giving them valuable tools in communication and group work. Some participants (n=4) noted a greater ability to resolve a dispute or build connections across political lines. These participants described how their clinical work provided them with a greater abilities in "helping people

see something from a different perspective," "really listen . . . look for compromises, win-win solutions . . . develop a relationship and trust between you that you can work together," "really connecting with people's internal resources . . . rather than using guilt and fear to scare people," or in "understanding of and tolerance for people with different opinions." Still more (n=4) reported a greater sensitivity to underlying dynamics within groups, or, in the words of one participant, "some awareness or sensitivity to a sort of basic human dynamics."

> I'm so glad I'm a group therapist and can go, and can constantly reflect back to these people that, that basically if he's misbehaving it's cause you're allowing it. This serves the group in some way. Just in not confronting his gross misbehavior, what is that - this is about the group, this isn't about him? So understanding group dynamics has been invaluable, understanding competition and dominance and sexism and . . . etc, has been invaluable. Understanding, you know, negative introjects and self-esteem and you know, understanding when I'm a European descendant working with a bunch of Africans in the deep South, to get voters registered, sort of understanding how issues of self-esteem and oppression are affecting the way this meeting is being conducted.

Participants in this subgroup described using clinical skills in community organizing to "take the temperature of the room" during meetings, identify scapegoating, and think about "how do we as radicals relate to each other and make decisions in ways that are reflective of our values."

Access to information. Three participants noted that their clinical work had given them greater access to information to use in political work. One had used her knowledge of addiction to influence a political council decision. One had met "hundreds and hundreds" of immigrant women through her work, and brought that personal awareness to advocacy on behalf of immigrants. One participant had gained a greater connection to Medicaid/Medicare, which she then communicated in politically advocating for these programs.

> It really sort of adds legitimacy to when I'm out there talking about economic human rights because I can be like, I have this client, and this is what they're going through, or when people say we need to cut Medicaid, and I say, "Medicaid funds my whole clinic, and if you cut Medicaid you cut my job," they're like, "Whoa, okay."

Self-awareness through political awareness. Slightly more than half of the participants (n=6) answered this question with some reference to a third theme - that of self-awareness. Four of these

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participants specifically noted "self-awareness" as something they sought in their political work. One noted this as a specific advantage she possessed in the political realm: "People are so not aware of their inner psychic selves, so people say and do things . . . I feel like that personal identity, individual experience, drops out when you're organizing around an issue." Five participants, whether referencing self-awareness explicitly or not, responded to this question by telling stories of their own background or internal processes. One participant noted that she had become involved in the Civil Rights movement to "resolve some sense of cognitive dissonance. I am well aware that Africans are people like the rest of us, I am well aware that our presumption of privilege is completely spurious and illegitimate." Four described their efforts at self-examination through completing anti-racism trainings, attending therapy or studying Buddhist meditation. As one participant noted, having described her decision-making process in taking up political causes, "I think those are interpersonal, clinical skills that I'm using to think about myself."

Movement towards the center. About half of the participants (n=5) described their clinical experience as having a moderating impact upon their politics, either in terms of the goals, or their strategies for pursuing them. Some of these participants (n=4) noted that their clinical work had given them a tendency to think outside the box of political ideology, in noting the influence of personal, as well as political, forces. These participants noted the importance of personal defensive structures and life experiences. They noted that their clinical work had led them to understand human behaviors and social structures as not merely a product of economic superstructure, racism and so on. As one of these participants noted, "Some cruder Marxists I think believe in things like raising children collectively. I think it's an open question in the sense that one-on-one relationships are very important for children." In the words of another: "She [fellow activist] was like, 'After the revolution no one will need therapy,' and I just thought that was so simplistic."

Another participant noted a change in the strategies she used to pursue political or social change:

I don't know if it's my clinical work or just natural aging or experience. When I was young, I was

definitely like all set to hit the streets and protest and yell and scream. I was kind of annoyed by people who were like let's wait and see, let's investigate, let's wait a while. Now I think more like that, let's take it slow, that the process of how you organize something is as important as how you organize.

Disillusionment. Finally, an important theme in participants' responses (n=8) to this question was that of disillusionment. Some (n=3) noted a pull away from their political work as they carried out their clinical work. These participants made statements such as "the more clinical work I do the less political work I do, it's a direct relationship," or "it makes me to tired to do it . . . it makes me feel less hopeful about political work." As another put it, "notions around self-disclosure and transference and countertransference have become, have actually driven a wedge between my political work and my clinical work."

Four participants spoke negatively of some leftists' politics, describing it as "crude", "un-nuanced," "simplistic," or "very rigid, and very dominating."

> I mean I guess I feel like if more activists did their own personal work, I might be more influenced by them. Just when I was growing up I felt like people were more dogmatic, and now I feel there's been a change in political groups and political thinking where . . . I think, maybe there's just more of a general acknowledgement of the problems we face as a planet and as a country. And so, I see them [activists] more as people - I mean, clearly everyone spins to their advantage. But I guess I feel like if we don't have a certain kind of self-awareness, if we're defended against parts of ourselves, there's only so much change that can really happen.

Despite the prevalence of the theme of disillusionment in responses to this question, the prior themes suggest the potential all participants noted for clinical social workers to conduct political work. One participant cast the role of clinicians in political work in glowing terms: "To me, clinical social work and social action, it could be beautiful. It could be great. Clinical social workers could add to community organizing and social work."

Question Six: How Does Your Political work Influence Your Clinical Work?

The final question of the interview concerned the impact of participants' political work and engagement upon their clinical perspective, theories and work with clients. Ten participants answered this question. One participant did not answer the question due to time constraints. The themes apparent

in participants' answers points to the tension between a therapeutic setting that emphasizes the individual, and political work that emphasizes the linked fate of many.

Empowerment. The majority of participants (n=6) described their political work and perspective as giving them a more empowering stance towards their clients - a stance that involved explicitly working to share power. This theme emerged in several different ways. Participants spoke of recognizing the potential for their clients to participate in political engagement and thinking. Several (n=3) spoke of questioning the devaluation of low-income folks or other marginalized individuals' potential to think critically. One critiqued this devaluation from a Marxist perspective, noting that "Marx talked about the division between mental and manual labor being a whole mark of capitalism." This Marxist perspective, she stated, enabled her to view clients from oppressed populations in a way that valued their "internal lives their subjectivity." Another discussed how her education about marginalized populations enabled her "to provide a kind of understanding of somebody that society labels as bad." In the words of yet another participant:

> I feel like you have probably gotten this already, but I feel like if you say you're a social worker, somebody will say, "Oh, that's so noble." Somebody actually said that to me once. You know, or they'll be like, "Wow, that's really altruistic of you." Or they'll be like, that's really . . . And there's this idea that I'm like sort of helping the people I work with in that way, like it's sort of a charity kind of a way. And I guess I feel like maybe more so than some other therapists, definitely a lot more so than a lot of people in society at large, that I do see the people that I work with as people who could potentially be engaged in political activism, people who have the potential to be more empowered, and have the potential to be more – like I don't see them quite as much as needing my help.

In line with this theme, participants also described specific strategies to share power with their clients. One participant stated that "I think I have an obligation to do it [the work] in a way that respects the information that I have been fortunate enough to get," and that "information is power." This participant used her understanding of systems in her city to help clients access resources. Another described how, because of her understanding that sometimes "you can't get a job because you'll lose your welfare and your subsidized childcare," she shifted away from a traditional careerist focus on self-improvement to helping clients to "look at what people could do to improve their lives outside of the

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ordinary box." Still another had arranged her office in a way that reflected the values of "radical psychiatry," emphasizing physically the goal of "sharing the self . . . in a way that keeps the client in the lead."

Consciousness-raising. Half of participants (n=5) also used their political experience and values to raise the critical consciousness of their clients. Participants spoke of a desire to "question clients' assumptions" about different groups, or "engage in these [larger social issues] and talk about them." One participant used her experience advocating for awareness about sex offender-related issues to "broker more of a human response" for clients in relationship with people convicted of sexual offenses. Another, using her skills as an advocate around GLBT issues, attended to "the gap in knowledge and awareness" between her own community and that of her clients, attempting to smooth the way for children with alternative gender identities. For one of the participants, this consciousness raising took a central role: "I feel like I'm a social justice educator. Everything I do . . . I'm teaching folks, or talking to them, or facilitating discussions on social justice. . . . For me since all the courses I teach have a social justice content, it's front and center."

Personal awareness. In addition to leading participants to a more empowering, consciousness raising stance with clients, participants' political experience changed the awareness of clinicians. Half (n=5) discussed their increased self-awareness. This pertained to participants' awareness of the limits of their own perspective. Participants spoke of increased "responsibility for my own attitudes and values", realizing "I made an error in making an assumption that people are on the same page as me," or being "aware of my own biases as a therapist in a way that's positive." One answered this question by describing her upbringing, explaining her theories about politics and the world in terms of her family and culture. One participant described learning about transgender issues in the 80s in order to counteract her own attitudes about it, while another described becoming more aware of the way in which her awareness of LGBTQ issues was based upon a particular socio-economic social location.

Another two participants reported that their political work had raised their awareness in terms of

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knowing more information. One participant described using her position as a local politician to help

clients access resources such as affordable housing. Another described the information that she gathered

as an activist as an essential part of her work:

> If anything, what I do in the community makes me a better clinician, because I know what's going on. Whether it's what's happening systematically, like with school board stuff or welfare board, or if it's just resources. I feel like I'm better equipped to sort of manage people holistically, because I know what else is going on beyond the four walls of my office. I'd probably be a pretty stale clinician if I didn't do this other work.

Toning it down. Themes of empowerment, consciousness-raising, and awareness were counter-

balanced in participants' responses to this question by several others. The first of these themes was that

of "meeting clients where they're at," a theme which has already emerged at other points in the interview.

About half of the participants (n=5) noted that they made efforts to tone down or modulate the influence

of their political perspectives and values. As one participant noted, in responding to verbalizations of

internalized racist or classist ideas, "You can't just say, 'That's not a good thing to say.' That's not gonna

be helpful." These participants noted that introducing political awareness or politically informed ideas

could sometimes be rejected by the client. Participants made statements such as "it's a balance between

really meeting people where they are and bringing the political awareness in," "there's a slippery slope -

trying to offer another perspective without impacting our therapeutic alliance," and "I feel like it might be

bringing my thinking into the room." One participant described her tension in terms of a particular client:

> I was very focused and very aware of just the human tragedy as their relationship broke down, and aware of what part of process and labeling and of criminal prosecution was going to play in the unfolding tragedy in their family. At the same time I needed very much to understand and be supportive of her horror and rage and recoil and everything else at him. But maybe I was more concertedly listening for any opportunities to begin to broker a more human response.

Separation of the clinical and political. Finally, a majority of participants' (n=6) responses

pointed to another theme: A feeling of the ineluctable separation between political and therapeutic realms.

One noted immediately, "Well, I don't know if the political work itself has shaped my clinical theories,"

only then explaining some key impacts of political work upon clinical practice. Some described the

nature of the work as inherently separate. One portrayed this in terms of theory, stating, "I just think the

[political and psychological] theories themselves don't intersect." Two others explicitly discounted the notion of their clinical work as inherently political in nature, stating "my clinical work isn't doing activism" and "I'm not organizing - the work I do doesn't really deal with power disparities, I don't consider it political inherently." Two others, though not rejecting the notion of a politically informed therapy completely, described therapy as limited in its potential to take on a politically or socially informed tone. One noted that, in thinking of a politically informed therapy, "part of what's really hard for me is that I really do believe conditions in the world need to change;" for her, therapy, no matter how activist in nature, was not enough. For another, broad social or political agendas could be easily dwarfed by the intensity of individual, immediate need. She stated that, "when I came out of school I really felt like my activism and my systems work [was important] . . . I think it just gets harder to maintain that perspective for me." All of these six participants went on to enumerate ways in which they brought political work and perspectives into the therapy room. However, the theme of separation remained a strong and prominent theme in the responses.

CHAPTER FIVE

DISCUSSION

Introduction

This study was meant to offer an exploration of the practices of clinical social workers who also identified as activists. The study was guided by an application of Paolo Friere's *Pedagogy of the Oppressed*, and was focused on several key areas in the integration of political and clinical work. These areas included: What framework did activist clinicians use to understand oppression in the lives of their clients? In what ways did particular theoretical orientations serve as a hindrance, or a boon, to addressing social conditions in clients' lives? How did these clinicians incorporate their political selves into the therapy room, and their clinical selves into the political arena? The following chapter reviews the findings in the following order: (1) A review of key findings, using Friere's *Pedagogy* as a framework for analysis; (2) limitations of the study and directions for further research; (3) implications for clinical practice.

Review of Key Findings

Psychoanalysis and Its Discontents

One of the central questions that this thesis was meant to explore was that of how particular clinical theories furthered or detracted from the goal of *conscientization,* as conceived by Friere (1970). Participants described a number of theories as influential in their practice, including Gestalt, somatic therapy, DBT, CBT empowerment theory, and psychodynamic theory. Of these, only psychodynamic theory offered itself for close exploration under the original goals of the study. Seven participants described themselves as primarily psychodynamic in orientation, with some additional theoretical influences. The remaining four described themselves as "eclectic," or stated that they did not rely on any

explicit theory.

Participants used psychodynamic theory to further *conscientization* in a number of ways consistent with the literature. Leary (1997), Comas-Diaz & Jacobsen (1995), and Altman (2010) had claimed the importance of talking about race with clients, both to acknowledge hard social reality and to access underlying intra-psychic dynamics that used race and racism as personal metaphor. Altman (2010) expanded the conversation to include class status, while Comas-Diaz focused on ethnicity and culture. Several participants described the significance of developing this conversation with clients. The example below provides such an illustration.

> For example, if I saw a Latina woman, I thought about, I didn't think about her as just a person, a woman who experienced violence, I thought about how her ethnicity impacted the meaning making she may have. . . . Thinking about class and relationship violence. Was there a way in which economics played a part in her, somebody deciding to stay with the perpetrator of violence? . . . At the macro-level, when a Black woman experiences gender violence, thinking about the ways in which Black women's bodies are marked, historically.

Participants also questioned the rubrics of assessment used in psychodynamic theory. Again, they echoed voices in the literature. Chodorow (1989), Lerner (1988) and Comas-Diaz (2007), in her work on ethnopolitical psychology, question the assumptions that traditional psychodynamic theory makes in their particular construction of gender, sexuality, culture and what is normal. Similarly, clinicians interviewed in this study embraced more contemporary psychodynamic theories, or sought their own perspective from which to critique traditional psychoanalysis. One participant, who identified as strongly psychodynamic, stated this response to a question of how psychodynamic theory accounted for homophobia and disability phobia: "Well, my theory does. I'm not sure psychodynamic theory does. Psychodynamic theory is so Euro-centric and so wrapped up in itself, that I don't think it has the adequate tools."

Despite these factors, the findings indicate that psychodynamic theory aligns only imperfectly with Frierean theory. For Friere (1970), so-called individual or familial problems - such as alcoholism or authoritarian parenting - were in fact social problems, writ small. Participants in this study, however,

questioned the primacy of social factors. This echoes the likes of Altman (2010), Leary (1997) and

Lerner (1988), who explained social forces of oppression as metaphorical expressions of dynamic

processes such as issues of vulnerability and control. Participants in the study, in contradiction to Friere,

questioned the validity of interpreting clients' maladies without taking stock of uniquely personal

characteristics and experiences. The participant below, for example, critiqued traditional Marxist

analyses of social problems as overly rigid. For this participant, as for others, a story of oppression was

only part of the story.

> There were a lot of people who had what I thought was such a narrow view of material conditions
> essentially, your class position . . . There are many elements to what sort of motivates human
> beings I think . . . I think it has to do with the complexity that I sort of view human beings
> through the lens of, more than anything else. And my understanding of, for example,
> developmental issues, and how important I think early experience is for children.

Finally, psychodynamic theory appeared for the participants in this study to offer an obstruction

to egalitarian relationships between therapist and client. Psychodynamically oriented participants were

less likely to describe themselves as taking a stance of client-as-expert, while those that did describe

abrogating their authority for the client did so in a circumscribed way. One participant articulated

psychodynamic theory as inescapably hierarchical in nature, depicting the therapist as charged with the

task of holding boundaries for the client.

> For me the container of therapy is very important, the fact that very clear boundaries are very
> important to me. I get kind of uncomfortable when I hear about more touchy-feely kinds of
> therapies or people kind of love their therapist, or boundaries are kind of fuzzy. I think for really
> powerful intense work, really clear boundaries are important.

Furthermore, though several of these participants described their approach as strengths-oriented,

that orientation was a deliberate countering of traditional psychoanalytic tendencies. "I'm not interested

in thinking so much in terms of pathologies," one participant stated, describing how she used critiques of

psychoanalysis in her work. While clinicians in this study worked against the grain of psychodynamic

frameworks, those frameworks in themselves resist Friere's teacher-as-student approach. In this

approach, teacher and student share in the struggle against oppression, a struggle in which power

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differentials only serve to perpetuate a status quo of dominance and subjugation (1970).

Missing Frameworks

One of the central questions of this thesis was that of how activist clinical social workers understood oppression in the lives of their clients. Almost all of the participants in this study found the concept of oppression to be valuable in their clinical work. However, findings indicate a notable lack of agreement about the nature and definition of oppression. Some, but not all, participants identified concrete material conditions as the defining feature of oppression; others focused on discrimination by others, or on the internalization of oppressive ideas. Others incorporated some combination of all three. Two participants rejected the idea of oppression as a useful category at all, then went on to acknowledge the harmful impact of racism, poverty and discrimination later in the interview. The following comment illustrates the ambiguity in categorization that results from the absence of a well-articulated framework for oppression.

> I don't know that I would call it oppression but I'm always watching to make sure their medical treatment is fair and informed. Sometimes a women asks for a procedure like a tubal ligation or a birth control method and doesn't get it and it's really just cause of the system, it's not an act of discrimination . . . It really bothers me that the staff, many of the nurses, don't make the effort to use the interpreter phone. So they speak to them loudly and in very obnoxious ways, and I have yet to be able to influence that, but that's a way that I don't know if I would call it oppressed, but disadvantaged, by not having full access to information . . . Well, there are acts of oppression. You know, not being given the chance to speak in a language in which you have facility is oppressive, but it's not inherent in the fact that she has a different primary language.

The lack of a coherent framework for oppression can also be seen in the variation in how participants categorized women as oppressed or not oppressed. Two participants, for example, despite explicitly stated connections to the feminist movement, rejected the notion of categorizing women as an oppressed group. For four others, the inclusion of women in the category of "oppressed populations" appeared obvious.

Friere (1970), of course, had a working definition of oppression that incorporated all of the above elements of material deprivation, discrimination and internalization. For Friere (1970), oppression manifested in "domestication" (p. 34) of the oppressed - their internalization of discriminatory attitudes of

the oppressors that naturalized material inequities. Many participants - though not all - did report that an important part of their clinical work with oppressed clients involved helping clients to identify and resist oppressive internalizations. For some, however, this work entailed increasing the focus on the individual, rather than expanding it outward. As one participant stated, "I must say, a couple of times a week . . . people don't come to therapy, I will say to the client, because of what someone else is doing. People end up here because *you're* unsatisfied with your own operations." Such interpretation may, according to thinkers such as Botticelli (2004), detract energy from one of the most powerful modes of Frierean activism - that of class-based action.

Findings reveal a second missing framework: a model for rich integration of political thinking into the clinical setting. Even those participants who found utility in the framework of oppression for understanding their clients expressed hesitancy in raising the issue in the therapy room. This was true regardless of the participants' political leanings. One participant spoke passionately of her years as a social activist for economic human rights, and described her work as in part rooted in feminist theory. She stated, "I do see myself as being able to have some kind of impact . . . Being able to talk to them about oppression, and really listening to what they have to say. But I don't really see that as part of therapy." This participant was not alone - almost all other participants reported that at times discussions of oppression felt contraindicated, irrelevant, or difficult to integrate into therapy.

Given the permeation of oppression into all areas of physical, mental and interpersonal life, Friere understandably postulates that ameliorating the conditions of oppression was central to the role social worker (1990). He describes social workers as those who "uncover and make explicit a certain dream about social relations, which is a political dream" (*ibid.,* p. 5) - a dream that was held as a "progressive obsession" (*ibid.,* p. 7). Friere would have explicitly rejected the notion of therapy as apolitical, particularly with clients experiencing the most concrete difficulties. He would have argued, as he did in the *Pedagogy* (1970) that any attempt to individualize problems could only support the status quo.

The participants in this study can be seen as responding to Friere's insistent politicization at

several points. First of all, a majority of participants expressed the idea at various points during the interview that political health arose out of attention to intra-psychic dynamics and mental health. One participant explicitly rejected Friere's argument that an individual focus on emotional problems would serve to support the dominant class.

> I know there's a theory that we sort of let enough steam off, like that we being social workers are a buffer zone where we let off enough people's steam that work with us that the pressure doesn't build up to a revolution. But I have to say that . . . I don't feel like trauma necessarily leads people to become activists . . . My experience is that for most people that have experienced trauma - that takes up all their energy.

Secondly, findings suggest that for clinical activists, a non-individual, political understanding can feel incomplete in political settings. A majority of participants also cited their clinical experience - their knowledge and skill in areas of individual, inter- and intra-personal problems - as a means of greater efficacy in the political realm. One participant, for example, stated, "One of the things I find fascinating being in political spaces is that people are so not aware of their inner psychic selves . . . I bring it in by naming some of the dynamics." This participant, as others, saw an ability to account for non-political, deeply personal dynamics as a leverage point for success in activist work.

With greater attention to non-political dynamics comes a potential detraction from the Frierean progressive vision. Five participants in the study reported that their clinical experience moderated their political goals or strategies. Eight had experienced disillusionment, exhaustion or pull away from their political work as a result of doing clinical work. Political work, it seems, was experienced by participants as an activity distinct from clinical work. Findings thus indicate a lack of a well-articulated explanation of oppression, the perceived contradiction between political goals and rich clinical insight, and the isolation of micro- and macro-level practice. These phenomena appeared even among participants who overwhelmingly saw an understanding of oppression as crucial to their work, and who engaged in activism in their own lives.

A better framework is needed if Friere's vision of social work is to be made manifest in clinical work. This is consistent with prior research on political engagement among social workers. Previous

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researchers have found that even to engage in activism outside of a clinical setting, social workers require a sense of competency in that arena (Andrews, 1998; Domanski, 1998; Hamilton & Fauri, 2001; Ritter, 2008). Findings indicate that professional support was crucial to participants' abilities to engage in anything like Friere's *conscientization.* As one stated, describing her work in a community counseling center, "I think it's easier to do activism and be political when you're a part of these community organizations." Another stated, "The community healing element is really left out of our training. I say our training but really our understanding . . . I just don't feel like it was really integrated into clinical work."

The possibility of a coherent integration of macro- and micro-frameworks can be seen in the response of one participant. For this participant, an understanding of the "cradle to prison pipeline" was as essential to her work as attachment theory.

> From such an early age, there's both family systems, there's family dynamics that are obviously impacted by racism and intergenerational trauma, and then there's what happens to these kids when they go out in the world and what they pick up in terms of how people deal with them because they're young black males. . . . I felt like thinking about it in terms of, and helping families to see how those overlays really were affecting the way that they were seeing their child . . . was the more important thing.

The Revolutionary Alliance and the Therapeutic Alliance

Friere had imagined an alliance between the goals of teacher and student for his revolutionary *Pedagogy* (1970). For the participants in this study, however, such an alliance of political interests appeared at odds with the needs of the therapeutic alliance. A majority of participants spoke of directing therapy towards the external conditions of clients' lives - any kind of political or social action - with caution. Participants described an external orientation as in some way in conflict with the needs expressed by the clients: "They are still the expert, you know . . . Even if we're choosing to be disempowered in certain ways it's because there's still more to work through." Some participants expressed a sense of greater conflict between political and therapeutic goals when working with clients in particularly dire straits, as in the statement below.

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Nobody comes to our clinic to be a community organizer. People are pretty much in crisis, in this mental health clinic, they're dealing with fairly low-level Maslow hierarchy stuff. They're barely getting through the day when I get them.

The latter statement, of course, directly contradicts Friere. He believed that the progressive social worker (1990) and the educator of the *Pedagogy* (1970) must possess unshakeable faith in the power of even the most downtrodden to awaken to revolution. He argues that the progressive educator cannot wait for the oppressed to gain the capacity for critical reflection, as alienation of that capacity has been the hallmark of oppression itself. Instead, he states that from the beginning, "his efforts must be imbued with a profound trust in people and their creative power" (1970, p. 56). Friere would have likely also expressed skepticism at the idea that therapy should not be guided towards politicization unless the client leads it there. The profound trust he endorses is that felt for the side of the oppressed that has not internalized the oppressor, and bought into capitalistic, oppressive concepts of success. As he puts it, "Neither invasion by the leaders of the people's world view nor mere adaptation by the leaders to the (often naïve) aspirations of the people is acceptable" (1970, p. 163).

The caution expressed by participants about bringing politics into the conversation did not mean that participants *never* brought up politics. A majority of participants did, albeit tentatively. Three participants even expressed a sense that empowering their clients to political action provided them with professional sustenance. As one stated, "It would be a really satisfying case if I could turn somebody into an activist." The theme of countering clients' internalized oppressions came up over and over again in responses, suggesting that the participants in this study, like Friere, were attentive to the effects of "cultural invasion" (Friere, 1970, p. 134) on clients. Thus, for example, one participant used the following to describe the primary goal of her work:

> One thing that's important to me is to try very hard not to reflect, not to be a part of the values and the culture . . . There's a certain kind of moralism that people often internalize that's often problematic . . . My goal is to help people feel comfortable with themselves and be able to envision making changes, not only internally but also in their lives.

Given this, the contradiction between participants in this study and Friere may have more to do

with the strictures and limitations of the therapeutic setting. In a clinical relationship of confidentiality

and neutrality, in which client and clinician meet in a setting isolated from the home life of each,, the

possibility of an explicit union of political goals may be remote. Only one participant in this study

reported that she had connected clients with political events with which she was involved, and in which

she had an interest. Nonetheless, the majority of participants expressed an intention and desire to discuss

oppression and work against it through their therapy. This suggests that the therapeutic alliance has

potential to align with Friere's revolutionary alliance.

The Centrist Activist

Among the eleven participants interviewed, one participant's responses placed her outside of

categorization in most thematic groups. Though two participants rejected the use of "oppressed

population" as a category for assessing clients, one participant later went on to describe African-

Americans as an oppressed group. The second participant, the one under discussion in this category, only

described one client as a member of an oppressed group. She rejected the utility of a concept of

oppression, stating, "It's this victim tinge that I feel uncomfortable with - I'm more about empowerment

than victimization." Slightly more than half of participants identified material deprivation as an

oppressive feature in clients' lives; still more participants described the social safety network as a

valuable asset to clients. When asked about the role of poverty in determining whether or not clients were

oppressed, this participant stated, "Actually what I think about more is the role of the social safety

network and the role that plays in people's lives and how some people do become dependent on it and it

sort of saps their will to do anything."

Given this stance towards the concept of oppression, it is perhaps unsurprising that this

participant also differed from others in this study in her willingness to consider he impact of social forces

in the lives of clients. This participant tended towards determinedly individualistic accounts of clients'

difficulties. To explain the financial disaster experienced by one female client through a romantic

relationship, for example, this participant stated, "I think it's just bad luck." When asked explicitly about

how she thought about the role of social forces in the lives of client, this participant named factors

distinctly different from the issues of racism, poverty and oppression named by other participants.

> I guess I don't think about it as much as you do and as sort of is the framework for this study . . .
> Well there's also substance abuse. I think that that's a huge social force. There's a - I'm learning
> just how many people smoke weed regularly and have for years and years and years, and that's
> just a regular part of their life and it doesn't seem like it's helpful to them . . . It wasn't just
> abusing substances as a way to cope, but - maybe partly this answers your question - it's sort of
> there's this whole alternate reality of people who don't, sort of, think about the world the way we
> do, in terms of the structures of society, they're in there to help them, they see themselves as
> outside of that.

In this response, the participant indicates certain assumptions about the functioning of agencies such as

the police from a particular, and unnamed, class, race and national perspective. When the participant

described this perspective of thinking "about the world the way we do", she indicates that she applies

these assumptions outward to me, perhaps because of my white skin and apparent class identity. Many

participants in this study referenced anti-racism training and personal work on racial identify development

as an important component of their clinical and political practice. This participant's assumptive stance,

however, potentially speaks to a different framework for working from areas of one's own privilege. She

appeared to espouse a color-blind framework, for example, for conducting interracial clinical work. She

stated, "I just don't think about my caseload in terms of race."

This difference may be attributable to the distinction in this participants' activist identity, as

opposed to that held by other participants. This participants' activism had centered around environmental

issues, and had grown out of the fight for nuclear disarmament in the 1980s. All other participants'

focused on issues that more explicitly impacted clients, such as poverty, racism and disability rights. This

participant also took an extremely active role in local politics, serving in the government of her city, for

the purpose of furthering her environmental work. Thus, unlike participants who had not served in the

government, this participant would perhaps be more inclined to hold a view that was more reformist than

radical, and to take a more favorable view of the role of agencies such as the police.

Though, in this study, this participant appeared as an outlier, it may be that this participant is in

fact more representative of the social work field as a whole. Though limited research has been done on

the political engagement of social workers, researchers have found that political engagement among

social workers is frequently unrelated to issues at stake in the lives of clients (Salcido & Seck, 1992).

Historical factors may play a role in moving mental health practitioners towards the political center,

because of the ties that developed between the mental health fields and the capitalistic medical

establishment of the United States (Aldorando, 2007). Certainly Friere, though holding some hope for the

revolutionary potential of the social work field (1990), expressed a great deal of caution about

professionals (1970). Friere saw the education of professionals as one designed to promote separation

from the people, providing them with an elevated class position and a tendency to be "'afraid of freedom'

and reluctant to engage in humanizing action" (1970, p. 139). The outlying participant in this study may

be representative of a larger bulk of social workers occupying the political center.

Limitations of the Study and Directions for Future Research

The limited sample size of this study limited its more general applicability. The small sample

size, as well as the snowball sampling method used to locate potential participants, likely also led to a

relatively homogenous sample with regard to sex and race. Participants were located through my own

contacts in the social work world, who are themselves primarily white. Recruiting was also done through

professional organizations such as the Smith College School for Social Work Alumni Network and the

NASW, both of which contain predominantly white members. Prior research does suggest that race and

sex impact the level and nature of political activism among social workers, both in and out of the therapy

room. Researchers have suggested, for example, that experiences of oppression may lead to greater

politicization among social workers (Ezell, 1994). Authors such as Leary (1997), Comas-Diaz &

Jacobsen (1995), and Hardy (2008) have written about the difference in experience for white mental

health practitioners and those of color in having conversations about race and oppression. Given this

prior work, it seems possible that revisiting this study with greater attention to diversity would yield new

insights and results.

Furthermore, all participants in this study lived in major urban areas of the coastal United States. One researcher (Ritter, 2008) has identified location in an urban area as crucial to determining the political activity of social workers. Thus, the strategies used by activist clinicians in rural areas to invite political and social considerations into therapy may differ from those used by urban counterparts.

Though I aspired, in this study, to explore a variety of theoretical clinical orientations, the only one that readily offered itself to thorough examination was psychodynamic theory. Further research could explore the impact of the use of family systems theory, narrative therapy, and empowerment theory or liberation psychology on the integration of political and clinical practice. Such research would offer greater possibility for comparison. This could help those who seek an activist clinical practice to better focus their clinical training.

Finally, this study did not explicitly seek to investigate the impact of setting upon the potential for *conscientization* in therapeutic settings. Nonetheless, the impact of professional setting on participants' ability to address issues of oppression in the lives of clients came up repeatedly. More than half of participants in this study cited setting - either of work or supervision - as a limiting factor for this area of focus. Further research into qualities of work settings that engender better integration of macro- and micro-practice would help those agencies that aspire to such integration better cultivate and nourish an oppression-oriented clinical practice.

Implications for Social Work

The findings in this study have several implications for social work practice. The first concerns training. The NASW Code of Ethics (1996) enjoins all social workers to "promote social justice and social change with and on behalf of clients" (p. 5). This statement appears to imply the incorporation of social justice goals into all levels of practice, including micro-level, that involves interaction with clients. Despite the injunction, findings in this study indicate a lacuna in social work education in terms of the mechanisms by which one might orient one's clinical practice towards social justice. Even for clinicians with varied and extensive leadership experience in the field of social justice, incorporating concepts of

oppression, social change and resistance into therapy proved a challenge. For some, success was a matter of avoiding the lessons of social work education. As one participant put it, "I had to train myself to actively work against my micro-level training." Ideally, social workers will leave school with a sense of how to incorporate social justice into therapy work - rather than being trained to erect barriers to doing so.

One participant valued her clinical training. She stated, "Clinical work and social action - it could be a beautiful - it could be great - clinical social workers could add to community organizing and political work." This participant, and many others, expressed gratefulness for the complexity with which clinical training helped them to understand the world, not least of which the political arena. Yet participants also expressed a sense that adhering to political ideology and practice would require abandoning the rich insights of their clinical experience. Better integration of the political into the clinical is needed - but also better integration of the clinical into the political. Macro-level training should involve the use of clinical skills and insights, to maximize the potential of social workers in the political world.

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Appendix A

Informed Consent Form

Dear Potential Research Participant,

My name is Anna Cable, and I am a second year student in Master's program at Smith School for Social Work. I'm writing to you, first of all, to thank you for your interest in participating in my study. This study involves research into the integration of clinical and political practice in social work with clients from oppressed populations. Specifically, I would like to find out how clinicians integrate political consciousness and action into therapeutic work with these clients. I will be using this research to author my MSW Thesis, which will be electronically published and available on the Smith College libraries website. The results of this thesis will also be presented to my fellow students and faculty during the summer term of 2011. It may also be used for publication or presentation thereafter.

If you choose to participate in this clinical study, I will interview you on your clinical practice, the theoretical stance underlying your therapeutic work, and about your work as a therapist for clients from oppressed populations. I will also be asking you about how you understand your role in political action as a social worker and how you think about political and social systems in the lives of your clients. I will also be asking for demographic information about your gender, racial and ethnic identity, your professional clinical work, and your political activities. The interview will take approximately 60 minutes, and will be audio recorded via iPod. I will then be transcribing these meetings. In addition, I will be taking notes as we talk, which I will then save.

To participate in this study, you must fulfill several criteria. You must:
1. Be an LICSW
2. Work at least 20 hours per week conducting individual or family clinical work.
3. Spend at least half of your clinical hours working with clients from oppressed populations (this includes women, differently abled people, people of color, LGBTQ individuals, recent immigrants, people in poverty, and other categories).
4. Self-identify as a political activist.
5. Be willing to travel to the interview or communicate by phone or Skype for the duration of the interview.

Participating in this study may have a positive impact on you and the people around you. You will have the opportunity to share your experiences as a social worker and gain new perspectives on your work. Limited research has been done on the ways in which different theoretical perspectives help clinicians weave politics into their work with clients from oppressed populations. Participating in this study may start to lay the groundwork to understand how this may be done, which may in turn increase therapeutic efficacy. Working with clients from oppressed populations offers a number of challenges to all clinicians, and this research may offer

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you or others new ways to think about and gather strength for this important work.

Should you choose to participate in this study, all identifying information relating to you will be kept confidential. All notes, recordings and transcripts from my interview with you will be labeled by code, rather than your name. These materials will be stored separately from your signed consent form. All materials will be stored in either locked filing cabinets (in the case of hard copies) or in password protected computer systems (in the case of electronic data). The only person other than myself who will see any data before publication is my research advisor, Fred Newdom, who will only see the data after all identifying information has been removed. When data from this study is presented, in the form of a written thesis, as a presentation to the Smith SSW student body, or in further publications or presentations, it will be presented as a whole, rather than by identifying specific participants. If specific vignettes or quotes are chosen for presentation, they will be disguised. All data (notes, tapes, transcripts, consent forms) will be kept in a secure location until no longer needed, and then they will be destroyed.

Your participation is voluntary at all times. At any point during the interview, you can refuse to answer a specific question or choose to stop the interview without penalty of any kind. If at some point after our interview, you decide you would like to withdraw from the study, you may do so up until the date of April 1, 2011, at which point my thesis will be entering the final phases of completion. Should you choose to withdraw, all materials pertaining to you will be destroyed.

Please feel free to contact me at any time if you wish to withdraw from the study, if you have concerns about your rights or about this study, or if you have any other questions. My daytime phone is 617-887-4124. My email is politicsthesis@gmail.com. If you have any concerns about your rights or about any aspect of this study, you can also contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974. I will be keeping a copy of this form, and you may wish to do so as well for your own records. Again, I thank you sincerely for your participation.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION, AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS, AND THAT YOU AGREE TO PARTICPATE IN THE STUDY.

Participant Name:_____

Signature/Date: _____

Researcher Name: Anna Cable_____

Signature/Date:_____

Interview Guide

Demographic questions:

- What is your race and ethnicity?
- What is your gender?
- How long have you been practicing social work?
- What agencies have you practiced in?
- Where do you practice therapy now?
- How long have you been involved with political work?
- What causes have you been involved in?
- What is the nature of your political work now?

Characterization of clinical population:
- How would you characterize your clinical population?
  - With regards to racial, ethnic, or national background, SES, religion, gender and sexual orientation?
- Would you describe any of your clients as being a part of an oppressed population? If so, why? If no, why not?

Theoretical orientation:
- What theories do you use in your clinical work?
  - *If respondent indicates that they do not use theories:* During your social work education, did you learn about any theories of clinical practice? Which ones appealed to you? Did you ever learn to apply any of these theories while in the field?
    - OR: How do you assess the mental health of your clients? What do you focus on in treatment? How do define success with your clients? What is your role as therapist (consultant, object to internalize, model of caregivers, etc)? How do you explain clients' problems (family system, internal conflict, societal pressures, early experiences, etc)? Which do you see as more relevant, present circumstances or past experiences?
  - *If respondent indicates they use an "eclectic" approach:* What does the word "eclectic" mean to you? What theories do you draw from in your approach? In what ways would you characterize yourself as _____ therapist (site therapy they listed as part of their approach)? How do you decide when to pick one theory over another? What do you look for when you assess a client?
  - *If respondent indicates a particular theory:* In what ways do you see yourself as that kind of therapist? In what ways do you use that theory in your practice? What would you describe as the goals of that theory?

Addressing social conditions in the lives of clients:

- In ways does your clinical work move your clients towards greater control over the external, social conditions of their lives?
  - *Possible follow-up questions:* In what ways do you see this theory as helping clients become more politically conscious about their lives? How does achieving the goals of your clinical approach (use examples given by respondents in question 2) help clients take more control over their lives? In what ways do you see this approach as helping clients to understand the impact of policies or social factors on their lives? Do you see this greater control as manifesting in more influence over the material/political circumstances of their lives? Why or why not?
  - *If answer is that this is not the goal of the therapy, or some related response:* Why do you believe that this is not the case? What does this clinical theory say about the influence of external factors on clients' lives? How do you understand the influence of those factors?

Limits of the theoretical/clinical orientation:
- In what ways does your approach in clinical work limit your ability to help clients gain greater control over the external conditions of lives?
  - *Possible follow-up questions, in cases of confusion or negative response:* Why do you not feel limited? Do you ever find that serving as a therapist limits your ability to help clients gain greater control over their lives? Why or why not?

Influence of the clinical on the political:
- How has your clinical work impacted your political work?
  - *In follow up:* What are the causes that you think are important? Have you come to change your opinions about different causes based upon your work with clients? Why or why not? Have you come to change your opinion about the correct approaches to political change? Why or why not?
- Do you use your clinical experience to think about your political work? How about your usual clinical perspective? Why or why not? In what way has doing therapy changed your political work?

Influence of the political on the clinical:
- How does your political work influence your clinical theories?
  - *Possible follow-up:* How does your political perspective inform or change the way you use clinical theories? What do you see as the role of your political perspective in the therapy room? How do you relate the work of political activism to the work of therapy? In what ways has your political activity changed your therapeutic practice?
  - *If answer is vague:* In what ways do you alter your usual clinical practice? How has political work changed your clinical practice overall? How does your political work change the way you think about clients who are oppressed (e.g., people of color, sexual minorities, women, etc)?
  - *If answer is negative – i.e., that there is no change*: Why is that?

Human Subjects Review Approval Letter

December 11, 2010

Anna Cable

Dear Anna,

Your revised materials have been reviewed and they are fine. I must admit, I had my troubles at times following everything with all the different colors and comments. Modern technology is something.

I have but one small informal suggestion. In your recruitment email, you start out with "do you care about making change?" that could invite anyone interested in any kind of change. Maybe you should focus your invitation like "are you a clinical social worker committed to social change"? You can phrase it better, by a more targeted invitation.

Also, don't feel that you have to abandon organizations. If you decide one would be a good bet, just send us a brief note from them giving you permission.

We are happy to give final approval to your study

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Fred Newdom, Research Advisor