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"Enacting something I didn't believe in": Clinician Experiences of Dissonance Related to Power and Oppression in Community Mental Health

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"Enacting something I didn't believe in": Clinician Experiences of Dissonance Related to
Power and Oppression in Community Mental Health

by Maisy T. Hughes

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Abstract

Systems of Community Mental Health (CMH) care often operate as apparatuses of oppression and social control over marginalized groups. Rooted in colonialism and racial capitalism, these systems have a history of causing harm in particular to Black, Indigenous and People of Color (BIPOC) (Metzl, 2009; Wade, 1993; Szasz, 2009). Pressured to comply within neoliberal practice environments, clinicians are limited in their ability to resist enacting oppression, and experience dissonance—a state of tension arising from psychologically inconsistent cognitions (Harmon-Jones & Mills, 2019)—as they find themselves caught between anti-oppressive practice ideals, and what is required of them by their agencies. In this qualitative study, I conducted individual semi-structured interviews with 13 current and former CMH clinicians, who were asked to reflect on their experiences of and responses to dissonance around power and oppression in these practice settings. I used content analysis to examine how white clinicians experience and respond to dissonance related to power and oppression in critical moments of the clinical encounter, exploring the ways that dissonance motivates acquiescence vs. resistance in these moments. My analysis revealed the ways that clinicians experienced *powerless dissonance* in areas where they don't have choice, and *discretionary dissonance* in areas where they do. Building on Dominelli's (1999) work, I found that in some moments, clinicians succumb to powerlessness, leading to *acquiescent accommodation* of oppressive agendas. In other moments, clinicians harnessed discretionary power, for *strategic accommodation* to find maximal space for their clients, or *explicit resistance* to push back against harmful practices. The role of clinicians' emotional experiences and

self-concept as it relates to their racial and professional identities in the drive to reduce

dissonance are explored through a critical conceptual framework centered on critical

whiteness theory (Applebaum, 2010; Frankenberg, 1993; Hook, 2011; Sullivan, 2014). I

conclude that dissonance can be *generative* if clinicians are able to sit with it in moments

where it cannot be reduced. These findings suggest the importance of clinicians

participating in practice communities that center anti-oppressive aims and provide tools

that help them lean into the discomfort of dissonance in their practice.

Keywords: Community Mental Health, therapy, dissonance, anti-oppressive

practice, neoliberalism, critical whiteness theory

Dedication

This dissertation is dedicated to the clinicians I interviewed for their vulnerability and willingness, and to clinicians everywhere coming up against painful contradictions in their work, sitting with difficult truths, and trying to find pathways forward that center their clients.

Dr. Briana Bogue Volpintesta, my forever friend and colleague, for being my living proof that completing this dissertation was possible, for always reminding me of that when I needed it, and for reading and editing my drafts.

James, my best friend, for the countless Pomodoro ("Pom") sessions over the years, and for always being there when I needed to cry it out. Your steady and reliable presence in my life has been an anchor.

Finally, my partner Scott, for witnessing and weathering the highs and lows of this process right along with me. Thank you for listening and loving me through this. I know you are as excited as I am for it to be completed. I love you and am so grateful for you.

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Chapter 1: Introduction, Literature Review and Conceptual Framework

I begin by sharing reflections on my own experience and process of developing and carrying out this project. My interest in this dissertation topic, as well as my approach to engaging with it, stemmed directly from my personal experiences and evolved against the historical context in which I conducted this research.

I was led to pursue a doctoral degree as a result of my practice experiences. After graduating with a Master's in Family Therapy (MFT), my first job was working full time as a fee-for-service clinician with children and families at a Community Mental Health (CMH) agency. At the same time, I worked part time carrying a small caseload in a private-pay group practice. I was immediately struck by the difference in the type and quality of care offered to clients who could afford to pay out of pocket as compared to those on Medicaid—namely, the ways that the system removed agency both from myself and my clients.

My MFT degree had primed me already to think about how an individual's experiences are shaped by the systems they are a part of, but my doctoral coursework in social work offered me the history and conceptual frameworks to be able to name how systems of oppression and domination were shaping the systems that I was practicing within. I had the intellectual tools to be truly critical of my role as a therapist, considering the oppressive historical and structural underpinnings of my profession. In new ways, I was examining more deeply what it meant to be white, and specifically, what it meant to be a white therapist working with primarily Black, Indigenous and People of Color (BIPOC) clients. In some ways, I remember this feeling freeing, as I began to more

thoroughly reject and challenge normative expectations in both my personal and professional life. However, it was also destabilizing—I felt unmoored as I struggled to build new structures of understanding and meaning to guide my practice. As my personal and professional identities were being deconstructed by my educational experiences, my practice experiences were also throwing me into a crisis of faith. My therapeutic tools constantly felt insufficient to combat the enormity of what my CMH clients were dealing with as a result of the material and emotional implications of economic and racial oppression. I was constantly feeling the limitations of what therapy can offer, and at the same time feeling the urgency of how dire many of my clients' situations were. I was becoming increasingly aware of my complicity in their suffering. I was becoming burnt out and cynical about my work. I was feeling powerless. My research interests began to center more specifically, though perhaps not always consciously, on trying to make sense of my experience and find my footing. At this time, I began slowly distancing myself from CMH work, instead increasing my group practice caseload. By 2023, I would leave CMH completely.

I was entering the stage of honing and finalizing my dissertation topic in 2020, the events of which further shaped my relationship with this project. As was true for white people across America, the racial justice protests following the murders of George Floyd and Breonna Taylor brought my whiteness more clearly into perspective. Like many of the white people I know, I joined anti-racist book clubs, began participating in mutual aid efforts, and did my fair share of shaming other white people who I saw as failing to do their part in this historic moment.

Interestingly, as I continued honing my dissertation topic during this time, I began moving *away* from whiteness. I was interested in how whiteness was embedded in neoliberal systems, but less compelled to focus on white clinicians specifically. I wonder now if I had run out of stamina for examining my whiteness. I think I also was, and am, embarrassed and afraid, in an age of cancel culture, to be a white person writing about race at all. I'm remembering clearly now the criticism that Robin DiAngelo received, and the ways that her professional success for *White Fragility*, which was at the top of everyone's anti-racism booklist, centered a white woman as an authority on race rather than centering BIPOC perspectives. I didn't want to be another white person writing about whiteness—not just because it felt superfluous, but because I was seeking to avoid potential scrutiny.

Yet here we are. As I'll describe further in my discussion of methods, my recruitment strategy, which was rooted in connecting with my (very white) communities, produced a sample of white clinicians. As is typical of whiteness, it inserted itself in moments throughout my research process where I was not as intentional as I ought to have been about decentering and deconstructing it. Though my study is about clinicians' experiences of dissonance related to oppression more generally, it became necessary to attend specifically to whiteness to critically engage with the narratives of my white sample. I notice an experience of guilt and shame arising from an awareness that my research centers whiteness. At the same time, perhaps this can still be a useful story to tell, and one that makes most sense for me to tell from where I am situated.

I've become increasingly aware of the ways that my own experiences of dissonance and powerlessness in my work, as well as guilt that I was holding as I made

the decision to leave CMH, were with me throughout the research process. I also noticed the ways that connecting with other clinicians through interviews and hearing that they have had the same experiences made my challenging feelings easier to sit with. In many ways, this research has been a way of making sense of my own experiences of dissonance in my work in CMH. I have wondered about how the selection of this topic may have been in the service of reducing my own dissonance through connecting with those who share my experience and perspective, but also hope that my participants had this normalizing experience as well during their interview. As I reflect in writing this statement, my own experience of dissonance—of trying to hold multiple truths—is apparent and indicative of what I bring to this work. The process of writing this dissertation has been a practice of embracing contradictory realities, and of continuing to cultivate my capacity to sit with the painful and uncomfortable ones. I encourage the reader to approach this work with a similar willingness to hold space for complexity and discomfort.

Background and Research Aims

Neoliberal systems of CMH care arise from colonial traditions that are highly racialized in their oppression (Metzl, 2009; Szasz, 2009; Wade, 1993). Within these systems, white clinicians are in ethically challenging positions as they attempt to resist being oppressive toward their clients. We struggle to adhere to our values while also meeting the increasingly neoliberal expectations for our agencies. These experiences create dissonance for CMH clinicians. Dissonance can be understood as a state of tension that arises when a person holds two psychologically inconsistent cognitions (Harmon-Jones & Mills, 2019). Literature suggests that clinicians may naturally be drawn to

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reconcile dissonance through acquiescence to agency expectations and culture (Burke et al., 2017; Dominelli, 1999; Gibson, 2019).

Yet, clinicians are also able to turn moments of dissonance into pathways of resistance (Carey & Foster, 2011; Dominelli, 1999; Ware et al., 2000). In so doing, they attempt to deliver liberatory care despite the constraints of their clinical setting. My research focuses on deep exploration of these moments of generative dissonance, to try to uncover the complex processes of resistance vs. acquiescence as clinicians attempt to enact anti-oppressive practice values. My guiding research question is: How do clinicians experience and respond to dissonance related to power and oppression in critical moments of the clinical encounter?

Clinicians' experiences of dissonance are important to examine for several reasons. First, chronic dissonance leads to burnout and considerable job turnover (Burke et al., 2017; Nielsen et al., 2023; Rosen et al., 2022), which creates unfavorable treatment conditions for clients that are already facing numerous barriers to receiving services (Cook et al., 2018). Clinician turnover means that clients must transition often between clinicians, posing a barrier to the long term, attachment-based treatment that has proven the most effective in the treatment of complex trauma (Herman, 2015). Given the prevalence of complex trauma, and thus, complex presentations, in urban CMH treatment populations (Sucich et al., 2023), it is a disadvantage to clients to not have a chance to work with more experienced clinicians.

Dissonance is also useful to examine because it can serve as a catalyst for positive change. When individuals become aware of a disconnect between their values and actions, it can motivate behavioral adjustments to better align with their principles

(Harmon-Jones & Mills, 2019). This research aims to explore the challenges clinicians encounter as they strive to establish healing and empowering therapeutic relationships within oppressive contexts. It seeks to uncover the creative and innovative strategies they employ to navigate these barriers, and to understand the role and impact of dissonance as clinicians work towards anti-oppressive social work practice. An anti-oppressive approach encourages a critical and political understanding of how systemic oppression impacts service users, and advocates for the use of critical awareness and resistant strategies that promote social change (Healy, 2014). If social workers are to provide care that truly centers the needs and priorities of service users in a system that prioritizes market forces, it is crucial to approach practice through this anti-oppressive lens and to understand the obstacles clinicians face in their pursuit of more radical and resistant clinical practice.

Literature Review

In this literature review, I will begin by examining the history of the colonial history of the social work field and the neoliberalization of the welfare state, highlighting empirical literature that articulates how the medicalization of the mental health field operates as a racialized tool of social control against BIPOC. I will then turn to examining literature on cognitive dissonance and moral distress, focusing on how social workers and other health professionals have experienced and responded to dissonance resulting from conflict between their values and the expectations of their work environments, and highlighting ways that social workers have turned this dissonance into opportunities for resistance.

Social Work as a Colonial Project

As a result of the complex interaction of individual, systemic and historical risk factors associated with living with a marginalized identity, BIPOC have an increased likelihood of diagnosis with severe mental illnesses yet are less likely to access services (Cook et al., 2018). When they do, they are more likely to use inpatient hospitals and emergency rooms rather than access less invasive levels of ongoing clinical support (Cook et al., 2018), and are found to discontinue services at a disproportionate rate (Kilmer et al., 2019). BIPOC are more likely to receive lower-quality, culturally insensitive care, in which they experience microaggressions and find that the impact of oppression is minimized or not acknowledged by their provider (Arora et al., 2022; Constantine, 2007). Literature has suggested that BIPOC clients may avoid addressing racial or cultural issues in therapy with white providers, finding that their therapists could not comprehend aspects of their experience (Chang & Berk, 2009). This has been described as a process of cultural concealment in which aspects of the racial or cultural self are hidden and distanced in therapy with white providers, limiting therapeutic trust and progress (Arora et al., 2022; Drinane et al., 2018; Esprey, 2017).

The limitations of mental health care for BIPOC are rooted in the historically colonialist and capitalist functions of the mental health field. Social work in particular, despite a parallel history of radical and emancipatory work (Carey & Foster, 2011; Ferguson, 2009; Strier & Bershtling, 2016), has operated as a tool of social control (Abulhul, 2021; Fortier & Hon-Sing Wong, 2019), serving increasingly neoliberal agendas (Brady et al., 2019; Dominelli, 1999; Schram, 2018). Social work originated in part to address the social paradox of high rates of poverty in a thriving economy (Stuart, 2013), and to help immigrants and other vulnerable populations develop "tools and skills

to escape economic and social poverty" (NASW, 2019) and thrive. Early social work viewed health in terms of Western ideas of healthy family life and worked to minimize deviant behavior through moral reform (Ehrenreich, 1985). While playing an important role in addressing social problems, social work has also acted as a "foundational component to the creation, expansion, and adaptation of the settler state (Fortier & Hon-Sing Wong, 2019, p. 437)." Conceptions of care in social work have always been shaped around racist paternalism due to how racialized constructions of BIPOC as inferior and thus in need of management have driven the development of the field. Badwall (2014) articulates the ways that social work values have always been intrinsically linked to white Eurocentric notions of what it means to be a civil, virtuous, and moral citizen, and behaviors or beliefs that stray from these notions are pathologized.

Mental health diagnoses as represented in the Diagnostic and Statistical Manual of Mental Disorder (DSM) are socially constructed in the service of racial capitalism. Racial capitalism is a concept describing how racialized exploitation and capitalism are mutually reinforcing (Robinson, 2020). The ways that the DSM has supported racial capitalism becomes clear when examining how definitions of health and wellness shifted in various revisions over time to align with shifting constructions of race and to thwart resistance to white supremacy (Metzl, 2009; Szasz, 2009). In 1851, Dr. Samuel Cartwright coined the term 'drapetomania' to describe the of an enslaved person running away as a mental illness (Opara et al., 2022). Metzl's (2009) historical analysis demonstrates how the diagnosis of schizophrenia has been racialized and weaponized against Black Americans throughout history. He articulates how this diagnosis was used

to undermine and delegitimize Black political protests by framing them as irrational psychosis rather than rational civil disobedience.

The DSM still uses racialized diagnoses to thwart resistance to racial capitalism. Black clients tend to receive more severe psychiatric diagnoses than white clients, including conduct disorders, schizophrenia, and bipolar disorder, especially when comparing patients from similar socioeconomic groups (Bresnahan et al., 2007; Walton et al., 2010). Conduct Disorder is also disproportionately diagnosed in Black youth due to diagnostic bias in the mental health and juvenile justice settings (Mizock & Harkins, 2011). By constructing normal responses to oppression as symptoms of illness and labeling them as antisocial, the mental health field pathologizes survival behaviors of marginalized groups, acting as a mechanism of social control in service of existing power structures (Abulhul, 2021; Szasz, 2009; Conrad, 2007; Foucault, 1975/1995).

The historical and continued construction of BIPOC as inferior, along with capitalist logic, legitimizes the exploitation of their labor and masks ongoing economic oppression as an issue of personal responsibility. Colonialism, capitalism, and neoliberalism are three strands of the same project, utilizing similar ideological and material mechanisms of oppression to maintain white superiority, and the neoliberal welfare state continues to justify the control, surveillance, and erasure of BIPOC under the guise of care.

Under neoliberalism, market rationality becomes generalized to non-economic spheres of society and individuals are expected to think and behave like market subjects in all areas of life. Neoliberalism has resulted in marketizing the welfare state so that it operates like a business and policymakers, administrators, clinicians, and clients are

motivated to act in market-compliant ways (Dominelli, 1999; Schram, 2018). Managed care is explicitly defined as a strategy to reduce healthcare costs by tracking treatment outcomes, incentivizing certain performance goals, and increasing efficiency (Centers for Medicare & Medicaid Services, 2019). For social workers and other mental health professionals, Managed Care Organizations (MCOs) dictate norms and expectations for practice, making the neoliberal welfare state rife with mechanisms of control and accountability that limit the providers professional autonomy (Brady et al., 2019; Dominelli, 1999; Schram, 2018). Through various systems of performance measurement and appraisal, quality assurance and risk management, providers are beholden to the priorities of racial capitalism and neoliberalism, which conflict with what may benefit the patient (Marston & McDonald, 2012). Under the guise of humanitarian concern, the welfare state represents subtler, sophisticated forms of social control that limited poor people's ability to dictate their own lives (Escobar, 2012; Schram, 2018).

Racial capitalism not only influences clinical practice at a structural level, but clinical research has depicted the ways that it is also embodied and enacted intersubjectively, particularly when white clinicians are working with BIPOC clients (Esprey, 2017 Liu et al., 2019; Layton, 2006). Cross-racial clinical dyads are common in CMH settings. Medicaid is the single largest payer for mental health care in the United States, and over 60% of Medicaid recipients are BIPOC. Social work students, who frequently complete internships at CMH centers, are over 68% White, with the social work field overall being 69% White (Salsberg et al., 2017).

Approaches to education and professional development to support successful cross-cultural encounters have historically taken a multiculturalism/cultural competency

approach, which fails to adequately discuss whiteness and structural racism (Beck, 2019; Daniel, 2008; Lee & Bhuyan, 2013). Literature has demonstrated how even clinicians who attempt to address and interrogate how whiteness impacts their practice are not free from unconscious reproductions of racism in the therapy room (Badwall, 2014; Esprey, 2017; Weir, 2021).

White clinicians working in CMH centers, attempting to enact beneficence, face challenges that stemming from the racial and colonial underpinnings of the therapeutic professions and the neoliberal institutional practices that reflect and reify these roots. In their professional lives, as they adhere to workplace requirements, clinicians participate in practices that feel at odds with their intentions, creating moments of ethical conflict and tension.

Cognitive Dissonance, Moral Distress and Moral Injury

The ethical tension states that clinicians inhabit in their work can be conceptualized using dissonance theory, and theories of moral distress which offer insight into how individuals behave when faced with value conflicts (Burke et al., 2017). Introduced by Festinger (1957), dissonance theory suggests that when individuals are aware of contradictory or inconsistent cognitions, they experience psychological discomfort and are motivated to reduce this dissonance. In the dissonance literature, "cognition" can refer to attitudes, emotions, opinions, beliefs, or awareness of one's behavior/ the behavior of others (Festinger, 1957).

Dissonant experiences arise in moments of having to take "responsibility for consequences that violate their moral frameworks" (Crane et al., 2013, p. 3). It is difficult to tolerate because it makes the individual question their sense of self and self-concept

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(Aronson, 1969; Steele 1988). Steele (1988) suggests that we are motivated to reduce dissonance in order to maintain a perception of the self as "morally adequate, that is, as competent, good, coherent, unitary, stable, capable of free choice, capable of controlling important outcomes" (p. 262). Dissonance then is particularly related to moments of moral conflict.

We can better understand the discomfort of dissonance by weaving in the concepts of moral distress and moral injury. Moral distress occurs when someone feels that they know the right thing to do but are powerless to pursue the right course of action due to institutional constraints (Burston & Tuckett, 2013). Situations that create dissonance are likely to also generate moral distress for individuals, and vis-a-versa. Moral distress can lead to moral injury, which describes the lasting impacts of perpetrating, failing to prevent, or witnessing acts go against one's morality. Reactions to moral injury include guilt, shame, disgust, anger, and existential and identity crises (Rosen et al., 2022). Concepts of moral distress and injury help us understand dissonance moments as rife with emotional experiences that result from one's self-concept being questioned or threatened.

Social work, nursing, and other healthcare fields have produced literature exploring the specific experiences of dissonance and moral distress for helping professionals. In a quantitative study of Finnish social workers (N=817), Mänttäri-van der Kuip (2016) found experiences of moral distress across the board in social workers, who felt that they were forced to work in ways that conflicted with their professional values. Insufficient resources related to budget insufficiencies and work overload were named as the structural predictors for moral distress. Mänttäri-van der Kuip (2016) also

found that as a result of moral distress, social workers took more sick leave and did not experience pride or enthusiasm related to their work. The literature on moral distress in social workers finds that this distress arises when social work values, ethics, and ideals, as articulated in social work education and training, do not feel possible to translate in practice, which challenges their sense of agency (Marston & McDonald, 2012). Unable to feel that they are "heroic agents" (p. 1027) of social change, social workers' professional identities are threatened (Marston & McDonald, 2012).

Professionals in the healthcare field are faced daily with "value laden decisions" (Ulrich et al., 2007, p. 2), particularly around patient autonomy. Social workers seem to feel considerable dissonance in particular around maintaining client autonomy in situations that require directive intervention (Scheyett, 2019; Taylor & Bentley, 2005). Taylor & Bentley (2005) identified "mandated or involuntary treatment, intervening in a consumer's decision-making about medication, breaching confidentiality to communicate with family members, and making decisions about a consumer's ability to direct his or her own life" (p. 472) as common dissonant situations that social workers are put in, as they conflict with the social work value around clients' right to self-determination.

Taylor & Bentley (2005) describe these as moments of "professional dissonance," or a discomfort that arises when professional values conflict with job tasks (p. 89). Generally, discussions of both dissonance and moral distress for helping professionals are focusing on moments of conflict between internal motivations and external conditions—between expectations and mandates. However, through examination of experiences of moral distress for physicians, Crane et al. (2013) proposed an updated definition, suggesting that while organizational limitations may precipitate moral distress,

it does not only arise in situations where decision-making is "non autonomous," but also situations where the actor has some level of autonomy and responsibility. Crane et al. (2013) suggests that moments of autonomous decision making may be even more likely to precipitate moral distress, given that one's sense of self is implicated in moments of agency.

This suggestion is consistent with cognitive dissonance theory, which argues that perceived choice plays an important role in how people experience and respond to dissonance (Harmon-Jones & Mills, 2019). Various paradigms have been experimentally tested in dissonance research to generate theory about responses to dissonance. The free-choice paradigm suggests that dissonance arises around moments of decision-making, and that the more difficult a decision, the greater need arises to reduce dissonance. Once a choice is made, individuals tend to change their evaluations of the choice, either by noting aspects of the chosen option to emphasize its positive aspects, or aspects of the rejected option to highlight its negative aspects (Harmon-Jones & Mills, 2019).

The induced-compliance paradigm suggests that when there is no choice around engaging in the behavior, a counter attitudinal behavior feels justified and thus dissonance is minimal. Research in these paradigms demonstrates that when people have a lot of choice, they are more motivated to change their attitudes after the fact to be more consistent with their behavior. In moments of low choice, there is less of a drive to reduce dissonant attitudes, as the behavior is externally justified (Harmon-Jones & Mills, 2019). However, together with theories of moral distress and injury, it is clear that in the case of healthcare workers, external justification of behavior does not necessarily alleviate feelings of internal inconsistency and distress.

Dissonance Reduction

In response to the discomfort of dissonance, we are driven to reduce it (Harmon-Jones & Mills, 2019). Dissonance scholarship has identified several different dissonance reduction strategies, generally centered around changing cognitions and changing behavior. Harmon-Jones and Mills (2019), building on Festinger's (1957) work on dissonance reduction, highlight four main ways in which dissonance can be reduced: (1) by removing the dissonant cognition (2) by adding new consonant cognitions (3) by reducing the importance of dissonant cognitions (4) by increasing the importance of consonant cognitions. McGrath (2017) in a review of the history of dissonance in the literature, identified the more specific strategies employed to create these shifts. The most empirically studied strategy for dissonance reduction is through changing one's attitude or values, which allows them to place less importance on the dissonant cognition. People also use distraction and forgetting, trivialization, self-affirmation, denial of responsibility, and rationalization to minimize the dissonant or affirm the importance of consonant cognitions (McGrath, 2017).

Dissonance can also be reduced behaviorally through direct action and behavioral change (McGrath, 2017). Concepts of compliance and commitment help us understand how an individual will respond, and whether their dissonance reduction will result in direct action. An individual may be more likely to reduce dissonant cognitions rather than change dissonant behavior in moments where these cognitions challenge what is required of them for compliance (McGrath, 2017). Another key factor influencing how one responds to dissonance is commitment. Harmon-Jones (2000) noted that increasing the importance of consonant cognitions through commitment can be a more generative

response to the experience of dissonance that are geared toward value driven action rather than rationalization, denial, and other escapist reduction tendencies. This suggests that if a person can remain committed to a set of core values, they are able to respond to dissonance by engaging in behavior change and action that honors this commitment. For instance, if someone feels a strong commitment to quit smoking, they will be more likely to respond to dissonance by reducing or eliminating smoking-consonant cognitions and recommit to the cognitions that align with their value commitment (Festinger, 1957). In this way, though dissonance can be reduced through behavior change, dissonance theory would suggest that changes in behavior are facilitated and motivated by preliminary changes in cognition.

Steele (1988) offers an important critique of Festinger's dissonance theory, suggesting that self-affirmation plays an important role in dissonance reduction, and through self-affirmation one can successfully reduce dissonance without necessarily addressing or resolving the inconsistency that generates it. He returns to Festinger's (1957) example, the smoker who feels shame and lack of integrity when continuing to engage in a behavior that challenges his sense of self. Rather than quitting smoking, Steele (1988) suggests that the smoker "need only engage in some affirmation of general self-integrity…for example, join a valued cause, spend more time with his children, or try to accomplish more at the office, and in these ways affirm a larger sense of being an adequate person" (p. 262). While the drive to reduce dissonance has the potential to create behavioral shifts, these may still be shifts that successfully restore a person's sense of comfort with themselves while allowing actions that are at odds with values to persist. This is important to remember as we shift toward thinking about dissonance for

clinicians, and its potential role in creating social change. Overall, motivations to reduce dissonance are linked to feelings of guilt and shame that arise when moments of dissonance threaten self-integrity, which points to the importance of examining the role that emotions play in how individuals experience and respond to dissonance. Cancino-Montecinos, et al., (2020), in a review of the literature on cognitive dissonance theory, suggest that dissonance-reduction strategies can be understood as emotion regulation strategies.

Dissonance Reduction in Social Workers. As described above, helping professionals face numerous conditions and workplace expectations that generate dissonance and moral distress. The literature has explored various ways that dissonance in moments of professional moral conflict is reduced, and the implications of dissonance reduction for practice. While not writing specifically about dissonance or moral distress, Dominelli (1999) describes how social workers respond to the neoliberal policies that characterize social work practices, and their responses are consistent with the literature on dissonance reduction. Dominelli (1999) identifies three ways that social workers have responded to the state of the social work field: they accommodate, escape or resist. In practice, these responses operate fluidly, with many practitioners who stay in the field moving between accommodating and resisting at different moments (Scheyett, 2019). Accommodation, escapism and resistance all employ cognitive and/or behavioral changes to reduce dissonance.

Escapists experience professional disempowerment and develop a cynical view of the system, often leading them to leave the public sector or the field altogether. Burke et al. (2017), in a qualitative study about dissonance reduction for social workers facilitating

transracial adoption (N=21), found that many social workers will change jobs to an agency that is more aligned with their values as a dissonance reduction strategy.

Accommodationists, while they may be aware of value contradictions, generally accept these limitations and work to provide the best services possible under given constraints. The dissonance reduction literature suggests that accommodationists may seek to reduce dissonance through changing their cognition. Burke et al. (2017) found that social workers change their dissonant cognition by rationalizing the role and importance of social work intervention. For example, in work with Aboriginal children in out of home placements, participants justified foster care as an acceptable alternative, arguing that it provides stability while still allowing for cultural connections. Thus, social workers may be prone to inflate the importance and success of social work programming to reduce dissonance. Finally, participants reduced dissonance by focusing on positive outcomes they've seen in their work (Burke et al., 2017).

Taylor's (2007) work on dissonance reduction in social workers described how social workers reduce dissonance by changing cognition in the service of accommodation. She articulates how Harmon-Jones and Mills' (2019) four dissonance reduction strategies may look as social workers grappled with dissonance and attempted to alleviate their discomfort around hospitalizing clients. Clinicians may remove the dissonant cognition by emphasizing that they "had no choice"; they may add new consonant cognitions, such as "I'm helping her." They can reduce the importance of dissonant cognitions with justifications like, "She really doesn't mind being in the hospital." Finally, they may increase the importance of consonant cognitions such as "her safety is the most important thing" (p. 97). These reduction strategies all fall under the

category of changing a cognition rather than changing behavior, thus accommodating professional expectations rather than pushing back against them.

Dominelli (1999) identifies a third response: resistance. Resistant practitioners share the feelings of alienation that plague accommodationists and escapists, but they remain committed to confronting the inconsistencies that limit their work and seek political action to rectify the problems they see. Before delving into resistance, it's important to highlight the ways that the lines may be blurred for social workers between accommodation and resistance, and the ways that clinicians may move between the two in different moments.

Gibson (2019) offers a useful conceptual framework that can be mapped onto Dominelli's (1999) paradigm to further conceptualize the space in between accommodation and resistance, and the role that the threat of moral injury plays in both. In an ethnographic case study of a child protective services agency in England, Gibson (2019) examined how "self-conscious emotions" (p. 112)—pride, shame, guilt, and humiliation—shape social workers' practice, demonstrating how the threat of shame (and promise of praise) impacted how they responded to institutional norms and demands. His framework suggests five possible responses falling on a spectrum between active identification with, or active resistance of institutional norms and expectations. Dissonance reduction strategies to avoid moral injury can be seen in Gibson's (2019) findings in each of these categories.

In what Gibson (2019) called moments of *enacting*, social workers experienced pride and felt that they were doing a "good job" (p. 110), their conception of "good job" being aligned with dominant institutional logic. In moments of *complying*, they do not

agree with institutional logic but are compelled to comply anyway, resulting in feelings of shame and guilt. They engage in acts of *compromising* where they attempt to balance institutional standards with their own values and standards, allowing them to feel some pride in their work while avoiding the likelihood of being professionally shamed. In *concealing* acts of resistance, social workers disguised their resistant strategy to avoid detection by institutional systems of surveillance and monitoring. Finally, explicitly *influencing* the institution to change expectations (Gibson, 2019). Overall, putting Gibson's (2019) model in conversation with dissonance theory suggests that both experiencing, and the threat of experiencing guilt and shame in dissonant moments can motivate both resistant and oppressive behaviors. This is consistent with the notion that emotional reactions play a key role in how individuals respond to dissonance (Cancino-Montecinos et al., 2020)

Clinical Resistance and Anti-Oppressive Practice

What does it look like when social workers resist? Emerging from radical and critical social work traditions, anti-oppressive social work practice advocates for acknowledging power imbalances and structural inequalities embedded within social systems and institutions, and encourages for the importance of social workers' critical reflection and collaboration with marginalized communities to address oppressive dynamics (Baines, 2017; Healy, 2014). Healy (2014) identifies five key principles of anti-oppressive practice: critical reflection on self in practice, critical assessment of service users' experiences of oppression, empowering service users, working in partnership, and minimal intervention.

In the therapy room, anti-oppressive practice frameworks can inform clinicians'

therapeutic approaches and can be practiced interpersonally in the therapeutic

relationship through critical reflection about how oppression is playing out. While the

power they hold cannot be erased, clinicians may attempt to mitigate it through attuned

therapeutic presence and a non-dominant, client focused therapeutic stance that ensures

that the clients' needs and perspectives are driving treatment (Healy, 2014). Clinicians

can use feminist and postcolonial practice theory and narrative, constructionist models to

consider contextual issues around identity and social, economic, and political imbalances

(Healy, 2014; McLaughlin 2009). Clinicians practicing from an anti-oppressive

framework seek to empower clients through consciousness-raising and externalizing the

impact of oppression rather than pathologizing clients' responses to it (Healy, 2014).

However, as articulated, the context of neoliberal practice creates structural

conditions that may limit clinicians' ability to apply these anti-oppressive tenets in their

practice. As Carey & Foster (2011) point out, social work practice that is truly disruptive

and resistant requires that the practitioner engage in acts of deviance, deception and even

sabotage in the interest of resistance. Deviant social workers find ways to evade

managerial and policy-driven mechanisms of surveillance and control (Carey & Foster,

2011), possible through the social worker's discretionary power as a street-level

bureaucrat (Lipsky, 2010). Lipsky (2010) describes how social workers translate policy

into action, and in doing so can influence how policies impact service users using this

discretionary power.

As suggested by Gibson (2019), acts of deviance, deception and sabotage can

range from clandestine to more explicit, and vary in levels of personal risk. Low risk

deviance is enabled in areas where clinicians have more discretion and less oversight. Burke et al. (2017) found that social workers reduced dissonance by engaging in subtle acts of resistance, giving the example of social workers asking foster care applicants for Aboriginal children to complete extra exercises to demonstrate commitment to cultural planning (Burke et al., 2017). Clinicians have been found to exaggerate client symptoms to obtain approval from MCOs for services that they felt were necessary for their client (Ware et al., 2000). Social workers can make small choices that evade formal policies, such as spending more time with a client than was permitted, or concealing and presenting information strategically to help clients meet criteria for certain services (Carey & Foster, 2011).

Using discretionary power for disruptive resistance involves risking professional status in some way. For instance, some social workers refuse to utilize interventions or enforce policies that are punitive or harmful (Carey & Foster, 2011). Gibson (2019) gives the example of a social worker who put her job on the line by refusing to recommend the separation of two siblings that her senior managers were advocating for, and threatened to resign if this action was taken. Her managers agreed to further assessment, which concluded the siblings shouldn't be split, but the social worker's "name was mud" professionally after this event (Gibson, 2019, p. 124). Engaging in truly disruptive practice requires that the practitioner push back against the neoliberal rhetoric of risk that mobilizes fear in the interest of maintaining compliance (Stanford, 2010), as well as the potential for shame or embarrassment for violating professional norms (Gibson, 2019).

Resistant, anti-oppressive practice efforts can be impactful for individual services users but can also lead to substantive change in practice over time. For instance,

providers pushing back against unrealistic session limits for mental health has led to greater flexibility in many managed care settings of the average length of treatment (Ware et al., 2000). There is global evidence of a social work of resistance being practiced today. In Hong Kong, New Zealand, England and Canada, research has demonstrated that social workers have engaged in resistant practices including challenging institutional policies of their agencies, anonymous whistleblowing to news media and other protest around budget cuts, refusing to provide data to support the implementation of harmful practices, striking, and becoming involved with local social movements that impact their clientele (Scheyett, 2019; Strier & Bershtling, 2016). The Eromin Center was an example of clinicians responding directly to unrecognized needs of a stigmatized group by using discretionary power, life knowledge, and affirmative approaches to care to resist the harmful practices that characterized treatment at the time for LGBTQ+ people (Byers et al., 2019).

Despite the possibilities for disruption, resistance, and anti-oppressive mental health practice, more research is needed to explore the conditions that make resistance a feasible, tolerable, and sustainable response to moments of dissonance. The role that guilt and shame plays in how clinicians respond to dissonance also needs further exploration, as these emotion states, or a desire to avoid them, have the potential to motivate action both in the direction of resistance and in the direction of oppression.

As I conclude this review of the literature, I want to address the fact that the majority of the literature covered comes from the social work field, but has implications for the mental health field as a whole, and healthcare professionals more generally. While it is easy to locate paternalistic roots in social work in particular, which was originally a

field dedicated to moral reform, we can see the same traces of racialized moral superiority operating in mental health disciplines across the board. Professional identities in the field of social work are uniquely tied to a capacity to work toward social justice and social change (Marston & McDonald, 2012), so it follows that the social work literature in particular would illuminate the dissonant experiences that follows when these goals are limited, as well carry frameworks and clinical wisdom to guide a conception of anti-oppressive practice. While the data presented in this study was collected from a variety of mental health professionals and not limited to social workers, I believe the literature on social work is relevant, given that the participants who opted into this study did so because considerations of power and oppression were relevant to their professional identities, regardless of their educational background.

As Badwall (2014) articulates about "helping professions" more broadly, "whiteness works through practices of empathy, love, and nurturance, which are essentialized as universal human qualities of the helping professional…practices of regulation are masked in discourses of charity, helping and care (p. 6)." Across the ethical codes of all therapeutic professions is the moral imperative of beneficence (Kinsinger, 2009), and thus professional identities are challenged when clinicians encounter barriers that may prevent them from fulfilling this imperative.

Conceptual Framework

The conceptual framework informing my work is epistemologically rooted in critical and postcolonial theories that focus on the role of power in shaping individual and collective experiences, and help to conceptualize how individual subjectivities are shaped by structures of oppression. Black radical theory contributes to my understanding of the

power-laden structures of capitalism being inherently racialized (Robinson, 2020). I utilize postcolonial theory (Fanon, 2004; Memmi, 1957/2010) to highlight the dynamics between the colonizer and colonized in colonial systems as they play out in the therapeutic encounter, and the inherent dissonance in both positions. Critical whiteness theory (CWT; Applebaum, 2010; Frankenberg, 1993; Hook, 2011; Sullivan, 2014) further sheds light on the dissonant experience of engaging in anti-racism as a white person, and the way that allegiance to moral superiority thwarts meaningful resistance. Double consciousness theory (Fanon, 1963/2004) along with structural dissociation theory and lessons from treating complex trauma (Nijenhuis, Steele, & van der Hart, 2006) offer a possible framework for moving beyond these barriers to resistance. The resulting framework situates the literature on dissonance and moral distress for clinicians, shedding light on the mechanisms through which neoliberal systems of care create an inherently oppressive context for social work treatment, and the dissonant experiences that result when white clinicians try to resist being oppressive in their roles.

Racial Capitalism, Neoliberalism and Colonialism

Black radical theory (Robinson, 2020) argues that common critiques of the neoliberal ideology fail to name how racism and capitalism have historically worked together to mutually construct harmful social conditions for BIPOC, and thus the way that racially minoritized groups are uniquely harmed under capitalism. Given that capitalism is not racially neutral, this discussion includes attention to how white supremacy and neoliberalism construct and maintain each other (Issar, 2020; Robinson, 2020; Szasz, 2009). The characteristics of white supremacy culture—perfectionism, sense of urgency, defensiveness, emphasis on quantity over quality, worship of the written

word, paternalism, either/or thinking, power hoarding, fear of open conflict, individualism, emphasis on progress/always more and right to comfort (Okun, 2021)—closely overlap with principles of capitalism and neoliberalism that emphasize cost reduction, productivity and individual responsibility. Racism and capitalism ideologically justify each other, and each have roots in colonial thought. Highlighting the influence of colonialism in shaping current capitalist structures emphasizes how racialization has and continues to operate in neoliberal systems.

The construct of racial capitalism elucidates the way that marginalized groups are forced into interaction with oppressive systems that continue to undermine their autonomy and cause harm under the guise of "supposedly deracialized neoliberal agendas" (Laster Pirtle, 2020, p. 504). Under neoliberalism, market rationality becomes generalized to non-economic spheres of society and individuals are expected to think and behave like market subjects in all areas of life. Neoliberalism frames human wellbeing within principles of capitalism, creating an institutional framework defined by private property rights, free markets, free trade and "possessive individualism" (Dominelli, 2010; Harvey, 2007).

The harmful logic of neoliberalism shapes behavior of neoliberal subjects via internalized neoliberal governmentality, a cultural apparatus that shapes individual subjectivities to align with market logic (Foucault 1975/1995, Schram, 2018). Through encouraging governmentality, "successful" individuals under capitalism will have internalized a set of internalized motives, desires, and qualities that support the government's agenda, and an accompanying set of habits, abilities, and skills that allow individuals to act in socially desirable ways and make them more governable (Foucault,

1975/1995). It is characterized by the governed participating unknowingly in their own continued oppression.

Bourdieu's (1977) concept of habitus helps explain how governmentality is translated into a set of power-laden dispositions that impact the clinical encounter. Habitus consists of habits, morals and schemes of perception, classification, appreciation, feeling, and action engendered through socialization. It is a "a structuring structure, which organizes practices and the perception of practices (Bourdieu, 1977, p. 170)" based on dominant values, thus privileging the dominant class to exert symbolic power and maintain the social hierarchy. Many have highlighted the lack of explicit attention to race in Bourdieu's (1977) theory and add that habitus is a racialized structure (Merolla, 2014; Perry, 2012). It is through these unconscious enactments of racialized habitus that the clinical encounter has the potential to cause harm. The clinician wields both literal and symbolic power in the clinical interaction.

Adding a postcolonial framework to the theories outlined above helps to further elucidate the neoliberal clinician's dissonant position, as it highlights the ways that colonization is also violent and destructive to the colonizer. Memmi (1957/2010) notes that colonizers experience guilt for debasing the colonized, which breeds further need to justify their actions. Then, there are those colonizers who do not necessarily become colonialists ideologically and resist the devaluation of the colonized. Memmi (1957/2010) notes that the material conditions of coloniality gives one two options for refusal: withdrawing physically from the conditions or remaining to fight and change them. Even if they chose to fight for change, the colonizer remains in a dilemma, as they continue to benefit from the privileges of the system he is denouncing. In these responses

to coloniality, we can see Dominelli's (1991) escape, accommodate and resist paradigm implicated.

A clinician attempting to engage in anti-oppressive practice, having an internalized neoliberal governmentality and racialized habitus that is inherently at odds with anti-oppressive values, experiences dissonance related to competing value systems. In many ways, the demands of neoliberal practice are at odds with some of the stated fundamental values of social work practice (Marston & McDonald, 2012). Despite a history of unavoidable participation in racial capitalism, social work at its core is based in solidarity with people suffering from all forms of oppression. A radical definition of social work ethics positions active resistance against injustice as a core guiding value (Banks, 2014; Ferguson, 2009). Radical social work theory suggests that reclaiming ethical practice requires critical and anti-oppressive frameworks of care (Banks, 2014).

Complicating Anti-Oppressive Practice: The Dissonant State of White Anti-Racism

Social work, in spite of its paternalistic roots, has been the helping profession that is uniquely concerned with issues of justice, equity and inclusion (Marston & McDonald, 2012). Across the board, in response to the racial justice movements of 2020, all helping professions have revisited and expressed re-commitment to social justice and anti-racism. Yet there are ways that social work, and all helping professions, particularly given the embedded mandate to "help," are irrevocably entrenched in the paternalism of racial capitalism that work against their resistant efforts. CWT (Applebaum, 2010; Frankenberg, 1993), and particularly the internal critiques of it (Hook, 2011; Sullivan, 2014), offer further nuance that helps us understand white clinicians' awareness of

themselves as potentially harmful actors, and the double bind that is created as they attempt to engage in anti-oppressive practice in response to this awareness.

CWT situates whiteness as a power-laden social construction that comes with material and symbolic privilege. It depends on and reinforces a hierarchy that relies on the devaluation of the racialized "other" (Applebaum, 2010). To return to the concept of a racialized habitus, whiteness is embodied, and passed down intergenerationally through body language, facial expressions, and ways of communicating and being (Sullivan, 2014). For clinicians, whiteness is also embodied and passed down in our professional training and as we learn through mentors. As white norms have shaped our profession, our professional scripts are imbued with these norms, and whiteness hides behind professionalism (Badwall, 2014). A key construct in CWT is the invisibility of whiteness. Because it is positioned as normative, whiteness goes unnamed, allowing it to clandestinely reproduce itself. To counter the invisibility of whiteness, critical whiteness scholars task white people with critically interrogating whiteness and their own role in perpetuating racial injustice (Frankenberg, 1993).

However, white people engaged in the process of developing an anti-racist white identity may unwittingly, through over identification with the moral imperative to be a "good" white person risk in fact reifying harmful aspects of white identity (Sullivan, 2014; Applebaum, 2010). Sullivan (2014) articulates the ways that white guilt and shame are mechanisms through which white people construct themselves as good, creating distance and attempting to disavow their white identity. White guilt has been named by scholars as a white-centering impediment to efforts toward racial justice, naming that it can lead to paralysis, inability to think critically about the role of systems in perpetuating

racism, and performative and virtue signaling actions to assuage guilt (Spanierman, 2022). DiAngelo (2018) names how white people often lack the *stamina* to push through the feelings of guilt and shame that are a natural part of confronting one's own complicity and racism, thus leading them to disengage from anti-racist work, and names the development of stamina as essential for an ongoing commitment to anti-racism.

The field of critical whiteness studies itself has been critiqued for keeping whiteness at the center, which risks becoming "a spectacle of pure self-reflection" (Ahmed, 2004, p. 3). Ahmed (2004) warns against getting stuck in the "politics of declaration" (p. 3)—the tendency in whiteness studies to conflate admissions of bad practice with signs of good practice. In line with this critique, Hook (2011) raises Biko's Black Consciousness critique of white liberalism to explore anti-racism in post-apartheid South Africa. Building on Ahmed's (2004) critique, Hook (2011) highlights that making visible the invisibility of whiteness is not sufficient to disrupt whiteness, and the idea that whiteness "is only invisible to those who inhabit it" (p. 7). Making this turn toward visibility a priority neglects to center and understand the experiences of BIPOC, to whom whiteness is already markedly visible.

Hook (2011) describes the ways that anti-racism is almost inescapably disingenuous and self-referential, writing that "many of the critiques I go on to develop in this chapter pertain directly both to this chapter itself (p. 3)." He articulates how antiracism efforts can become a "fetishistic preoccupation with disproving one's racism (p. 1)." This is often done through ostentatious or public action, and through "selective self-aggrandizement of certain behaviors", in which the white person softens the blow of having to confront their own complicity. He goes on to explore how anti-racism can

function as means of self-promotion professionally, and as a means of developing "white self-love. Through the redemptive gestures of antiracism, the white person is able to feel that they are heroic, self-sacrificial, charitable, humanitarian and generous and innocent—all of the qualities that are valued in white conceptions of goodness (Badwall, 2014; Hook, 2011). Hook (2011) argues that antiracist efforts by white folks actually operate to "consolidate and extend white agency" (Hook, 2011, p. 12).

Interestingly, Hook (2011) argues that antiracism can operate as a form of white self-love, allowing the white person to feel good about themselves for fulfilling the role of hero and moral superior. On the other hand, Sullivan (2014) talks about white self-love as the necessary next step for more authentic and meaningful anti-racist efforts. These two conceptions of the role of white self-love reflect the inherent dissonance present for a white person doing critical anti racist work—guilt, shame and self-devaluing are harmful, yet pride and self-worth can perpetuate systems of oppression as well. It's important to be critically aware of how whiteness is operating, but to sink into this awareness is to center and reify whiteness. The literature suggests that anti-racism efforts implicitly undermine themselves, inevitably reifying what they are fighting against in the same breath. This isn't to say that we should abandon anti-racist action, which can still be transformative, but to acknowledge that it will simultaneously cause harm.

Hook's (2010) warns against a white self-love in which one's self-concept is tied up in the moral imperatives of whiteness. Sullivan (2014) imagines a self-love through which white people "can find ways to live in their own skins *and* help bring about more racial justice in the world" if that self-love is based in "different virtues than the ones they've cultivated as masters of white domination…that aren't concerned with the

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conventional morality of white people. They would be virtues that challenge the narcissistic self-loathing at the heart of white people's racial quest for moral goodness (Sullivan, 2014, p. 284). She advocates for a "critically constructive relationship to the person or thing that one loves (p. 299)," in which criticism is viewed as a vital part of "healthy loving." Through a welcoming of criticism, white people "risk complicity with white privilege and white supremacy…out of a loving relationship with oneself (Sullivan, 2014, p. 234)."

The works of both Hook's (2010) and Sullivan (2014) suggest letting go of goodness in favor of wholeness. In practice, this means being able to face all parts of self, including ones that are shameful, and being able to tolerate and be with rather than try to reduce or avoid this shame.

Hooks (2010) describes this as the "wounding of whiteness…the puncturing of the narcissistic enclosure of self-contained identity (p. 19)." He describes this wound as "something which holds neither the promise of singularity, nor of any 'feeling better'…a painful remaining open, a refusal to close into one (p. 19)." Bringing this back to the notion that dissonance can be generative and that guilt can be positively motivating, this type of relationship with whiteness does not release the subject of guilt, but renders guilt tolerable by making it acceptable to be guilty instead of good.

Hooks (2010) argues that being able to let go of the narcissistic gains of antiracism, white people need to let go of "the prerogative to be the giver, the agent of help, of a charitable giving (p. 17)," which is inherently at odds with the how the mental health field is constructed. The pressure inherent in whiteness to be "good" is only intensified for the white clinician, who internalizes this pressure from both their racial

and professional identities. Despite attempts to interrogate and mitigate the impacts of whiteness in their clinical work, clinicians are limited in their ability to do so insofar as they are committed to their role as a "helping" professional. As described in the early discussion of the history of social work, mental health treatment is based on white middle-class norms, creating a moral imperative around what it looks like to be a healthy and functioning member of society that is informed by racial capitalism. Notions of "good practice" in mental health care are founded in the moral superiority, paternalism and emphasis on "goodness" and "innocence" that characterize both whiteness and social work (Badwall, 2014). As Badwall articulates, clinicians engage in processes of trying to "redeem themselves" and maintain "an identity of goodness and innocence through their acknowledgements of being more powerful, naming trespasses, and remaining client-focused" (p. 9).

Returning to the literature on dissonance, actors are motivated to reduce dissonance insofar as it challenges their self-concept and sense of being a moral person and elicits guilt and shame. Critical whiteness literature suggests that any act motivated by a need to reduce dissonance around self-concept is ultimately self-serving, and that the path forward involves abandoning the concept of singularity.

Beyond Dissonance Reduction: Double Consciousness and Generative Dissonance

While providing a useful foundation, traditional dissonance theory is insufficient for conceptualizing the experience of both clients and clinicians in managed care given its emphasis on the unified ego, and the need for dissonance to be reduced to maintain this sense of self. Dissonance may not be a state that can be successfully reduced. For

those living in constant tension between two sets of norms and expectations, dissonance becomes chronic.

The concept of double consciousness can be seen as a way to cope with chronic dissonance rather than eliminate it. Cognitive dissonance theory assumes that the individual is motivated to maintain a positive view of the self, and that this self is a consistent and unified whole. To reduce discomfort in this view, the individual is motivated to be rid of cognitions that contradict their self-concept and deeply held values. However, if we consider multiplicity and the idea that individuals can embody various ego states and experience splitting around identity and sense of self, the concept of dissonance becomes muddier. With the presence of multiple self-states, two seemingly opposing sets of values may be experienced by the individual as both consonant and dissonant at different times. How and when cognitive dissonance is experienced and dealt with is also highly culturally constructed. The pressure to experience the self as a unified whole is itself a Western norm (Galletta, 2017).

Fanon (1963/2004) suggests that colonialism "forces the people it dominates to ask themselves the question constantly: 'In reality, who am I?'" (p. 250). Repeated, constant interactions with a system which denies their humanity essentially creates a splitting of the ego in service of maintaining a sense of self while also responding "appropriately" within the colonized environment. Research has suggested that groups who are marginalized based on their identity experience a kind of double consciousness (Fanon, 1963/2004) that allows them to hold middle class white cis-hetero-patriarchal norms and act in accordance with these when required, while also preserving the norms

and attitudes that characterize their marginalized identity (Layton, 2006; Liu et al., 2019).

The theory of structural dissociation (Nijenhuis, Steele, & van der Hart, 2006), which sheds light on the sequelae of complex trauma, is useful here to build on the notion of double consciousness. Similar to Fanon's (1963) description of the splitting of the ego, structural dissociation theory suggests that children who grow up in abusive households engage in this splitting in order to stave off the despair of being harmed by the person who you rely on for care, and awareness of powerlessness to change this. We develop multiple "selves" to adapt and survive in an abusive context that we cannot escape (Nijenhuis, Steele, & van der Hart, 2006). Importantly though, structural dissociation theory tells us that *accessing* this material, its emotional charge, is often too painful to tolerate, leading to amnesic barriers and a complete disavowing of the parts of self holding this material. When treating dissociative disorders, processing the painful emotions keeping traumatic material locked behind these barriers facilitates the ability for co-consciousness, in which disparate parts of self are able to be present with one another, to know what the other knows.

I am not meaning to say that being white is traumatic, but rather to use trauma theory to shed light on how the psyche organizes around distressing emotions that challenge one's sense of self. CWT described above suggests that white people engage in this splitting off process to cope with incompatible self-views. This is consistent with the literature which conceptualizes moral injury as a type of psychological trauma (Rosen et al., 2022). I am also conceptualizing the white clinician in the neoliberal mental health

system as oppressors, but also as in some ways oppressed by the harmful capitalistic system that they work within, which may create further splits.

Double consciousness, then, can be on one hand an isolated fragmentation, and on the other hand, a conversation between disparate self-states. The capacity for dual awareness, which allows for conversation, is only possible from a place of being able to tolerate and work through painful emotions (Steele, Boon, & van der Hart, 2016). The concept of double consciousness and its potential to create a dialogic tension state holds generative possibilities as a way to navigate and sit with dissonance without necessarily reducing it (Galletta, 2017), which Hooks (2010) and Sullivan (2014) might suggest is a necessary skill for a white clinician attempting to be anti-oppressive in their work. While uncomfortable and painful, dissonance does not have to be an inherently intolerable state. The idea that all cognitions must be consonant with one another to reduce discomfort is perhaps both not realistic and missing an opportunity for generative experiences and processes that can arise from sitting in this tension state (Galletta, 2017).

Conclusion

The literature and framework I presented in this chapter situates the clinician as a neoliberal subject, shaped by power-laden structures that shape how they conduct their work (See Figure 1). It suggests that clinicians may be experiencing dissonance without being able to pinpoint its source, as the nature of both whiteness and neoliberalism is to operate as a norm that is not always consciously known, yet impacts their internal experience of their work. Yet even when they do acknowledge the source, clinicians are faced with further dissonance around how to respond.

There are generative possibilities here, as the clinicians experience of dissonance and ability to navigate it when working with marginalized clients, may be an important emotion-state that allows the therapist to face, without avoidance or minimization, their complicity in their client's oppression and use this awareness to sustain anti-oppressive efforts. In this study, I examine what this process of dissonance looks like for clinicians, where they find space to resist, and how they are able to maintain an ethic of resistance in the face of ongoing dissonance. In particular, I will look for moments of generative dissonance embedded within clinicians' stories of challenging moments in their work.

Figure 1: Conceptual Model of Dissonance in Community Mental Health

Chapter 2: Methodology

The purpose of this study was to examine the experiences of clinicians working under managed care constraints in CMH settings, looking specifically at experiences of dissonance and moments of resistance in clinical practice. I conducted individual semi-structured interviews with 13 current and former CMH clinicians, where they were asked to reflect on their experiences working in these settings, and their experiences of and responses to dissonance around power and oppression in their work. I obtained study approval through the Bryn Mawr College Institutional Review Board (IRB). All revisions to my methods that are discussed were submitted as addendums and approved through the IRB.

Approach to Inquiry

My approach to inquiry is informed by a critical constructivist epistemology. Like traditional constructivist epistemology, this acknowledges multiple realities and the ways that reality is co-constructed intersubjectively (Creswell & Poth, 2016). It also incorporates the realist perspective that acknowledges how existing structures and material conditions shape one's experience of reality (Houston, 2001), and how power is at play in the process of intersubjective meaning making.

A phenomenological approach to this research was indicated to allow a picture of dissonance to emerge from shared experiences of clinicians. The goal of phenomenology is to collect data from persons who have experienced a phenomenon and to distill these experiences down to a description of the *essence* of the phenomenon in question (Creswell & Poth, 2016). This was a useful approach for understanding how the

phenomenon of dissonance exists dynamically and contextually with the clinicians' place of work.

In alignment with my critical epistemological framework, this study will utilize a critical approach to phenomenology (Guenther, 2019). Critical phenomenology considers how individual subjectivities and experiences of the world are shaped by social and structural forces, and critically examines how social location impacts one's experiences as an "embodied being in the world" (Guenther, 2019, p. 14). This approach differs from classical phenomenology in that its goal is to reflect with participants on the "quasi-transcendental social structures that make our experience of the world possible and meaningful, and also by engaging in a material practice of 'restructuring the world' in order to generate new and liberatory possibilities for meaningful experience and existence" (Guenther, 2019, p. 15).

Critical phenomenology is defined by a shift from the concept of the first-person subject to an intersubjective understanding of meaning making and interaction between self and world (Ngo, 2020). In practice, this method of data collection acts as an intersubjective interrogation of taken for granted structures of meaning, allowing room for critical reflection upon habits, norms and behaviors engendered by these structures (Ngo, 2020).

Critical phenomenology seeks to contextualize the participants' accounts of reality in light of the structures that shape these accounts. Weiss, Salamon, & Murphy (2019) describe this approach as "a way of pulling up traces of a history that is not quite or no longer there—that has been rubbed out or consigned to invisibility—but still shapes the emergence of meaning" (p. 16). Critical phenomenology sees social structures and

social positions as embodied, thus shaping a subject's interaction with the world. This approach has been used to understand the phenomena of racism and oppression as embodied habituated ways of being in the world (Chandler, 2019, Ngo, 2020). In my work, I hold the framework of racial capitalism and white supremacist ideology as shaping clinicians' accounts.

The phenomenological research process begins with a phenomenon of interest to study and uses purposive sampling to recruit participants who have experienced the phenomenon. Data collection consists of in-depth interviews, with the recommended sample size ranging from five to 25 individuals (Creswell & Poth, 2016). Interview questions are generally broad, open-ended, and focused around eliciting experiences of the phenomenon and the contexts and situations that this phenomenon has arisen. In analyzing data, the phenomenological researcher develops both a textural description of the participants' experiences as well as a structural description of how they experienced this in terms of conditions and context (Creswell & Poth, 2016). Analysis of the data focuses on connecting how the lived experience of a phenomenon as narrated by the participant is in conversation with broader social structures (Guenther, 2019).

Finally, in addition to phenomenology, my work was influenced by an autoethnographic approach, which is appropriate for research in which the researcher has personal experience with the subject matter and group being interviewed. Autoethnography is an appropriate lens for this research as it sees the researcher's personal experiences and relationships as an inherent and valuable part of the research process and uses "reflexivity to name and interrogate the intersections between self and society, the particular and the general, the personal and the political" (Adams et al., 2014,

p. 2). It's an approach that seeks to balance intellectual and methodological rigor, emotion, and creativity, and centers social justice (Adams et al., 2014). Autoethnography aims to subvert dominant discourses and critique the self in social context (Muncey, 2010).

Reflexivity Statement

As I discussed in my opening statement in the previous chapter, I worked in CMH for my first six years of practice, and was in the process of transitioning out of CMH to solely group practice during my data collection phase. My research interests arose directly from my own experiences of dissonance working as a white clinician working with low-income BIPOC clients. I have my own strong convictions around the medicalization of mental healthcare. I tend to practice from a relational, client-led perspective, use manualized approaches with extreme caution and flexibility, and am skeptical of how the "evidence" in evidence-based practice prioritizes empiricism over lived experience. I have wrestled in my own clinical work with the ethics of being a white clinician working with BIPOC clients, particularly when the client has no choice in provider.

I believe my shared experiences with my study participants added both richness and challenge to this research. At the beginning of each interview, I shared with participants about myself and what led me to this research, which may have made participants feel more comfortable opening up about the ways in which they feel they may have been oppressive in their clinical work without feeling judged or shamed. However, I was also aware of how my own experiences shaped my orientation to this research.

My identity and experiences shaped the research in a number of ways. As described in detail previously, this research question was of interest to me due to my own experiences. From here, it shaped my sampling and methods, as I was interested in recruiting clinicians with a shared experience of the phenomenon of dissonance. This led me to recruit through engagement with my extended networks and the clinical communities I am a part of around a shared experience of working in CMH in urban areas. I was aware of how this shared experience impacted my orientation to the work, and in analyzing my data and writing my findings, I engaged in self-reflective methods to make sure that I wasn't only telling the story that validated my experience. I intentionally looked for nuance and contradictory narratives throughout my analysis. I found myself challenged by some of my participants to notice and soften some areas of rigidity in my thinking, which was evidence to me that I was both shaping and open to being shaped by my research.

From within a critical constructivist epistemological perspective and an autoethnography framework, it is inevitable that my research and the conclusions I drew from it are impacted by my identity, social location, and my past and present emotional experiences. Through this research I sought out clinicians to connect with who have my shared experiences, and as I connected and critically examined their stories it helped me process and make sense of, and find new perspectives on my own.

Sampling and Recruitment Methods

This research used a mixture of convenience, purposive and snowball sampling to recruit clinicians who currently or have previously worked in CMH agencies. For the purpose of this study, I define a CMH center as any mental/behavioral health agency in

the United States that accepts Medicaid. Outpatient clinician is defined as any provider who delivers mental/behavioral health services on an outpatient basis. I created a recruitment flier (See Appendix A) advertising a study examining power and identity in clinical practice. Given that I did not offer compensation for this study, this sample method would lead to a sample of clinicians who have experienced the phenomenon of interest in that it would attract clinicians who already think about power in their work and have reflections on this topic.

When I began recruitment, I limited my sampling frame to clinicians working in one major city in the Mid-Atlantic. This city's MCO had a website listing all Medicaid-participating agencies and contact information for these agencies. I intended to send my recruitment flyer along with an introductory email (See Appendix B) to those agencies providing adult outpatient services, including the agency I worked for. I also intended to use snowball sampling to connect with other participants from there.

I was able to recruit three participants directly through this method, though they were all clinicians I knew through my professional networks. I encountered barriers to distributing my materials cold to agencies where I did not have a personal connection. First, the contact information provided through the city's website was a mixture of emails and phone numbers, and many of the emails provided were general information emails rather than program director contact information. As many outpatient agencies in this city are part of larger public health organizations with a wide range of programing, my recruitment request would have to be passed on to the program director. I sent 5 emails to agencies, but only heard one response. In the response I did receive, the director was hesitant to distribute the material, and indicated that I needed to receive IRB approval

directly from the MCO given that I was recruiting specifically clinicians who work under this MCO.

In light of these barriers, I decided to rethink my recruitment methods to elicit more participants. First, I expanded my sampling frame to clinicians in urban areas across the United States rather than limiting to one city to address the concern raised about recruiting directly from one MCO. I also decided not to limit only to outpatient clinicians working with adults. I revised my flyer (See Appendix C) to reflect these changes, wrote a blurb to go along with it on social media (See Appendix D), and revised my recruitment email (See Appendix E). In addition to updating these materials to reflect the new sampling frame and recruitment strategy, I also added more personal reflection in the outreach about who I am and what led me to this research to align more with my epistemological stance and frame the interview for potential participants as an opportunity to connect around a shared experience.

To recruit, I looked for nationwide listservs, social media, and other online forums where mental health providers can connect and distributed my materials in these communities. I looked specifically for groups dedicated to diversity, equity and inclusion work in clinical practice. I posted my materials in the Facebook group Students with SWCAREs: Social Work Coalition for Anti-Racist Education, as well as a local Facebook group I am a part of for practicing social workers in my city. Facebook recruitment yielded a few participants, but they were all individuals already in my extended network. I also shared my recruitment materials in a listserv through the American Counseling Association called 'Diversegrad-L', which is a forum to discuss multicultural/cross-cultural and diversity issues in the counseling profession. This last

method yielded a number of interview sign ups but none of these participants followed through with the interview.

Therefore, my sample ended up consisting largely of participants recruited through engagement with my extended networks around shared urban CMH experiences. I asked individuals in my clinical community to pass on the study announcement to clinicians that could be interested participants. From here, snowball sampling was used, and as participants made thoughtful recommendations to colleagues of theirs that they knew would be passionate about the topic at hand. The fact that participants who engaged were recruited through my extended network was in part a result of using a convenience sample. While I made attempts to cast a wider net, they were less successful. This could be in part a result of the subject matter being challenging to explore with a complete stranger. The use of snowball sampling and distribution within my networks meant that participants may have felt more comfortable engaging when someone they know and trust referred them to the study.

An important thing to note about my sample is that all participants were white. Given that the field is dominated by white clinicians (Salsberg et al., 2017), this was not completely surprising. It also makes sense that my extended networks do consist largely of white clinicians. During the racial justice movements of 2020, I built connections within my clinical community in both formal and informal ways around interrogating whiteness in practice, and these were some of the folks that I connected with to recruit potential participants. As a result, my findings and discussion of dissonance are specific to the experience of white clinicians. Given the ways that this work is informed by my lived experience of dissonance as a white clinician, it made sense to allow my research to

zoom in on this particular experience of dissonance, with an awareness that people of color would have different complexities around how institutionalized white supremacy impacts them and their clinical work.

Sample

My resulting sample consisted of 13 clinicians with the following characteristics, which are summarized Table 1:

Race, Ethnicity, Cultural Background. Everyone in the sample was white, with five identifying as Jewish. Two participants identified as Italian American, one as of Irish descent, and one of Norwegian/English/European descent.

Gender. Nine participants identified as female or cis-women, and one as male. Two identified as nonbinary, with one using they/them pronouns and another using they/them or he/him pronouns. One participant identified as genderqueer with they/them pronouns.

Age. The youngest participant was age 28, the oldest was 43, and the mean age was 35.

Location. The participants in this sample resided and worked in 3 different major cities, with 12 out of the 13 in the Mid-Atlantic, and one of the 13 in the Midwest. Nine of the 13 participants are currently living and practicing in one Mid-Atlantic city in the United States. Three participants had practiced in the same Mid-Atlantic city in the past, and had since moved. Of those three, one is still in CMH in another major Mid-Atlantic city, one moved to private practice in a suburban area, and one has changed careers. Therefore, the data in this study is heavily reflective of the experiences of CMH clinicians in one Mid-Atlantic city. This is important to acknowledge because how a

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CMH center operates is influenced by the requirements of the regional MCO, therefore aspects of work experience are likely to vary from city to city based on differences in funding structure and priorities of the MCO. For instance, different MCOs may have different billing requirements and metrics for measuring treatment outcomes, with some MCOs requiring more documentation and imposing more oversight than others. These different variables impact how much clinical freedom clinicians feel that they have.

Work History and Degrees Held. Six participants held a Master's in Social Work (MSW). Two participants identified generally as having a Master's degree, but did not specify the type. One participant held a Master of Science (M.S.) in Counseling in Clinical Psychology, and one in Community and Trauma Counseling. One participant was a Doctor of Psychology (PsyD). One participant held a Master's in Philosophy of Education in Counseling and Mental Health (M.Phil.Ed). Finally, one participant identified as a Licensed Professional Counselor (LPC) but did not disclose their specific degree type.

Participants' years in practice ranged from 1-18, with an average of 8.5. Participants' number of years of experience working in CMH specifically ranged from 3-10+, with an average of 8.7 years. The reason for the discrepancy between total years of experience and years in CMH is that one clinician had worked in CMH in the past with a bachelor's degree prior to becoming a Master's level mental health professional. Six clinicians were former CMH clinicians, and seven were current. Of those currently in CMH, two of them work part time. Of the seven who left CMH, four went into private practice, one became a school counselor, and two left to pursue further schooling and a career in a different helping profession.

Table 1: Sample Characteristics as Reported by Participants

Pseudonym	Age	Gender Identity/	Degrees Held	Years of Experience	Years in CMH	Current/ Former
Chloe	32	Female	LPC	9	3	Current
Jennifer	40	Cis female	PsyD	18	10+	Current
Alice	38	Female, she/her	MS Counseling and Clinical Psychology	12	12	Current
Laura	43	She/Her	MS Community & Trauma Counseling	1	5	Current
Lisa	31	Cisgender female,	B.A., MSW	5	3	Former
Mary	31	Cisgender female,	BA, MSW	4	3	Former
Candace	32	Woman- she her	MSW	8	8	Current
John	32	Male He/Him/His	MSW	6	2	Current
Dave	34	Non-binary they/them and	MSEd, MPhilEd	3	3	Former
Julie	36	Female; she/her	MA	14	10	Former
Charlie	36	Genderqueer, they/them	BS, MA	~15	10	Former
Riley	28	Non-binary, they/them	MSS, LCSW	5	4	Former
Sara	40	Female, she/her/hers	AA, BA, MSW	~10	4	Former

Data Collection Procedures

Individual interviews took place between December 2022 and May 2023. Data was collected from individual interviews conducted through a secure Zoom connection. Consent was obtained via an oral consent process (See Appendix F) No deception was used in this study.

Interviews lasted around one hour and used semi-structured interview guides (See Appendix G). The interview guides for current and former CMH clinicians differed slightly to capture former clinicians' reasons for leaving. Participants were also invited to complete a brief demographic and work information form (See Appendix H) via the website JotForm. This was an anonymous form, and clinicians were asked in the form to enter the date and time of their interview so I could track responses. An excel export of this spreadsheet file was stored securely in Bryn Mawr College's secure OneDrive, and the original form deleted from JotForm's website. Interviews were recorded electronically on my password protected computer and manually uploaded to OneDrive within 24 hours of the completion of the interview. Upon download, the original recordings were erased from the Zoom server. Only audio recordings were stored on OneDrive until they were transcribed and reviewed, at which point original audio files were deleted. Transcripts were completely anonymized, with reference to local agencies and their local MCO edited out.

Consistent with an autoethnographic research approach during these interviews I was not a blank slate, and my clinical work has prepared me to use self-disclosure with intentionality and care. I communicated with clinicians when something resonated with me, joined them in frustration about certain experiences, and shared glimpses into my

own beliefs and perspectives. I was careful to do this in moments when I felt aligned with the participant and could affirm or validate their experience through use of self. I was careful to not let this take up too much time or shift the conversation, but to use it to amplify and add to what was already being brought to the interview.

Initially, I had planned to recruit participants from individual interviews to participate in a focus group. The purpose of the group would be to reflect collectively on vignettes from individual interviews and discuss methods and opportunities for resistance. I planned to complete individual data collection and use this data to structure the interview guide for the focus group. However, I realized as I began to collect themes and see an emerging story in the individual interviews, there was already a lot to say about clinicians' experiences of and responses to dissonance. Focus groups with this same group of clinicians, all of whom consented to be contacted about a focus group when asked, would be a future path for a follow up study from a participatory action framework. It felt useful for this project to instead focus on deeper excavation and exploration of clinicians' experiences and illuminate the resistant practices they are already engaging in.

Data Analysis Methods

Interviews were initially transcribed by freelance transcriptionists through Upwork, and I reviewed each transcript alongside the original audio to ensure accuracy. This process also allowed me to begin familiarizing myself with the data and I began memoing about themes during this initial review. Interview transcripts were uploaded into Dedoose, a qualitative data analysis software, and stored, coded and analyzed through this platform.

My coding strategy was guided by conventional qualitative content analysis outlined by Hseiah & Shannon (2005) and guided by a critical phenomenological approach. The aim of conventional content analysis is to generate thick descriptions about a phenomenon and allow meaning from participants' responses to emerge without preconceived categories. Like phenomenology, it seeks to stay close to the data to generate a nuanced picture of a phenomenon. During first cycle coding, I utilized in vivo, descriptive, emotion and versus coding as outlined by Saldaña (2013) to achieve this thick description. I used descriptive coding to capture their descriptions of their context, versus coding to capture dissonance, and emotion coding to capture their emotional experience. Looking at codes developed from these three methods alongside each other enabled me to begin to build a picture of the phenomenon of dissonance as white CMH clinicians experience it. I coded my first four interviews paragraph by paragraph using these methods, which yielded 146 codes. I then used axial coding as an analytic tool to integrate structure (context) with process (behaviors and actions) and produce a meaningful story about the interplay between the two (Saldaña, 2013). Saldana describes axial coding as a process to determine which codes are dominant and reorganize the data set so that it consists of the most representative codes. I used conceptual mapping to aid me in this process, as well as analytic memo writing, which Saldaña describes as a crucial component of rigor in axial coding.

Consistent with critical phenomenology, I wanted to capture the ways that systems and structures were influencing the clinicians experience, and to bring experiences of power and oppression to the foreground through my analysis. During axial coding, I was sensitized by my theoretical framework, which lent itself to the emerging

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story in the codebook about clinicians' beliefs and values bumping up against systemic

constraints. My codebook included one theoretical code to capture aspects of white

supremacy culture that were apparent in clinicians' descriptions of these constraints.

After developing a codebook during first cycle and axial coding, I conducted second

cycle coding using this codebook. While used as a guide, this codebook went through

multiple iterations and was revised as I continued to interact with the data. Once coding

was complete, the final codebook reflected six main themes.

I utilized a constant comparative method of joint coding and analysis to

systematically generate theory in conversation with data using both inductive and

deductive processes (Padgett, 2016). I moved between my data and my theory with

attention to rigor, using conceptual maps, memoing, and peer debriefing to aid me in this

process (Padgett, 2016, p. 212). As I wrote my findings chapters, I simultaneously

revised and added to my first chapter, engaging in further review of new bodies of

literature and refining and adding to my theoretical framework to more critically engage

with my findings.

Chapter 3: "In their hands as much as possible": Clinicians' Practice Philosophies

and Opportunities for Dissonance

When I interviewed clinicians, I asked about their beliefs, ethics, and values about therapeutic practice, which I am calling philosophy of practice. This included what they believe about what makes therapy effective, ethical, and empowering, and how their values and ethics shaped their priorities in clinical practice. Participants' answers centered around three interconnected themes: Centrality and quality of the therapeutic relationship; the notion of creating and holding space; and the importance of giving clients choice and letting the client lead. These themes pointed toward larger priorities of client safety and helpfulness. As clinicians articulated their philosophies of practice, they reflected potential for internal contradiction and resulting dissonance around what is safe and what is helpful. My conceptual framework informed my analysis, highlighting the ways that white supremacy culture is implicit in practice standards and approaches and helping to make sense of some of these potential contradictions, which center around ambiguity about how and when clinicians should wield their power.

The Therapeutic Relationship

Consistent with common factors in the literature citing the therapeutic relationship as instrumental to positive therapeutic outcomes (Cuijpers et al., 2019; Wampold, 2015), participants in this study unanimously named the centrality of this relationship in how they think about ethical and impactful work. Clinicians described the importance of this relationship feeling safe and described relational safety as something that must be actively and intentionally built through consistency, validation, and positive regard.

Mary, an MSW with 4 years of clinical experience, described how through the creation of "psychological safety and safety in a relationship," the relationship becomes a "jumping off point" for other therapeutic work to take place. She suggested that therapists build this relational safety by being "somebody who you know views you positively with…unconditional positive regard and is not going to judge you…and wants the best for you." This notion of the importance of unconditional positive regard and validation were echoed by most participants as essential in creating psychological safety for clients.

Clinicians also named consistency as a crucial component of creating safety in the relationship. Lisa, an MSW with 5 years of clinical experience, shared that "just showing up and being consistent with a person was one of the ways I saw the most change." Candace, an MSW with 8 years of experience also explicitly named the importance of "having a consistent relationship," one where "you can come in and privately share what's on your mind. I think that is what makes therapy work." Clinicians painted a picture of a therapeutic relationship that is reliable and predictable for clients—where they know they can trust that they will be positively received and held when they enter the therapy room. Clinicians described this relationship being a necessary base for further therapeutic work to take place.

While clinicians like Mary named the relationship as a "jumping off point" for further intervention, the relationship was also understood as a mechanism of change in itself. Chloe, an LPC with nine years of experience, named in the "corrective experience of the therapeutic relationship" as an essential component of effective therapy. Lisa described feeling surprised in her years of practice to learn that when it came to mechanisms of therapeutic change, "a lot of it was more of the relationship." Charlie,

who had a Master's in a counseling-related field and 15 years of therapy experience, echoed that "human connection" itself, "even without doing any sort of unburdening" can be healing.

Dave, an M.Phil.Ed in Counseling and Mental Health with three years of experience, discussed the therapeutic relationship as the primary mechanism through which other therapeutic tasks could be accomplished, naming that "everything that can be modeled and demonstrated within the context of the therapeutic relationship around understanding and working with our emotions." They saw the therapeutic relationship as offering the client "new ways of existing relationally" that the client can then "flex and exercise and practice in, in the context of other relationships." Dave spoke to how the relational safety and positive regard offered through the therapeutic relationship can offer relational shifts for the client that create change for them outside of the therapy room as well.

Through my analysis, I found that the way clinicians discussed the therapeutic relationship suggested that the content of the therapy is often not as important as the process, which is constituted relationally. Sara, an MSW with ten years of experience, spoke to how she tries to convey to her clients that the "primary focus is going to be on building a good relationship with you…Because I use a variety of different techniques…and modalities…it wasn't so much on the 'what' are we doing but how are we with each other." Overall, clinicians emphasized the importance of moving at the pace of the relationship, the strength and quality of which has the capacity to either limit or enhance how useful or successful an intervention will be. Whether seen as a primary mechanism of change or a necessary condition for it, clinicians in this sample all viewed

a strong therapeutic relationship as paramount in their conception of effective and ethical therapy.

Clinicians also described a strong therapeutic relationship as one that is collaborative. For instance, John, an MSW with six years of experience, articulated the importance of "trying to minimize…power differentials by incorporating the client's input" and letting his clients know "we work as a team." As I will discuss further in the following sections as I expand upon the role of collaboration, safety in the therapeutic relationship was talked about as a way for clinicians to use their power in a way that is most empowering for clients.

Creating, Holding, and "Dropping in" to the Space

In discussing the therapeutic relationship, clinicians simultaneously spoke about the concept of the "therapeutic space," giving a sense that the relationship is something that both constitutes and is impacted by what occurs within this space. Julie, who has a Master's in a counseling-related field and 14 years of experience, articulated that "when there is a strong rapport between the clinician and the client," the clinician and client can "foster a place…in the therapeutic space but also mentally in that kind of potential space between the client and the therapist" within which the client is invited to " think differently. About life experiences. About relationships." To bring in what other clinicians stated about the importance of validation and positive regard, this is also a space where clients can learn to think differently about themselves. Julie and other participants spoke of the therapeutic space as the place where clients can practice "new ways of existing relationally," both with the clinician and with themselves. Clinicians describe "holding space for emotions, activation" in their clients, or "letting them have

the space to say that wasn't okay." Clinicians describe their work as holding a space for clients to experiment with new ways of being, and in particular, inviting them to advocate for themselves within the context of therapy.

Clinicians also expressed an awareness that in order to take these psychological, emotional and relational risks, the client needs to feel that the space is safe enough to do so. Riley, an MSW with four years of experience, describes the importance of this space being "supportive, open, curious, non-judgmental, open, [and] compassionate," all qualities that were echoed by other clinicians in describing what makes the therapeutic space "safe." In order to create and hold safety in the therapeutic space, clinicians described the importance of intentionally around how they show up within it.

Presence and attunement were named by many clinicians as useful ways to orient one's client within the therapeutic space. Riley spoke to the role of first "being present, being attuned to the extent possible, which means not just showing up physically, but being fully embodied within the therapeutic space." Laura, new clinician with an M.S. in Community and Trauma Counseling, and a background in yoga and meditation, described it as a process of "dropping into a space" with her clients. She discusses "syncing with them with breath" as a way that she is able to drop into this space. Lisa named this type of deep presence and attunement as an essential component in making therapy both effective and ethical. She reflected on how presence allows clinicians to ensure that they are "using the clients time valuably" rather than "going through the motions." She spoke of presence as a way to demonstrate to clients "that you're respecting them in those spaces."

In addition to being present with clients, my analysis suggested that clinicians were aware of the importance of being present with themselves during the clinical encounter, and in particular being critical about how they were wielding power in the interaction. Sara described how "recognizing that I am in a position of authority" is crucial, and that "if I'm not reflecting on that enough…it can become oppressive." Participants talked about being aware of one's own biases and moment to moment internal reactions. In order to facilitate this awareness, many clinicians talked about the crucial importance of personal work specific to diversity, equity and inclusion in clinical practice. This included engaging in training, working through self-guided workbooks designed to help them reflect on their social location and identity-based power, and connecting with other clinicians to reflect together about power in their practice. Overall, my analysis indicates that for these clinicians, showing up ethically in the space and being intentional about their use of power meant holding a balance between introspective self-awareness and presence with the client.

Power and Boundaries in the Creation of Space

Clinicians across the board discuss space as something that the clinician "creates" and "holds" for the client. My analysis demonstrates the ways that clinicians are the arbiters of the therapeutic space, holding the ability to both empower and disempower their clients through moment-to-moment clinical decision making. As arbiters of the space, clinicians identified their role in creating and holding the boundaries of the space and of the relationship. They described having the power not just to dictate the norms of the therapeutic relationship but to hold clients accountable when they violate these norms. Regarding boundaries, clinicians described ways that this power can actually be

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used to increase the safety of the therapeutic space, but also acknowledged the importance of not overusing this power.

For instance, Mary talked about how safety means "having a sense of…control as the client over, you know, your boundaries and what you do and don't feel comfortable talking about…and knowing that those boundaries are gonna be respected." In addition to respecting client boundaries, clinicians named that upholding their own boundaries and the boundaries of the therapeutic relationship was necessary as well. Candace, an MSW with eight years of experience, named how important it is to "stick to the frame of therapy," which means "respecting the person in front of me enough to put down the boundary of…the relationship we entered into…we didn't meet on the street, we are not friends…I care…but I can't care in XYZ way." Thus, clinicians did not talk about their power over the space as something inherently detrimental or disempowering for clients, and at times inhabiting this power and using it intentionally to dictate what happens in the space was actually seen as an important component of maintaining client safety.

"Letting the Client Lead": Giving the Client Agency and Choice

The last interconnected theme that arose when clinicians were asked about their philosophy of practice was the idea of "letting the client lead," which was another way they sought to use their power over the clinical space to give power back to their clients. This looked like client-focused decision making, where clinicians take both implicit and explicit feedback from the client in their clinical decisions. However, my analysis did not suggest that letting the client lead meant the clinician abandoned their own agency and power over the therapy process. Clinicians sought collaboration with clients, and letting

them lead where possible, but also noted instances where they feel it's important to take the lead as well.

When asked about ethical therapy, Mary spoke of the client being "in charge of their experience in therapy." Julie shared that empowering therapy is "really allowing the client to make a good chunk of the decisions as far as what they want to work on. Or what they are not wanting to work on…giving…permission to say no thank you or I don't want this…respecting their opinions." Charlie, a Master's level clinician with 15 years of experience, described an experience of "finding joy in the client's lead" and "following what's best for the client as opposed to like what you think would be best" and being "all in whatever it is that their determining is the best for them at that time." They go on to say that their clients seem to feel the most empowered "in moments where like they were coming up with something" and Charlie is "supporting their independence. Supporting them needing me less." Charlie named giving clients choice as essential not only for therapy to be empowering, but for it to be effective based on the client's unique situation and experiences:

> Each case I felt like needed a different thing. It's like sometimes people really
> needed to be connected to a resource. Sometimes people just really needed to get
> in to see the psychiatrist and then once they got meds it, they felt a lot better. Or
> some people really did wanna do that kinda like relational…healing work around
> their trauma. Some folks their baseline of like safety or stability wasn't like ya
> know, for whatever reason that wasn't in the cards for our relationship.

This clinician's thinking also reflects to the idea that clinical decision-making ought to be informed by the strength and quality of the therapeutic relationship and the ability for the

client to feel safe with the clinician. By letting clients decide when and how to discuss or disclose traumatic experiences, for instance, clinicians can ensure that clients are not being asked to engage in a process that does not yet feel safe. Julie articulates "truly not embodying the expert mentality and allowing the client to feel safe enough to say eh, you know what I want to do this and not this" as essential to giving clients agency in their treatment. Again, safety within the therapeutic relationship is named as an important component for clients to be able to articulate what they do and don't want from their treatment.

Yet my analysis suggests that clinicians did not find it useful to fully disavow their role as expert. Many acknowledged their role as holders of certain knowledge and expertise and named this as a necessary component of therapeutic progress. My analysis suggests that most clinicians ultimately believed that they held useful knowledge that clients do not necessarily have, and that it is their responsibility in their role to share this knowledge in order to give clients more power. For example, Sara discusses "psychoeducation" as "an empowering tool," articulating that "there is a real power in being able to understand…something about my experience that is…relatable and there are, there are things that I have done…and now I have the evidence to back up why." Other participants agreed with Sara that psychoeducation is a useful intervention for helping clients understand their experiences and better identify and define the problem.

Other clinicians talked explicitly about their ethical obligation to provide the most effective treatment possible based on available research and evidence. While prioritizing client agency, Charlie also talks about the importance of using diagnosis and clinical frameworks to help clients "just identify baseline what was going on. That was really

helpful for folks. It's like they come in and things feel really chaotic and then there's sort of this like a little bit of clarity." Charlie and Sara's examples demonstrate moments where the clinician feels they ought to step into their power as the expert, but naming empowerment as the ultimate goal in doing so. The potential for paternalism inherent in standard practice models (Badwall, 2014) comes through in this moment of contradiction. Jennifer, a PsyD with 18 years of experience, in describing what makes therapy "work," captured how paternalism creates contradictions:

> We're offering unconditional positive regard while still holding boundaries and structure. And I think that like this…[sigh] this re-parenting almost…like teaching a skill that they didn't learn in early years…that is what works…telling people how great they are all the time, reminding them of their successes, holding all of the bad stuff and not judging them for it is why therapy works.

Here, Jennifer places the therapist in a parental role, in which they are both teaching skills, holding boundaries, as well as providing positive regard. She went on to reflect on how she views her own therapy, naming that "I wouldn't say I'm working toward a goal. I just am allowed to exist." Reflecting back to her beliefs about therapy more generally, she described how "allowing this person to exist in a space in whatever way they need to, and holding it all for them, not responding with anger or negativity, I think is why people do get better, even if you're literally doing nothing else." Jennifer, who is trained in multiple evidence-based practices and reported using them "in a very collaborative way and meeting a very specific need," wrestles with whether these more specific interventions matter as much as simply holding space. Like other clinicians, Jennifer

oscillated between framing the clinician as the parent, and thus, the authority, and emphasizing a collaborative relationship instead.

My analysis suggests that echoes of the therapist-as-parent are seen across many clinicians' descriptions of their philosophies. For instance, some clinicians spoke to the importance of the therapist holding clients "accountable" as a crucial part of enhancing a client's sense of agency both in the therapy and in their lives. Candace named the importance of "creating a space of accountability" where the clinician can be honest with the client about things they might be doing that are "contributing to their own issues." Again, as with the clinician's role in holding boundaries, there are times where clinicians found it important to actively use their power in the dynamic and take the lead to ensure therapy is both safe and helpful for the client. Here Candace points to an underlying assumption that came through in my analysis that the clinician sometimes knows better than the client, and can see things the client can't. Most clinicians, then, seemed to acknowledge the ways that they do ultimately hold the power in the relationship, but seek to make sure, as Alice, an M.S. with 12 years of experience, put it, "that the control still feels in their [the clients] hands as much as possible."

Clinicians in this sample fell on a spectrum, with some placing more importance on structured intervention and evidence-based practices, and others emphasizing the relationship as the primary mechanism of change. However, all clinicians noted the importance of both and sought to find a balance, where the therapist is providing the most effective treatment to the best of their knowledge, while also letting the client have ample agency and choice in what this treatment looks like and maintaining a strong therapeutic relationship. I found a general sentiment that models and techniques should be used

flexibly and involve both explicit and implicit feedback from clients to assess for the client's satisfaction and comfort throughout the course of therapy. As Dave described it, "psychoeducation, cognitive skills, relaxation skills…they're fine if you're thinking relationally around them."

Again, relational attunement and presence in the therapeutic space are implicated as necessary for clinicians to truly go at the client's pace. In her discussion of presence, Lisa added that it is necessary in ethical practice because it allows clinicians to support clients "with goals they view as important in those moments." The idea that letting the client lead can only be truly achieved when there is presence and attunement with the client's moment to moment goals and how they are responding to the process. True relational attunement also involved an awareness of the inherent power they hold over the therapeutic space, clinicians sought to critically, intentionally, and ethically wield this power to create the most empowering experience possible for clients.

What is safe? What is helpful? Opportunities for Dissonance

When looking across these three articulated priorities—maintaining relationships, holding space, and prioritizing client agency—I can identify two meta-themes within clinicians' practice philosophies: the values of *safety* and of *helpfulness,* which seem to be at the core of what "good therapy" looks like. They want clients to feel physically and psychologically safe with them, and they want to be using clients' time in a way that is helpful toward their clients' goals. However, my analysis suggests that when trying to enact their clinical priorities, conflict around what is safe and what is helpful can arise.

For instance, inherent in clinicians descriptions of their philosophy of practice is that while giving clients choice and agency is of utmost importance, there are also

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limitations to client agency, and ways that the clinicians feel they ought to take control of the therapeutic space to some extent in order to "hold the frame" of therapy, and that taking control is at times necessary and can actually be to the clients benefit and toward the goal of enhancing client agency in the long term. Similarly, while clinicians named the importance of not embodying the "expert" mentality, and following client's expertise in their own experience, they also expressed a belief that the therapist does hold skills and knowledge that it would be unethical *not* to use to benefit the client. This came up around discussions of evidence-based practice and the importance of offering best available known treatments to clients. As will be discussed in later chapters, there may be moments where enacting what they believe to be most helpful and safe in therapy may involve the removal of agency from the client, and thus threaten emotional and psychological safety within the therapeutic space.

My analysis highlights the ways that the clinicians' I interviewed do center anti-oppressive practice values. In particular, critical reflection on self in practice, empowering service users, and working in partnership (Healy, 2014) are clear priorities in their accounts. However, their philosophies also, to varying degrees, reflect internalized professional expectations, and in turn, neoliberal practice logics. Clinicians described moments in which wielding power and dictating the norms of the therapeutic space are actually in the clients' best interest. Their accounts suggested that attunement both with themselves and the client, and a resulting awareness of how power is at play in the dynamic, may allow them to more effectively use their power to support the *clients'* articulation of their own best interest rather than the clinicians. The tools held within neoliberal practice logics do not seem to be inherently at odds for clinicians, as they

emphasize relationality and presence as ways to offer neoliberal content through an anti-oppressive process.

Dissonance within clinicians approaches to care will continue to be explored throughout the remainder of my analysis as I dive more into what clinicians actually *do* in practice rather than focusing as I do here on what they say they want to do. However, an important goal in discussing philosophy of care in this chapter is to create a picture of clinicians practice *ideals*. From within my theoretical framework, we can understand these ideals, and ability to enact them, as connected to clinicians' professional identities, and likely to their sense of self more broadly (Marston & McDonald, 2012). These articulated ideals reflect a sense of collaboration and balance, where the professional tools and expertise clinicians hold can be used in ways that are in alignment with anti-oppressive practice values. Clinicians sought to be aware and reflective enough about their power to use it for good. As dissonance theory suggests, clinicians will experience dissonance when they cannot enact these ideals, and their self-concept is challenged (Aronson, 1969; Steele, 1988). In the following chapter, I will shift towards exploring the systemic conditions of CMH that make these ideals feel difficult to achieve, and the powerlessness that results.

Chapter 4: "Working for the system": White Supremacy Culture and Neoliberalism in Community Mental Health

In their interviews, I asked clinicians to what extent their priorities in therapy aligned and were possible to enact within CMH. The systemic and contextual factors at play within CMH were universally discussed as a barrier to enact their philosophies and practice as they described above. This section will explore the ways in which clinicians characterized CMH practices enacting values of white supremacy, and how the material and ideological realities of the neoliberal clinic were at odds with and posed barriers for clinicians to enact their philosophies of practice. Clinicians described feeling powerless to enact their values in their work due to policies, practices, and expectations in CMH that felt at best, limiting, inconvenient, and unhelpful, and at worst, harmful toward themselves or their clients. In these moments of powerlessness, clinicians experienced dissonance as they felt forced to engage in oppressive dynamics.

Important to note here is that clinicians' philosophies of practice, overall, were not completely misaligned with that of their agencies in my analysis. As discussed previously, clinicians did believe in the utility of the evidence-based interventions that are viewed as the gold standard within CMH. Clinicians also expressed a sense that their agencies in theory cared about issues of justice and equity in therapy. As Jennifer put it, "I would say on paper they align great. I think the agency has a lot of really good things on paper that didn't "align in practice." Lisa articulated that she thinks her agency "always wanted to be founded in doing good work" but that "their priorities were also kind of more numbers-based and just kind of logistics," because the agency is forced to

operate as "a business." There was a general acknowledgment of the way that CMH centers are shaped by structurally oppressive larger systems, such as the MCOs funding the agency, and statewide policies and laws, and that these larger systems, as Riley put it, "enact white supremacy." As Lisa stated, it's a "system based on certain assumptions that just do not align with what the actual patient is experiencing," and these assumptions create the need for agency structures and guidelines that are misaligned.

"The Face of Whiteness": Identity Difference in the CMH Workforce

The first limiting material reality of CMH described by clinicians is lack of diversity in the workforce, which posed challenges to the therapeutic relationship and giving clients choice. When considering ways that the reality of CMH conflicts with their clinical values and priorities, Riley named the challenges of "who's available at these agencies…who works there," stating that the agency they work for is "claims to serve queer and trans people, and be good and do good in the community." But that "most people were white, and cis…that was at the therapist level." They go on to describe how "when you get above the therapist level, my direct supervisor, who supervised all of us, was a cis straight white man. And the person above him who's the Director of Behavioral Health was a cis, lesbian, white woman." Riley went on to say that "in higher levels at that agency there is so much racism and transphobia, so much general grossness too and that, like that, trickles down onto the clients." Other clinicians spoke about a similar phenomenon where leadership in CMH is even less reflective of the client population demographically, and expressed concern that clients with historically marginalized identities cannot be ethically served when the hierarchy of CMH reflects these historical systems of domination.

Clinicians in this study, all of whom were white, universally discussed the challenging dynamics of being a white clinician working with largely people of color. They explicitly named whiteness as a barrier to building the therapeutic relationship and creating psychological and emotional safety within the therapeutic space, and felt powerless to accomplish these clinical priorities. Furthermore, clinicians described whiteness as an inescapable barrier from the very start of therapy. While clinicians may try to show up in ways that are not oppressive, they also felt that the negative impacts of their whiteness can only be mitigated so much, due to what it represents symbolically to clients, and the limitations it posed in understanding their clients' experiences.

In clinicians' discussions about whiteness, many seemed to feel powerless around maintaining safety, feeling that there was no way to avoid causing harm as white person working with BIPOC clients. As Riley puts it because "these agencies enact white supremacy…there's only so much not doing that that you can get away with…and when you're a white person enacting white supremacy against a client of color…that doesn't feel good for them…that just sucks." Clinicians described this enactment feeling inevitable not only in choices they are forced to make through their employment obligations, but in subtler relational ways, calling into question whether it is even ethical for white clinicians to work with Black clients at all, regardless of the setting. For example, Riley felt that "working with Black children in foster care as a white person in your twenties who doesn't have kids…there's a lot of stuff around race and class that gets enacted there regardless of my intent."

Clinicians felt that their very presence in the room as a white person limited the possibility of safety in the therapy space. Chloe shared that BIPOC clients "have told me

specifically that I remind them of the DHS workers that come to take their kids…I was a reminder of…system players that they'd worked with before, just in the way I appear physically and the way I present…being literally the face of whiteness." Chloe spoke of this as something that clients "had to work past" in building a therapeutic alliance with her, and this did not always feel possible. Riley echoed that "working with people of color, especially people of color who…do not have class privilege and are actively poor, while being a white person with class privilege representing the mental health industry…it can be really challenging to build any level of trust or comfort."

Clinicians expressed concern that their CMH clients may not feel that they will be understood by their therapist due to their difference in background and life experience. Similarly, clinicians were concerned that they can never fully understand what their clients are experiencing, as a result of a difference in background, making it harder to find resonance and validate their experience. Charlie expressed how, in spite of their best efforts to "be aware of my biases and like things that I know or don't know, you know do my own learning, put their experiences first and be like very person centered or whatever, there's gonna be things I miss…I'm missing something about their experience." Charlie reflected a feeling of having inevitable blind spots due to identity differences that pose potential barriers to connecting with clients.

Laura, who expressed the therapeutic values of being "in resonance" and "dropping into space" with her clients also felt that she is "never gonna really be in the same headspace" as BIPOC clients in certain instances. This came up as she reflected on her clinical work during the time where Breonna Taylor was murdered, and her murderers were subsequently acquitted. She expressed an awareness that "it didn't

viscerally hit me the same way that it hit some of my clients…I was aware of it. But it didn't feel like an assault on my personhood." Riley expressed the same sentiment that "when you don't have the lived experience that a client has, especially when it's systemic or structural in some way…it can be hard to like, be there appropriately." Riley, Laura and Charlie's experiences all highlight the barriers to presence and attunement as a result of identity difference. Overall, clinicians reflected a sense of powerlessness to enact their clinical philosophies and successfully avoid oppressive dynamics with BIPOC clients due to their whiteness and other identity-based power they held.

Many clinicians advocated that clients deserve to have the choice of provider, and should have the opportunity to work with clinicians who share their identity and thus have some commonalities in lived experience. Riley noted that "there were just so few options" for clients with multiple historically marginalized identities, saying that where they worked "you would have people who are like black, trans, queer, autistic, polyam, kinky, and they're like 'I need a therapist who's good about all these things'…and I'm like 'pick one'." Laura also describes how the lack of diversity in the CMH, combined with the fact that the CMH system is understaffed and overburdened, creates lack of choice for clients:

> It's not like you go to Psychology Today, and you're like, okay, that person seems to, you know, they share my racial and ethnic and gender makeup. And that's important to me. So I'm going to call that person and see if they're a good fit from there. It's like, you're on a waitlist for six months, and then somebody calls you and unfortunately, sometimes it's me…you're in pain and you want the pain to

stop. And you've been waiting six months. And you'll literally take whoever

walks through the door.

Here, Laura is highlighting the intersecting vulnerabilities of the average CMH client,

who often is living with severe mental health challenges that further limit the

accessibility of choice. Mary stated that it felt like the underlying assumption was

"because they're poor (pause) they just have to take what they can get."

Even in areas where the client could ostensibly have more choice over their

provider, clinicians described rigid practices around assigning and scheduling clients that

further reflected a "take what you can get" sentiment. In the agency she works for Chloe

described explicitly limiting practices around client's access to psychiatric services:

A lot of my clients have issues with a particular psychiatrist and have asked to

switch to our other prescribing psychiatrist and have been just straight up

denied…or told they have to meet with…supervisors and like submit a

request…that was disappointing to me to see [CMH center] sort of limiting a

client's agency.

The sentiment that clients have to "take whoever walks through the door" when it comes

to their care reflects a sense of paternalism toward clients in CMH that was inherent in

many other agency policies and practices which limit the client's choice and power over

their own care. As Charlie described, this could be "oppressive to somebody that maybe

doesn't wanna work with me but doesn't have another option." They go on to describe a

feeling of not being able to fully trust that the therapeutic relationship is tenable,

describing how "that can be conscious or unconscious…the person could know that they

don't wanna work with me. Or the person can be like this is great…I'm working with

[name] and they're so nice…but they don't…know that there's somebody who would be better suited for them." Dissonance arises for clinicians in response to this awareness that clients lack options. Clinicians feel that they are a last resort, and thus the therapeutic relationship begins from a place of limited autonomy.

Mandated Reporting and Involving Carceral Systems

All clinicians interviewed named their power and legal responsibility to involve disciplinary and carceral systems as an inherent barrier to creating safety and giving clients choice. Involuntarily hospitalizing clients and making reports of suspected child abuse were two specific areas where clinicians felt that their "hands are tied" and they had no choice but to, as Charlie put it, "step into an oppressive role." Riley spoke to the challenge of being an arm in "restrictive and carceral" systems imbued with structural racism and oppression:

> I mean we're in positions of power and we can call in police, child welfare, and psychiatric incarceration. Ideally when needed, but really when we feel like. And I think a lot of clients have a lot of well-founded fear around that…and a lot of negative experiences around that, and so us just having all of that power…to call in systems that are often oppressive to our clients and to their communities, is really challenging.

Clinicians identified inherent challenges to collaborative care and building trust in a therapeutic relationship when the client knows the clinician has this power and can wield it at any time. As Mary put it, "instead of your helper now I'm like your police." Chloe

described being "seen as in the shadow of the P.O.[1], of the [child welfare worker]…'Oh, you're already one of them' in the client's mind. And anything they say to you could get them in trouble." Along with being "the face of whiteness," Chloe describes her clients as acutely aware that the therapist is "working for the system," making it hard for clients to develop a trusting and transparent relationship with the clinician, which further hinders their therapeutic progress according to the value of client agency articulated in the previous chapter.

While clinicians clearly stated the importance of client agency, many clinicians described involuntary hospitalization as a particularly challenging practice where the clinician has no choice but to strip their client of agency. In describing an experience of having to take on the "oppressive role" of hospitalizing someone, Charlie identified "feeling really bad about how, how it went down…I'm deciding where somebody's body is gonna go. And like especially when they don't want to. Like that feels pretty crappy." They go on to say that "it's part of our ethical system as counselors. That we sort of follow a particular set of regulations. But it's still just…never felt, it never felt good to sort of like have to violate somebody's autonomy in that way." This clinician is speaking to the discomfort and powerlessness of dissonance. They are bound to a set of ethical regulations that feel at odds with their values or personal ethics.

For many clinicians, it was not necessarily the mandate to protect a client from harm that felt at odds, but rather an awareness of the systemic reality that the options that exist to protect clients are not actually safe for clients. Dave, in discussing their work

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[1] P.O.: Parole Officer

with trans youth experiencing suicidality, expressed the sentiment there is often no safe option:

> Your two options might be lack of safety and even greater lack of safety. First option…this person wants to die or hurt themself in some way. The alternative…crisis response…the kid gets outed to their parents or, or some other, or put in some other unsafe situation which further perpetuates or compounds…everything that was going on for them leading to the suicidality.

Dave emphasizes the importance of "thinking with complexity around like safety when we're talking about getting 'crisis' involved as like the way to keep someone safe. It's not always that simple." The powerlessness clinicians experience around keeping clients safe, and the difficult choices they have to make in these scenarios, creates dissonance and reflects experiences of moral distress (Burston & Tuckett, 2013).

Riley shared that in the CMH centers they have worked at, the protocol when a clinician has to involuntarily hospitalize a client is to call the police, who then escort the client to the crisis center. Riley described this practice as "disturbing," and leading to a deep sense of internal conflict. Regarding this practice, Riley stated "I couldn't do it…Like we don't need the police to do it" but goes on to say, "I don't know…what are you gonna do if someone is like 'I'm gonna go kill myself'?" The dissonance in how Riley is describing the experience of having to involve police is clear—they indicate both that they "couldn't do it" but also a sense that they didn't have another choice. Later reflecting on the involvement of systems as a whole, Riley identified that "there need to be better options" for keeping clients safe. Riley named this conundrum as a reason they eventually decided to leave CMH—they could no longer participate in "enacting

something that I didn't believe in." Clinicians, who valued protecting client's safety, struggled to do so in ways that were aligned with their anti-oppressive aims.

Clinicians reported they wrestled with similar feelings of powerlessness around decisions to involve child protective services. The ethical mandate for clinicians to do no harm did not itself seem to be at odds with clinicians' values, but they seemed to struggle with the concept of how much power they realistically can and should have over preventing harm. My findings indicate that the value of creating and maintaining safety clashed with clinicians' values around clients' right to autonomy and personal choice, leading to dissonance as well. While choosing to involve systems at times felt like the less harmful options in moments of imminent threat of death or bodily harm, clinicians sat with an awareness that the emotional and even potential for physical harm once clients are involved with these systems may put the client at further risk in the long term.

When it came to making decisions about involvement of larger systems, clinicians spoke to feelings of responsibility for the client's safety and a sense from larger systems that they are expected to be able to control and predict client behavior. Laura names how "liability in general and litigiousness of our society really make it so that you can very easily wield power in a way that at the end of the day is harmful." Laura is speaking to a fear that other clinicians name, that if they don't successfully "keep clients safe" by calling in carceral systems, they will be held liable and punished. Laura explicitly named the "paternalistic energy" inherent in regulations pertaining to involving systems, and in the event that a client experiences or causes harm, clinicians are made to feel like "you should childproof better…like, this is somehow your fault for not foreseeing that this can happen." Clinicians described feeling that they are expected to prevent harm, but the way

they are expected to do this is by calling in systems that they know to cause harm. Clinicians are not only interested in preventing harm because they are expected to, but because they also hold safety as a core principle in their philosophy of care. Here, we can see how the threat of moral injury (Gibson, 2019; Rosen et al., 2022) is implicated no matter what clinicians do, as their professional values clash with their anti-oppressive values.

While the inability to truly do no harm was often made clear in bigger dissonant moments around whether to involve carceral systems, clinicians also felt this in smaller ways. The theme of paternalism can be traced throughout my analysis as clinicians give accounts of these subtler ways that they felt powerless but to take power or enact power over clients due to agency policies and expectations.

Attendance Policies and Caseload Expectations

Another commonly cited agency practice that clinicians found limiting for their clients was around attendance policies, and expectations around caseloads. Clinicians largely described feeling pressure from their agency to maintain a full caseload of clients that are consistently attending weekly appointments. Clinicians described this pressure as coming in different forms. For one, clinicians described being made aware of the length of the waitlist and being actively pressured to take on new clients and reminded to discharge clients who aren't attending consistently. Candace described a frustration that agencies don't seem to respond by hiring more therapists, but by expecting clinicians to "churn it out" as if they were therapy machines.

When the pressure didn't come from the agency directly, it came from the need for consistent income. Fee-for-service work was described in some ways as coming with

a greater degree of freedom over one's caseload, yet fee-for-service clinicians were limited in their ability to set boundaries around their caseload due to needing to make a living. Mary described how the fee-for service model encourages overloading one's caseload. She discussed the scheduling practices that her agency uses to maximize billable hours:

> You're only getting paid if the client shows up which means you're also not getting paid for the time you spend doing notes…in order to make it pay like a full time position the agency that I worked at would stagger their clients so that they were overlapping…so even though they were billed as the you know…hour long sessions they were only actually scheduled as 45 minutes because the expectation was that somebody's not gonna show up so we have to fill your schedule.

In addition to creating a frantic and rushed pace of work, Mary articulated that this practice "never sat right with me ethically because it's not providing the service that people are going there to get or being told that they will be receiving," reflecting on how this scheduling system often meant making clients wait when they arrive for their scheduled appointment time. Practices like this designed to maximize productivity did so at the expense of clients' service experiences. For marginalized clients who are treated in larger society as if they do not matter, having this sentiment reflected in systems of practice is another site of oppressive dynamics. The negative effects on clinical care when the clinician is working at a frantic pace will be discussed later in this chapter.

Clinicians also described feeling that caseload pressure necessitated they be firmer with clients around attendance than often felt appropriate. Charlie described how

"when people wouldn't come in and then they would call and be like can I just try to see you tomorrow or something? It would be like, no. You can't. Like I felt very kind of like boundaried…I'm being asked to see so many clients and if you don't come in like tough luck, you know?"

Clinicians in the sample discussed these policies as "punitive" toward clients and often clinically at odds with the needs of the population that CMH serves. Lisa raised an issue with the structure of weekly appointments, noting that "asking them to attend like weekly appointments at the same time…that is based on this idea of scheduling and like convenience for providers and facilities rather than like what works for a patient." Many clinicians expressed that enforcing these policies for clients with barriers to access does not feel clinically appropriate. Alice described how challenging it can be to feel pressure to discharge clients who have been unable to attend due to understandable barriers and systemic disadvantages:

> People report like, 'I've just lost housing and I'm homeless, I'm trying to figure it out.' And like then, they don't come for a couple of weeks because they don't have anything, right? It always feels really terrible to, like, discharge somebody who's already down, with things not going well in life right now or has additional stressors and this might be their one safe space. And it's all based off of…factors that for many are hard to come by, right? Like, for families…to find childcare…to get bus fare.

Clinicians described these policies as feeling punitive—as Charlie put it, "like if, if you did make a mistake. If you weren't able to keep up with the workload like you're punished…it felt really bad."

My analysis indicated that clinicians are motivated both by the agency and for their own self-interest to enforce inflexible boundaries around attendance, yet are also acutely aware of systemic and access barriers that impede a client's ability to attend sessions regularly, which are not reflected in attendance policies and practices. As a result, clinicians describe pressure and lack of power around how to manage their caseload and dissonance around enforcement of strict attendance policies. The ways that clinicians themselves are disempowered within the system limited their ability to respond to client behavior from within an anti-oppressive framework. Instead of contextualizing their behaviors in light of their experiences of oppression (Healy, 2014), they feel they must take actions that punish clients for their experiences of oppression.

The expectation that clinicians "churn it out" in their work, making sure they are as productive as possible by filling each available hour with a client, speaks to the way that CMH operates like a business, with an emphasis on maximization and productivity rather than intentional, individualized care. My data suggests that the ways that clinicians are financially disempowered in these systems limits their ability to prioritize giving power to their clients.

Worship of the Written Word: Paperwork in CMH

Along with the pressure to maximize productivity, clinicians expressed challenges with corresponding practices around proving productivity and justifying clinical decisions. A theme in the participants' accounts was how working for managed care means that more documentation and paperwork is required of the clinician. Clinicians were aware of how agencies must answer to the MCO, who requires detailed, thorough, and sometimes invasive data to continue to fund the agency's services. As a result of

these requirements, clinicians describe strict oversight over what is written in the notes and their timeliness. As Sara described "you have to justify your billing. So what are you doing in session that justifies us paying your agency and therefore paying your therapist?" She goes on to speak about how the CMH center operates according to a "business model" rather than a clinical one.

Clinicians spoke of the overwhelm that can come from, as Dave put it, the "wild amount of paperwork" required of them. Dave recalled how their agency was "always tacking on new forms, new documents, new assessment pieces. All this stuff you gotta remember for every client." Dave named the resulting overwhelm as "a huge factor to burnout. I would definitely have my moments where I would feel like another thing really? Now I gotta do this for everyone?"

While keeping up with this paperwork was described as "too much" by most clinicians interviewed, many also noted high levels of pressure to not fall behind. The pressure behind paperwork for many clinicians was a result of how paperwork was directly linked to income for the agency. When and how paperwork was completed impacted whether the agency could bill for a service, and in turn, whether the clinician would get paid. Charlie discussed the resulting rigidity in her agency around paperwork deadlines. They described how the MCO funding agency required paperwork to be completed within 48 hours, so "if you didn't get it in after like 48 hours you" would get locked out of…the EHR[2] and unable to see any clients until you finished your notes. Charlie went on to describe how these policies did not account for extenuating

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[2] EHR: Electronic Health Record

circumstances, and how lack of flexibility around these policies can trickle down and impact clinical work:

> If you were sick…you were still expected to complete those notes. Even though you weren't onsite, and you had no access to (laughing) you know…the EHR. But then you come in and you're locked out. You're already behind cause you like missed seeing all these clients and then…your clients are like waiting in the lobby for you…and if you were able to, if you managed to…get your notes done that's great. But sometimes like I'd still have a few left…and people are waiting on me.
>
> And I had to be like hey sorry I'm locked out of the system, so you have to wait.

Charlie's example here about illustrates how CMH, operating from a business model rather than a clinical one, leads clinicians to have to prioritize administrative tasks over client care.

Clinicians describe paperwork in some cases as getting in the way of meeting clients where they are and being present with them. Laura describes how paperwork can be a barrier to relationship building early in treatment, describing a feeling that "I've got to get these assessments in, and I've got to get the treatment plan in, and I've got to do…you know, it's like, there's so many things to set up that those first couple of sessions don't feel as rapport building as they could be."

Again, my analysis indicates how the initial creation of safety and prioritization of client agency in the building of the therapeutic alliance is threatened by bureaucratic tasks. Alice named how these tasks "it can take away from my genuine (pause) being present. If I'm like, 'Oh, wait. We've got to update that treatment plan' right?" Overall, clinicians discuss how when a treatment plan is due, it takes priority, and their client's

goals and aspirations for the session must take a back seat. Clinicians lack of power within these systems is enacted in ways that remove power from clients in the clinical interaction.

Clinicians expressed that while treatment planning in general can be helpful, the type of treatment planning expected in CMH did not necessarily feel helpful or feasible. Julie discussed how with "Medicaid…they wanna see attainable, achievable, specific goals. Which is great…but if you write a goal where it's like child reduced tantrums…on three out of five occasions. Like who's keeping track of that?" Julie describes having to "throw a number in there for whatever reason." Other clinicians echoed that the required treatment plans were too detailed, time consuming and created an expectation of linear progress.

Sara discussed how "in the notes like you have to say something about how you're addressing their treatment goals," but addressing these goals doesn't always feel possible clinically because "people have multiple stressors…and so [treatment plan goals] may take a back burner." Julie described a similar conflict: "We're saying…we're gonna increase coping skills…but then you come in and say well now we're homeless…we're not gonna talk about coping skills today. We're gonna talk about where you're gonna live tonight." Clinicians described challenges with session documentation when they spend the session connecting clients to resources rather than working toward treatment goals. With the MCO Julie worked under, that's considered "case management…not therapy," so the MCO had the power to say it was not billable and refuse to pay.

Given that treatment plans required measurable goals, clinicians described having to use structured assessment tools frequently with clients to measure progress. Collecting

this data at baseline during intake and initial evaluation, was described by participants as invasive and potentially harmful to clients given the sensitive nature of the data being collected, and the lack of safety built in the early stages of a clinical relationship. Charlie described "strict criteria about what screenings you're supposed to do based on what the referring problem is." They described this as particularly problematic when the presenting problem was trauma related:

> I could get a referral that's for somebody…who has just recently been shot and they're having a lot of trauma symptoms and I'm coming in and I'm really expected to do like the PDS-5[3]…now I'm asking this person really vulnerable information about themselves right off the bat. We just met each other. But it's like I need to do this screening because that's just like how things work here.

Laura echoed discomfort around early and in-depth assessment of trauma required during the intake process at her agency, which does not feel clinically appropriate for the population, particularly when combined with the long wait times for services at her agency:

> If someone was like oh like I'm not ready to talk about my trauma…you were like nope…And then you would list it. Like, have you experienced sexual abuse, physical abuse? How many times? At what age? Like having to list every horrible thing that happened to you and just go home…It's like, in six months you might be called, hopefully you have the same number. Don't lose your number.

Intake and evaluation practices in CMH overall were described as focused on collecting as much data as possible and documenting all of it. My data suggests that paperwork sets

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[3] PDS-5: Posttraumatic Diagnostic Scale for the DSM-5

the pace of therapy rather than the client and strength of the relationship setting it, posing a challenge to clinician's philosophy of practice which emphasizes letting the client lead.

Inherent in the assessment and documentation requirements for the agencies discussed was the assumption that treatment goals in therapy are observable, behaviorally measurable, and progress in a somewhat linear fashion over time. This reflects another expectation in CMH settings that clinicians struggled with: that they should use short-term, behaviorally focused interventions focused on reducing symptoms.

Medical Model and Symptom Reduction

Many described their freedom to practice how they want in CMH to be limited by the expectation that they use short term, behavioral interventions focused on symptom reduction. Candace noted that emphasis on behavioral therapies "cramps the creativity of the clinician," and Chloe described a "pressure to jump to solutions rather than…staying with the problem." Dave named how these models are "linear…there's a very specific start and end order of events." In general, trying to adhere to more structured or manualized treatments was described by clinicians as impeding their ability to practice flexibly and in attunement with the client, and following a medical model of mental illness that expects healing to be linear and observable.

Dave described how within these models "you're essentially playing the role of teacher more than a therapist" in that you are teaching clients skills. They name that teaching skills can be "fine if you're thinking relationally around them" but notes that "there's very little room to do that in a community mental health clinic" due to the expectation that the clinician "spit someone out with…measurably decreased symptoms in the short term." For Dave, "that doesn't feel ethical or in alignment in what I believe to

be the value of psychotherapy." For Candace, the "push for behavioral therapies only" raises the ethical question of "who gets what type of therapy":

> They wanted everything to be short term. Time limited…I think that that's egregious…it doesn't allow people to say what they want from a therapy and get what they want from a therapy…people who…have Medicaid insurance have to…conform to a certain way of being in order to get help that they need…there's this sense of like…people who live in poverty…don't deserve insight into their behaviors…they just deserve symptom reduction so they can go back to work. And…that's gross (laughing). That's very, that's very upsetting.

Candace's reflection here aligns with the notion that social services can operate as mechanisms of social control in the service of racial capitalism (Abulhul, 2021; Conrad, 2007), and she highlights the ways that the emphasis on symptom reduction is toward the goal of making low-income clients more productive within this system.

Many clinicians in the sample shared explicitly their awareness of how medicalization in CMH and the resulting focus on behaviorally measurable change is inherently oppressive of clients who are marginalized. Riley felt that the interventions they are expected to use send their clients the message "don't be who you are or how you are…become someone else…how you are is wrong." Clinicians articulated that how mental health "problems" are constructed and labeled fail to take into account the client's context, namely the historical and present impact of systemic oppression. Julie talked about her work with kids as being focused on "less noise…be quieter in school. Be quieter at home. But no one ever asked why? Like why are they making this much noise? And like systemically why is that an issue?" Julie described feeling like there was no

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room to "change some of the roots. It was like just…when you have a big feeling just squeeze a pillow. Which isn't bad. But it's also like how long until that's just unsustainable?" Julie is speaking to both the limitations and inherently invalidating aspect of teaching coping skills to clients facing inherently unmanageable systemic stressors and barriers.

Dave similarly echoed how "individualizing experiences of symptoms…doesn't get close to the root of what's going on for most people." They discussed how they have seen this play out in their work with their "adolescent queer and trans clients coming with symptoms like depression, anxiety, cutting, suicidal ideation, all these things." They described the "inherent oppression in the medical model framework" and how emphasized how teaching "coping skills to reduce the symptoms" is a "losing strategy in my opinion," as it ignores the role of oppression in the conceptualization of client symptoms:

> If you're not looking at the, the what's going on in this person's life, in their home, in their school, in their neighborhood…when there is developmental trauma that's an ongoing process in their lives…bullying at school…lack of access to any form of social support…not knowing any other queer or trans teenagers. All of these things that are…deeply implicit in the experience of those symptoms.

Dave goes on to say that if you're not looking at these factors, and "putting the onus on the individual to manage their symptoms…I just think it does a lot of damage. Because what happens with a lot of these kids and teens is they internalize that message. They internalize this idea: 'I have a broken brain, somethings wrong with me.'" Dave hones in on how an emphasis on symptom reduction means that "if someone is talking about

anything related to racial oppression, transphobia…you're pivoting immediately toward, like you're the problem. This issue is located in you" rather than validating the ways that clients' reactions are sensical and normal responses to systemic oppression.

In sum, clinicians across the board spoke to the glorification of behaviorally based treatment within CMH agencies they worked in, which emphasized short term work focused on symptom reduction. As with other CMH expectations, like caseload and documentation requirements, clinicians describe this emphasis on behavioral therapies stemming from a medicalized perspective on mental health symptoms as leading to less choice and agency for both clinician and client, thus restricting their ability to give their clients agency. They also describe how these models and approaches to care create an inherently oppressive dynamic in which the client is held responsible for their symptoms rather than symptoms being contextualized and validated as normal responses to oppression.

Thus far, this chapter has explored the barriers to clinicians being able to enact their practice ideals, and the ways that they are required to prioritize the goals of the CMH agency as a business over their clients' needs and wellbeing. The conditions of the CMH put clinicians in positions of power and authority to enact oppressive dynamics, and the therapeutic relationship is rife with complexities around identity-based power within the therapeutic dynamic and ethical practice within these conditions requires deeper presence, awareness, and attunement to properly attend to these complexities. Yet the picture the clinicians paint of the CMH center is one where the resources necessary for this depth of presence were not available. There is a theme of scarcity that arose, around time, money, and resources, which impacts their ability to balance and navigate

agency procedures and expectations and remain in alignment with their values. The next section will dive deeper into this theme of scarcity, including its impact on clinicians and their practice.

"Overworked and Underpaid": Scarcity of Time, Space and Resources

Clinicians' descriptions of work in CMH reflected a general dynamic of simultaneous "too much" and "not enough." Clinicians described a frantic pace of work, where they are expected to be producing, as Dave put it, "spitting out" clients who are "better." Yet clinicians described feeling under-resourced and unable to maintain this expected productivity without a cost to themselves.

The majority of clinicians clearly stated that they are not compensated adequately or appropriately for their time, citing low wages and unreasonable caseloads. While the ways this imbalance of time and money manifested differed based on whether the clinician was salaried or fee-for-service, there was a pervasive sense of scarcity around time, money, and interpersonal/emotional resources. Jennifer, who left CMH for some time and then returned to work part time, spoke to both the pressure and unsustainability of seeing such a high volume of cases:

> $35 an hour is not a sustainable wage for a fee-for service clinician who has a 50% show rate…and if you're…full time…you have to keep up a certain standard that like, really isn't in your control…Like 28 clinical hours a week is a lot, to do 28 trauma clinical hours a week. And like, even if you hustle, it's really hard to do that….and I don't have any sort of…work life balance or do your notes or go to the bathroom…it's just…it's too hard.

Lisa, who left CMH after three years, described it as a "go, go, go" environment that "breeds burnout." Charlie, who worked in CMH for ten years before leaving, described it as a chronic feeling of being "spread very thin" and spoke to how unsustainable it felt to work in these conditions:

> I'm busting my ass and like I've never made over 50,000 dollars a year…and now I've spent ten years in the field, and I have no savings…how is that possible that I now feel like a seasoned clinician and yet I have no savings for my future?…I'm not making enough to be like working this hard…It feels bad. You know?

Charlie went on to describe how this impacted their clinical work, stating that they "started to feel really resentful that I'm…giving so much. I'm giving way more than I'm getting…I think I got to like a breaking point…where I could…feel it coming out on my clients." This dynamic of enacting power over clients from a place of powerlessness will be addressed further in the next chapter.

In addition to scarcity of time and money, clinicians reflected a scarcity of support within the agency. Overall, clinicians described feeling frustrated and undervalued by those in positions of power within their agency. Riley, who left CMH after four years, experienced this sense of not being valued on multiple levels, including feeling like their identity was not respected or protected by the agency at large:

> They say they care about us and that they care about clients, but they don't show up. Often literally…our supervisor canceled a whole lot or no-showed a whole lot but yeah, that difference, which is also white supremacy culture…that difference between what we say we do and what we say we value vs. what we put into it. Which felt even more true…where I was fee-for-service and didn't have an office.

Where it was like, okay you do not care about me or value me. Financially,

physically, in the basics of my pronouns, and therefore you don't care about my

clients.

Riley is pointing here again to the ways that CMH, limited by white supremacy culture,

fails to prioritize the wellbeing of clients and clinicians alike.

Other clinicians also reflected on the scarcity of support they experienced in these

systems, and particularly the type of support that they needed to stay connected with anti-

oppressive practice values. There was variation in how much clinicians' supervisors felt

aligned and made space for a more radical philosophy of practice, but some clinicians

described supervisors as being too beholden to the policies and procedures of the system

to provide more radical supervisory support. Charlie described their experience meeting

with supervisors as being all about how they can be more compliant with agency policy:

When I did meet with a supervisor, they were like so let's go over your last

treatment plan and what was wrong about it…or like let's…try to figure out why

you can't see ten clients a day…they would be like yeah I understand that

you've…been going through stuff. But like you know you need to step it up.

Mary, who worked in CMH for three years before leaving, found that even though she

did feel value alignment with her supervisor, he was also subject to the scarcity and

corresponding pressures of the system, making him less available:

My supervisor at work who I like a lot and like feel very supported by has been

given…a second (pause) full time responsibility…this year. He has like two full

time admin level jobs…which just means that he's like never available and he's

always very very busy.

Mary concluded that "the system is not set up for me to have access to support in the way that I would need."

Overall, clinicians in this sample describe being, overworked, underpaid, and not having consistent support from the supervisors and the agency at large. My analysis of their accounts suggests that this scarcity limits clinicians' ability to enact anti-oppressive values in their work. High caseloads, low pay and frantic pace of work were described as making it challenging for clinicians to wield their power intentionally. Laura, who is new to the field and has worked in CMH for 1 year, described it as feeling impossible do this emotional work at such high volume and be fully present:

> Bringing your A game…sustained focus of genuinely being with a person and listening and watching and hearing and trying to find that resonance between the two of you…you can't do that 27 times a week, it's not possible…I just don't think that we can muster that level of empathy and being with, and maintain the ability to then go back into ourselves and live our lives and practice that self-care they're so fond of telling us about.

Clinicians described in the previous chapter how self-awareness and self-interrogation were critical in being able to show up ethically in the clinical space, yet describe having no time for this crucial reflection. Jennifer expressed this clearly:

> It makes it very hard to do your own work, you know, to have time and space and energy to work on yourself and just think critically and strategically…what you're bringing into the room, what you're taking home with you, how you are engaging with clients. You know, like you just don't have the energy, time, any of it. Like it just doesn't happen…when you are overworked and underpaid.

She went on to name how intentional anti-oppressive work in particular is "not something you can just skim through," and requires "time and energy" that feels challenging to find in a CMH context. As a result, Jennifer feels that she is "not going in as my best self because I'm not being given these opportunities or resources to be my best self. And…and then that is, you know, increasing the likelihood that my whiteness will come out." Scarcity of time and financial resources that characterize these settings were described as interconnected a scarcity of emotional space—space to reflect, to sit with oneself, and to do the personal work necessary for ethical clinical work—this work being particularly important in CMH where clinicians hold identity-based power over their clients.

Conclusion

This chapter has explored the ways that working in Medicaid funded settings and the corresponding policies and procedures governing CMH practice led to clinicians often having to engage in actions that fall on a spectrum from unhelpful to actively harmful toward their clients, and are misaligned with anti-oppressive goals. Overall, they felt powerless to avoid wielding power in oppressive ways. The reflections clinicians offered around the working environment in CMH spoke to the negative impacts of neoliberalism and the resulting market logic that dictates practice in government-funded social welfare programs (Schram, 2018). Clinicians' descriptions of their experiences in CMH were consistent with the literature and framework presented in Chapter 1, which suggest that characteristics of white supremacy are inherent in the norms, values, and practices of the neoliberal welfare state. Sense of urgency and an emphasis on quantity over quality (Okun, 2021) are apparent in how clinicians talked about the push to

maximize billable hours, and turnover clients by focusing on short term symptom reduction rather than long term, attachment based, insight-oriented work. Individualism and emphasis on progress (Okun, 2021) shape approaches to treatment in CMH, which place the onus on the individual to control their symptoms rather than addressing root causes of mental illness and presenting symptomatology. Clinicians are required to measure and demonstrate linear progress. Worship of the written word (Okun, 2021) is paramount in CMH, in which nothing is considered to be true or real unless it is measured and documented. Another major theme in clinicians' accounts was paternalism (Okun, 2021). Clinicians made it clear that in how the CMH center operated, their clients were not given choice or autonomy in their treatment. Similarly, clinicians felt that their own agency and freedom as employed clinicians was limited in how they practiced and cared for their clients.

Another theme that was apparent in clinicians' accounts was that of scarcity, and the ways that a scarcity mindset reinforced and upheld the oppressive norms of racial capitalism. Clinicians reflected a sense that the CMH center had to operate from within a neoliberal business mindset due to a scarcity of resources. The emphasis on productivity and efficiency that created strain for clinicians seemed to be justified by the agency as necessary to provide services to as many clients as possible, with an awareness of the high demand and low availability of services. Scarcity was also a rampant theme in clinicians' discussions of how they were compensated for their work, and the emotional resources available to them in the agency.

My analysis suggests that both clinicians and clients alike are subject to oppressive dynamics within CMH. Clinicians' experiences of the ways that their "hands

are tied" in these systems reflect a sense of disempowerment and the oppressive nature of neoliberal agendas. Clinicians are oppressed in these settings insofar as their professional standing and economic security is contingent on their complicity in these agendas. From this place of disempowerment, clinicians experienced dissonance around the ways they felt forced to be complicit in their client's oppression in large and small ways. In the next chapter, I will explore how clinicians made sense of and responded to this experience of dissonance related to their powerlessness.

Chapter 5: "What can I really do?": Powerless Responses to Dissonance

The previous chapter explored the ways that clinicians feel powerless to adhere to and enact their beliefs and values in their clinical work due to the constraints and realities of the managed care system. Dissonance arises around awareness of relative power/powerlessness—both their own and their clients. More specifically, clinicians experience dissonance in moments where they are aware of disempowering situations for clients, but experience powerlessness around how to use their own power in a way that gives power back to clients rather than enacting power over them.

This chapter will explore what clinicians do with that dissonance. How do they make sense of it? How does it impact their clinical work and decision making? As clinicians reflected on their experiences of dissonance, their stories spoke to the ways that they related to knowledge of their powerlessness. This chapter will explore how clinicians' relationship with and identification with powerlessness impacted them, and the actions they took in response. These responses were layered and often cycling through or shifting day-to-day or even moment-to-moment in their work, so these three responses should be understood as overlapping rather than mutually exclusive. My analysis will demonstrate how dissonance resulting from an awareness of powerlessness to resist oppression had the potential to generate further moments of oppressive action, which in turn created further dissonance.

In discussing powerlessness as both a precursor to and a response to dissonance in the following sections, it's also important to point out that powerlessness describes both a feeling state and a material state. As described in the previous chapter, clinicians do lack

power in certain structural and material ways in the system they are working within in some sense—for example, due to ethical codes and professional mandates there are certain areas where they may have no choice but to take harmful action, or certain requirements from their agency that must be followed for them to remain employed. They lack power in the hierarchy of the CMH, and as a result are subject to the limitations described in the previous chapter. However, as will be explored further in the next chapter, clinicians do have some amount of discretionary power (Lipsky, 2010) in their role. This is why it's crucial to note how the *felt sense* of powerlessness that clinicians experience due to their lack of power within the system impacts how they respond to dissonance. As will be explored in this chapter, this feeling of powerlessness may make it more challenging for clinicians to identify and leverage the discretionary power they do have.

Succumbing to Powerlessness: Guilt, Shame, and Burnout

In response to awareness of their lack of power, clinicians describe a corresponding emotional state of powerlessness. Clinicians describe feelings of guilt, shame, and despair around the ways in which they are powerless in their work, and feel in response to dissonance that no matter what they do, they are questioning whether they are doing good work. Many clinicians conveyed a sense of hopelessness around this, and many clinicians who left CMH cited this powerlessness as a factor in their decision.

Charlie's description of their experience in CMH offers insight into the cyclical nature of powerlessness and dissonance. Charlie, who left CMH for private practice, recalled that in their ten years of work in CMH, "never, never was there a day" when they left work feeling like "this was a great day and I really helped…I really sort of showed up

the best I could and I feel like people were helped in the ways that they needed to be and I feel like at peace with my organization and what they're asking of me." Charlie's lack of being able to feel "at peace" with the care they were giving was ultimately unsustainable for them.

Charlie's descriptions of their experience depict how dissonance in moments of powerlessness can become a vicious cycle—when clinicians are feeling powerless, they begin to relinquish power that they may otherwise have to care for themselves and their clients. Charlie described this cycle in response to coming up against systemic and material constraints when trying to advocate for a client:

It just leads to a lot of disempowering situations…and for me too. Because I feel all excited to help this person and then can't. And I feel really sad that they're calling me and I'm like I'm sorry I tried to talk to my supervisor. I don't really know what else to do…Then I start blaming myself. Maybe I should be doing more. Ya know it's just like, it's this terrible cycle. And so then I'm giving them worse care because I'm feeling shitty about the situation and disempowered.

Through feelings of guilt, shame and self-deprecation, powerlessness becomes cyclical. Charlie went on to describe how powerlessness began to seep into their overall approach to their work. They described that their "lack of self-esteem and like feeling of disempowerment sort of led to like some poor choices," naming situations "where I should be more proactive" but instead will "put things off until later." They described this playing out in situations where it was in their client's best interest to coordinate with other involved systems or members of their treatment team, but they felt "uncomfortable" and "intimidated," leading them to avoid taking these actions. In their work with clients,

Charlie began feeling like "a barrier to their care…as opposed to somebody who's facilitating their care." Charlie still reported that they still experience "a lot of guilt and…shame about the things that I kind of ignored" as a result of being "spread thin." Charlie's story depicts how in response to chronic disempowerment, clinicians lose the energy to be advocates for their clients and push back against systemic constraints. The resulting dissonance between their values and their actions engenders further powerlessness.

While Charlie's experience of disempowerment was emotional, this is not to ignore the role that material lack of power played in their experience. The type of advocacy and continuity of care work that Charlie named as important—connecting with other members of the client's treatment team, leveraging the power of their community, taking extra care to research and connect them to resources—were unpaid tasks due the billing structure of CMH, as was the case for most clinicians. Jennifer articulated how "a really big value of mine is helping others…even if I'm not the one who's gonna get paid to do it." This value leads Jennifer to "go and research and…get the resources. And I do that out of the kindness of my heart, because that's more important to me that they get those resources." She went on to acknowledge how this is not sustainable for many clinicians given their workload, time limitations, and financial stress. For clinicians to adhere to their values around providing resources for clients, they have to go beyond their job description and do so "out of the kindness of their heart" rather than being compensated for it. It's important to note that often using discretionary power to best support clients in these systems requires that the clinician engage in self-sacrifice.

When clinicians go above and beyond to support clients in ways that are aligned with their clinical values, but not supported infrastructurally in their agency, it can lead to resentment. Julie described how in her work, she noticed that while clients were often involved with many systems, "everyone was an island…no one talked to each other." In response to the awareness that this is not beneficial to the client's care, Julie "would try to advocate for interagency meetings if there were multiple people involved" but noted that "you didn't get paid for those…you weren't getting reimbursed by the insurance company for that."

Julie described dissonance and moral conflict around how to support both her client and herself, noting that "this is the right thing to do…that we have all four providers in the same room talking about the same goals with the client. And yet I am spending an hour plus of my time not writing notes and also not being able to bill for this…so there was sometimes where it bordered on doing the right thing versus…the fear of becoming jaded." She went on to say that she saw coworkers who had been working there "for like, ya know, 25 years and just resenting the clients." Ultimately, awareness of a growing resentment was what led Julie to leave CMH.

Leaving CMH

Other clinicians described similar gradual processes of becoming more and more disillusioned with their clinical setting as they attempted to enact their clinical values and pushed up against the limits of their power. Riley told a story about how they had taken over the role of facilitating a trans support group after the prior facilitator left. They described that prior to their becoming involved, the group had followed a peer support model, but it "turned out that the main person doing the peer facilitation is actively a

white supremacist" and had been making BIPOC participants feel unsafe and unwelcome in the group. As a result, when Riley took over the group, they questioned the appropriateness of being a white clinician leading the group and made the case to their agency that they at least wanted a BIPOC co-facilitator to begin making the space feel safe again for the BIPOC members of the trans community. They felt this was necessary and appropriate in light of the prior harm caused.

Riley took steps for over a year to advocate for this change, and became increasingly aware of the powerlessness they had to enact change: "I kept bugging them about it, at some point I went to the executive director about it. But nothing happened…It just felt really crushing." Riley did what they could to show up in the role in a way that felt aligned with their values, seeking extra consultation, educating themselves about transformative justice work, and shifting the structure and norms of the group through process conversations. But "when over time they wouldn't either add on or replace me with a person of color…it increasingly felt like I was just enacting something that I didn't believe in…I felt angry, I felt discouraged…I felt really crushed and heartbroken and unsupported." They described having "this moment where I was like…I'm not going to get my needs met here," reflecting that "I was trying to make things change and I was…a good employee…my employee evaluation is so flattering, I'm apparently the shining example of the kind of employee that they want…but they wouldn't do shit for me. I felt really unsupported." Ultimately this led to Riley leaving the agency, and eventually, after encountering similar disempowering experiences at their next agency, leaving CMH altogether.

Charlie described a similar process of slowly losing hope in their ability to enact change and practice in alignment with their values, and eventually leaving due to this experience of disempowerment. Charlie reflected on the dissonance involved in their decision to leave CMH:

It was…a hard and sad decision…I always had like thought that I would…I wanted to stay in community mental health. I was just like…all these people just going into private practice like what a cop out. You know? I was like these are the folks who need the help the most, you know? And everybody leaves to go do private practice…I should stay here and like offer good therapy to people…maybe try to change the system from within.

Charlie had creative ideas about how to enhance client care, thinking they would like to "have a better referral system so people can have clinicians that they really want….and offer really good programs…maybe I'll team up with…nutritionists and we'll do…diabetes education…a dance movement therapy group." They reflected on how "really having these like big ideas and then not ever being able to…enact them just felt really sad."

Ultimately, conditions of the work in CMH were described by most clinicians in the study as unsustainable, with 7 out of the 13 participants having left CMH at the time of interview. Of those remaining in CMH, two of the clinicians have managed to make the work more personally sustainable by only working part time. Clinicians were aware of the negative impact the level of clinician turnover has on CMH clients, putting them further at odds with their ethics. Mary articulates that "with a lot of the clients in community mental health they have a lot of trauma around abandonment and like

relational trauma in general" and as a result, the frequent turnover of clinicians "is often…retraumatizing them."

Leaving CMH, while reducing the day-to-day dissonance that arose in CMH work, engendered further dissonance for clinicians. All clinicians who left CMH were still sitting with guilt and shame about this decision, noting that leaving was not in alignment with their values either, but felt like a necessary choice for their wellbeing. As Julie described it, "there was a relief where I could be a little bit more like way more autonomous…but it did not feel great…because it felt like it was running away from this larger issue of like…working through systemic problems and trying to be a part of this bigger solution."

Engaging in Power Over

As Julie pointed out, leaving CMH felt like a necessary choice to avoid a situation that she saw around her of growing resentful of clients and risking causing harm. Clinicians described ways that their experience of powerlessness led them to engage in moments of exerting power over their clients or engaging in a power struggle. These were situations where clinicians did actually have some discretionary power (Lipsky, 2010) but feelings of being beholden to agency requirements took the fore. This response was often described as unintentional and something clinicians only became aware of after the fact.

Chloe described how the punitive nature of CMH for clinicians and resulting powerlessness made it feel more likely that they would in turn be more punitive toward clients than necessary. She discussed how in her CMH center, in terms of following agency policies and practices, "it felt like…if you mess up, you immediately have to hear

about it…it's punitive." She goes on to describe how this punitive energy "can be reflected in the therapeutic space. I'm like, 'Oh, you didn't do your homework?' It's like, this person doesn't have a place to live, like, of course they're not going to do their fucking homework." She describes this as "an expectation bias that happens because of the expectation bias on us…I'm metabolizing it by spitting it on my client." Rather than being able to engage in the critical assessment of service users' experiences of oppression that anti-oppressive practice dictates (Healy, 2014), Chloe described how she instead may enforce expectations over the client that do not consider their context. When this happens, Chloe describes it as directly resulting from ways she is feeling powerless in trying to meet the requirements of her agency.

Another pathway for acquiescing to agency norms and exerting power over is that when clinicians are burnt out and overworked, they are less likely to be acting from a place of deep intentionality and alignment with their values. Clinicians were aware that without this intentionality, they may be more likely to align with the default of the agency—to wield power in a way that protects the agency over the client. This came up regarding decisions to hospitalize. Candace expressed awareness that "anytime someone says that they wanna die and my knee-jerk reaction is..okay I'm gonna hospitalize you." For Candance, this feels "really fucked up…I have to make sure that I don't do that. Cause I shouldn't use any power, any of my power to incarcerate someone." While it is at odds with Candace's values, the knee jerk response to hospitalize clients as a safety precaution has been described as normative in a context that constantly emphasizes liability and prioritizes protecting the agency over the client's autonomy.

Dave expressed a similar feeling, describing an activation of their nervous system that occurs around issues of client safety, and how it takes energy and intentionality to soothe their nervous system and not act from this place of activation:

When a teenager or any client references wanting to die or hurt themselves, or anything like that there is this nervous system activation in the therapist around the concern with liability, culpability, and prevention of any kind of thing that can come back to bite you…if you're not managing that activation in yourself you can jump into this sort of like rescue stance.

Dave goes onto discuss how this activation leads them at times to abandon the clients' comfort in favor of the clinician soothing their own anxiety:

Suicide prevention protocol asks us to do that. No matter where we're at in the discussion. Turning toward the computer. Let's do this…form…assessment…document everything. Get into all these really specific questions that are usually quite uncomfortable for a client to have to respond to……. there were times that I just sort of like would freak out…and then I would see the resulting disconnect with the client. And also the resulting activation in them in picking up on what was going on with me.

Dave described this often instinctual response as at odds with a competing instinct to just be with the client in moments of distress, which would look like "maintaining a kind curious stance toward, toward the client…holding space for their feelings. Their activation. Not your own. And, and continuing to explore where they're at." These discussions of possibilities for unnecessarily exerting power over clients demonstrate how clinicians may be tempted to act in a way that returns them to a sense of feeling in

control in situations that may bring up feelings of loss of control. As Chloe put it in Chapter 4, there is a "pressure to jump to solutions rather than staying with the problem" which can lead to oppressive action.

Reflecting on reactions to powerlessness in light of the discussion in the prior chapter that reflected on paternalism in CMH, clinicians in CMH are more likely to feel powerless in light of CMH expectations of the power that clinicians ought to have. Clinicians are positioned as if they should be able to clearly define and resolve clients problems with evidence-based, structured treatment approaches. If clinicians hold themselves to these expectations, they are likely to feel powerless when clients' challenges feel insurmountable or not possible to resolve therapeutically. In moments of feeling pressure to "fix," they may be more likely to become frustrated with clients for not "doing their homework" or responding to interventions in the expected way.

Sara described how this played out when she was "very concerned" about a client's alcohol use, but the client was in denial that there was an issue. Sara described how because the client would continuously deny having a problem, Sara found herself getting into "power struggles" of trying to convince the client of their problem. From Sara's role within CMH, there was a pressure to address what she identified as a concerning and potentially dangerous problem, and a powerlessness to address this problem. Rather than allowing the client to set their own goals and define the problem for themselves, Sara found herself feeling a pressure to impose her definition of the alcohol use as the problem. She identified in general that she has been guilty of forcing interventions on clients at times because "as a therapist I wanted to feel like I was doing something…I put a lot of pressure on myself around that." Here Sara reminds us of

clinicians core goals of being helpful, how our professional identities are bound up in beneficence (Badwall, 2014), and the ways that the linear, medicalized framing of treatment as discussed in Chapter 4 creates a pressured expectation that clinicians should be able to resolve presenting problems.

Overall, given that default norms and values of CMH settings are paternalistic, clinicians describe feeling like if they are not intentional, they can easily slip into taking more oppressive actions, even in moments where they may have had the discretionary power to make different choices. Making clinical decisions from a place of feeling powerless made clinicians more likely to acquiesce to agency norms, thus engendering further dissonance and creating disempowering cycles. The material conditions described in the previous chapter and the potential for burnout are prime circumstances for these cycles. When clinicians act from an awareness of their lack of power, they risk losing awareness of the power they do have. This can render them unable to wield the power they do have in an ethical way, by exerting power over and relinquishing their discretionary power.

Accepting Powerlessness

While clinicians at times fell into despair around areas they felt powerless, leading them to fall more deeply into a powerless feeling-state, there were also some examples in clinicians narratives of coming to terms with or accepting the areas where they lacked power. This looked like a process of shifting feelings of responsibility, and not feeling or holding themselves responsible for aspects of their job that are out of their control, which changed how they experienced and responded to dissonance related to their role in oppression.

John, who is still working in CMH, reflected on how he sees institutional racism showing up in his work, noting that while "it's sad, it's frustrating, it can definitely be a bit discouraging," but reconciles by accepting that "I'm working on a micro level like how can I…like what, what can I really do? And I have to sort of cut my losses in some areas." Alice, who also still works in CMH, identified "feeling conflicted" ethically when working with court-involved clients, describing how clients mandated to therapy have very little choice, and the clinician is put in a position to be more punitive. She described having to take actions that are "a bit yucky and are not necessarily my preference" but that "it's sort of.. what's required, which stinks." When asked how she manages this "yuckiness," Alice said that "what comes next is not in my power or control…there is another person who has some power and control in this. I try to…remember that I'm only a piece of the pie…making sure that I don't take that full responsibility on myself. Because that's not just me. I don't…I do not determine what the judges do [chuckles]." Rather than despair, Alice's attitude toward her lack of control reflects a certain levity, which stands in contrast with the anguish other clinicians seemed to experience about being an arm in a carceral system.

She goes to name that the client has some power and control, stating that "we wouldn't have (pause) be even having the discussion if…the person said like, 'Oh yeah, let's try it out, see if it helps,' or 'Yeah, sure, I'll come to my sessions, I'll make sure I'm there on time because that's what you guys say I need to do.'" While Alice's practice of reassigning responsibility to appropriate parties seems to be helpful in reducing guilt and hopelessness, it also could lead her to hold clients accountable for things that are outside of their control. For instance, here she is not engaging with complexity around the

material, emotional and psychological barriers that may make a client resist engagement with court involved therapy, and suggests that it is in the client's best interest to be compliant. In some ways it is, as the client risks further incarceration if they are not compliant. However, in placing responsibility on the client, Alice may, as neoliberal systems do, blame clients for their resistance rather than viewing it as a normal and healthy response to oppression (Metzl, 2009; Szasz, 2009).

The issue of holding clients responsible and accountable is complex, and as articulated in Chapter 3, many clinicians saw holding clients accountable as an important piece of honoring client agency and providing effective and ethical care. Candace, in reflecting on moments where her privileged identities create tension, conflict or power imbalance in session with clients who hold marginalized identities, expresses a sense of acceptance of the inevitability of this imbalance, and a belief that holding guilt about this is not necessarily helpful: "It's just gonna happen…That's okay. It's okay and I think (sigh) some things that happen is that people like engage with the work from a guilty position…and don't treat their patients with different identities like human beings." She went on to tell a story illustrating how this guilt can play out in paternalistic ways:

> I have a, a young woman…she's my age. But she appears much much younger…she's super traumatized, was a child bride. And…she crosses my boundaries like with…no (laughing) care in the world. She's like physically in my space. Shows up here without appointment times. And…you see other people responding to her in the clinic or outside as like…oh poor her, I really need to take care of her…she needs help. But she also needs to not…aggress upon me all the time…we need to work out that dynamic…like with recognition that like…the

way systems have worked…impacted her and kept her in this developmental

phase that she's in. And I get that. And like…we need to talk about her behavior

still…I can't let myself feel like too guilty that I have X and she has Y so that I

don't treat her with the respect of proper therapy.

Candace raises the idea that just as telling clients what to do or taking too much control in

their treatment reflects paternalism, handling clients more delicately as a result of

awareness of their marginalization could be a paternalistic dynamic as well. In her view,

guilt seems to leave clinicians at risk to not set boundaries with their clients, and the

process of boundary setting itself may be an important interpersonal intervention that can

aid in a client's ability to set and respect boundaries in their other relationships.

Overall, a few clinicians gave examples in which they seemed to be aware of their

relative powerlessness in their role, but did not feel excessive anguish or despair about

possible oppressive dynamics. They seem to have some acceptance around aspects of

power and powerlessness in CMH without sinking into a feeling-state of powerlessness.

While helpful for making the work feel more emotionally sustainable, this process of

abdicating responsibility for what larger systems are doing also means that clinicians may

be less likely to push back or take action to change these systems. Acceptance of

powerlessness could lead to accommodation, or tacit acceptance of certain agency

practices as inevitable, when in actuality their discretionary power could be leveraged to

mitigate the impact of these practices.

On the other hand, as the previous section indicated, overidentifying with the

responsibility to change systems led to a feeling of powerlessness that did not necessarily

inspire action or leave clinicians with the capacity to push for systemic change either. It

made it challenging for them to use discretionary power in a way that might enable them to stay aligned to their values. Being unable to tolerate the things they could not control in their agency context led clinicians to leave CMH entirely. Working "from a guilty position" can even engender its own type of paternalistic dynamic in which the clinician's emotion is centered over what would benefit the client.

Clinicians' stories point to the importance of finding a balance, where one is aware of their powerlessness, but not overidentified with it to the point where they are also not aware of their power. Accepting powerlessness is a helpful step in reducing dissonance but risks being another form of overidentification with powerlessness, in which the clinician abdicates responsibility and accepts the constraints of the system rather than pushing back against them. When clinicians can use moments of dissonance as a cue to *tune in* to power, identifying where they do and do not hold it, they may be able to find this balance. The following chapter will explore ways that clinicians manage to walk this line, harnessing discretionary power (Lipsky, 2010) in attempts to reduce and mitigate oppressive dynamics.

Chapter 6: "Okay, my notes will reflect that for you": Harnessing Discretionary Power for Spacemaking and Resistance

Clinicians experience dissonance in CMH in moments where they feel that their philosophy of practice is at odds with what is being expected of them within their agency, and in moments where the material conditions and choices available bring aspects of their philosophy into conflict. This dissonance can be experienced in some moments as powerlessness—powerlessness to resist or avoid engaging in a harmful system and causing harm. Yet clinicians also told stories about responding to this dissonance by finding and using the discretionary power (Lipsky, 2010) they do have. This chapter focuses on ways that clinicians respond to dissonance by attempting to reconcile disparate values and expectations using their discretionary power. My analysis will explore the ways clinicians were able to leverage this discretionary power for spacemaking—creating maximal space for and humanize their clients within an oppressive structure—and will suggest that, when staying connected to their own power in moments of dissonance, clinicians found ways to give more power to their clients, staying in alignment with anti-oppressive goals.

First, I will discuss the ways that clinicians were aware of their own identity-based power and how they navigated differences in identity with clients. I will then discuss how clinicians sought ways to push back around oppressive systems, both in smaller ways using moment to moment relational work to accommodate the requirements of the system while also creating space for their clients, and in larger ways that explicitly challenged or refused to participate in practices that did not align with their values. Next,

I will explore how clinicians' discretionary power around documentation facilitates their ability to create this space. I will discuss the further dissonant experiences that arise when clinicians stray from agency expectations and norms and explore what factors enabled clinicians to resist in spite of discomfort.

Leveraging Discretionary Power to "Walk the Line"

Despite the limitations they were working within, clinicians in this sample described ways they were able to focus on moment-to-moment work with their clients, and talked about the subtle yet powerful ways they were able to be intentional about how they showed up. Jennifer, a seasoned clinician who left CMH and returned to work part time, describes the therapeutic space as having the potential to be a unique space, one that "is magical and does feel really safe"; in other words, a space that is protected in some ways from the chaotic and stifling CMH environment as a whole. She described a stark difference between "walking someone down the hall" and having them in her office, noting that once they are in her office she and the client can "co-create a very safe environment" She continues to point out, "they may not feel outside that door, but they certainly feel when they're in the room with me."

Here, Jennifer is speaking to how she feels able to stay connected to the clinical and relational skills that she has to build safety within the therapeutic relationship in spite of the context. Clinicians generally reported that they felt some sense of clinical discretion and power over what actually happens within the clinical encounter and use this discretionary power (Lipsky 2010) to return to the basics of the beliefs discussed in Chapter 3 around what makes for effective therapy: a strong therapeutic relationship,

creating and holding space, and prioritizing client agency. Across different areas of practice, clinicians were able to make clinical decisions aligned with these values.

Identifying and Naming Difference, Whiteness and Power

As discussed previously, the clinicians interviewed, all of whom were white, were aware of how their whiteness can create barriers to building safety within the therapeutic relationship. Many also spoke to differences in class and privilege, and were aware of the ways in which they are representatives and players of a harmful system and the power they wield as a result. They spoke to the need for awareness and intentionality around how social location and identity-based power differentials shape the therapeutic space. Clinicians note how this awareness in turn helps to minimize the power-over dynamics with clients.

First, clinicians across the board spoke to the importance of awareness and self-reflection around their relative power within the clinical interaction. Sara describes the importance of "being aware of one's social location…in terms of ya know thought processes and world views…belief systems…how our social location can inform each of those things." She also noted that she has to recognize "that I am in a position of authority…and if I don't recognize that enough, if I'm not reflecting on that enough then yeah it can become oppressive…and in ways that maybe neither myself nor the client are aware of." Many clinicians named that personal anti-racism work has been important in how they show up with clients across racial difference. Mary mentioned "working my way through the Me and White Supremacy book" as a concrete step she has taken to raise her awareness about her own power in clinical dynamics. Most clinicians discussed doing similar personal work. Overall, awareness of one's relative power based on social

location was articulated as a necessary component of anti-oppressive practice, and clinicians describe this awareness as a necessary step in being able to be intentional about use of power in their clinical practice. They describe this awareness allows them to bring more intentionality to how they are wielding power relationally.

Clinicians describe subtle ways that they symbolically and relationally moved with clients with an awareness of power, and made attempts to subvert power dynamics. Sara discussed the importance of the physical space of the office, showing up intentionally within it to convey respect and a sense of shared power with clients:

> "My office set up was really important…which I know sounds like such a small thing. But making sure that like ya know…my desk was against the wall and so my chair could turn and face the chairs that were opposite me so it's like ya know I'm trying to make sure that I'm on the same level.

Clinicians were also mindful of how they showed up in the space. With an acknowledgment that her "whiteness, cisness, able-bodiness" can be a "sign of danger" for those who do not share those identities, Sara points out the importance of paying attention to "body language and vocal tone," and attempts to combat this by being a "warm and accepting presence for people" and being "responsive to what it seems like the person I'm working needs or would be most receptive to."

Sara also describes creating an "environment of open communication" by explicitly telling clients, "if there's something that ya know has bothered you or if there's something that we've been doing that hasn't been working for you please let me know…or if you wanna do something else let me know that." This sentiment around the importance of openness to feedback and making clients feel like active participants in

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their treatment through this feedback was reflected across the interviews to try to circumvent or subvert power-laden interactions.

For these clinicians, being present and attuned with clients in the moment and following their lead provided avenues to subvert and challenge oppressive dynamics. Dave, who in Chapter 4 discussed the oppressive and harmful nature of mental health care within the medical model, talked about relational work as a way to push against it: "That moment-to-moment clinical work around naming and honoring the…affective experience of what's going on in relation to the environment…validation." Through being with, the clinician is able to validate the clients experience of distress, pushing against the institutional ways that clients experience of distress tends to be pathologized.

When it came to working with power, clinicians also explicitly described naming identity difference and inviting discussion about power with clients. Julie described feeling more confident in having these conversations directly "as I got older and more seasoned in my work." She reported that increasingly throughout her career it has felt like there have been "a lot more training opportunities available to us. And a lot more reading available to us, and studies." With guidance from these professional development opportunities, Julie would have frank discussions with clients about what her identity and role in the system represents:

> I would ask point blank like how do you feel about this relationship? How do you
> feel about this…knowing that ya know our team of folks…we're all Caucasian.
> How does that impact you as a Black woman? I can't help but notice I'm the one
> in the khakis here. (laughing)…I got the fancy ID badge that swipes us in and
> out…and I can't help but imagine that that reminds you of…the time you were

inpatient…and no one acknowledged you…and you felt really isolated and

ostracized.

Julie expressed feeling like if she doesn't talk about it, she risks perpetuating it.

Other clinicians agreed that naming difference feels important to make clients feel comfortable to be more honest with the clinicians about how they are experiencing them. John stated that "in terms of power and oppression…I try my best to make it like well known that like I, I know about it." He goes on to discuss how in working with women who have experienced trauma by male perpetrators, he will acknowledge his gender and ask, "how do you feel about that?" He reflects with these clients about if it feels like working with a male is a "good fit" and gives clients express permission to decide they want a female clinician instead.

Many clinicians express that if they do not explicitly invite conversations about race, clients will not feel empowered to bring up how they are impacted by race and racism, both within the therapeutic interaction and in their lives more generally. Mary discussed this:

Sometimes I can tell that I'm working with people or kids who…know that they are not supposed to bring up racism with a white person" So in those interactions sometimes I will name like…you're a Black male student with a white female teacher and when she says these things to you that's different. Like that hits differently you know? I'll like name something explicitly so like they know that we can talk…explicitly about…race or other systems of oppression.

As discussed in Chapter 3, clinicians were aware of the power they hold to dictate not just what happens in therapy, but the norms and expectations of the therapeutic space.

Mary and others reflected a sense that without intentional intervention, these norms will be assumed to be those of white supremacy culture, which protect white people's right to comfort.

Clinicians attempt to resist white supremacy culture (Okun, 2021) by intentionally showing that they are comfortable—or at least open to sitting with the discomfort—of talking about race. Dave, for instance, describes "trying to open up and hold space for experiences around racial difference that might have been outside of my realm of awareness." Here Dave reminds us that clinicians are the arbiters of the therapeutic space and that spacemaking is an active process. As discussed in Chapter 3, the clinician has the ability to create a container for the client to fill with their experience, and spacemaking must be done intentionally with an awareness of the nuances of power dynamics with clients. Clinicians articulated the importance of actively managing their biases and assumptions to remain curious and maintain space for the client's experiences to lead within this space.

While clinicians agreed on the importance of being willing and prepared to have frank and direct discussions about power and identity difference, many felt that these conversations were not always necessary, and in many cases, can be actively unhelpful. Some clinicians raised the notion that these conversations can actually be a source of oppressive dynamics in themselves. Mary noted that if or how she discusses identity difference varies from client to client, and that "sometimes I will like directly make comments about…the differences between me and my clients…if it seems relevant and valuable to that person…it sometimes feels important to name it and sometimes it really

doesn't." Other clinicians echoed the importance of a relational, context based approach to deciding how to approach identity difference.

Charlie described "a difference between what I was reading in like literature about how to…talk about power and oppression in the therapy relationship…and when I would try those things in session." Rather than prompting a discussion, Charlie stated that there were instances where her clients "would be like what are you talking about? Or…it would make people feel very uncomfortable…or they would change the subject." Riley was aware that as "the therapist I have this position of power so there's a lot of incentive for a Black client, for example, to be like no no it's okay…I don't notice that…there's sort of like elements of power that are at play in how a client would respond." Many other clinicians echoed this sentiment that clients would often respond that they are not bothered by the racial difference, and spoke to the importance of being curious about the possible dynamics at play without forcing the issue.

Clinicians' accounts suggest that explicitly inviting discussions of race does not necessarily signal to the client that it is safe. The act of naming racial difference was described by clinicians as a complex power laden interaction that has the potential to backfire. Riley reflected on a dynamic that played out between them and Black female client in which they brought up their whiteness and the limitations it could pose in the therapeutic relationship. Yet in reflecting on it later, Riley felt regretful about how they handled it:

> It sort of felt like I was saying 'I don't know that I can work with Black people because I'm white.' Which isn't verbatim what I said…but I don't know that that came through…I think it's one thing to name whiteness and name limits around

that but this felt a little more like…there might have been a way in which I let her

in on…a little bit of anxiety or stress or uncertainty which isn't hers to hold

around my whiteness.

Riley expressed concern here that sometimes in naming whiteness, the clinician risks

centering whiteness in the dynamic. They highlight that there is a difference between

what they said on a content level, and what "came through " based on emotions they were

carrying, leading to a dynamic that centered whiteness. Dave expressed similar concerns,

noting a sense of "pressure…for white therapists trying to do the anti-racist thing to sort

of like name racial dynamics and like explicitly bring them into the room." They

expressed concern that this is often not helpful because "there's just so much baggage as

far as what's at stake psychologically for the white therapist in doing that." Dave

described how sometimes, stepping back and choosing not to name racial dynamics or

oppression felt the most appropriate therapeutically. Dave described this playing out in

their work during the 2020 racial justice protests, during which time they were just

starting at their agency and meeting new clients:

> Race was very much sort of the backdrop in the formation of these early
>
> relationships and…for me it looked like a lot of…hands off as far as like my own
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> values, my own projections…I had to really sort of…back off…because I have
>
> my politics, my views, my whatever, around all that stuff…and I'm talking to kids
>
> and teenagers who are scared…about what's going on their neighborhood.

Dave spoke to how naming oppression in these cases might have centered the clinicians'

beliefs and values over the clients immediate lived experience. Overall, the clinicians

who reflected on the drawbacks of naming difference explicitly reflected a sense that this

can become paternalistic and reify whiteness if the clinician is not attentive to power and how whiteness shapes the relational process. They also reflected on the power of whiteness in particular to insidiously shape this process.

Even the clinicians who named potentially harmful power dynamics at play in discussions about race acknowledged situations where it felt important to raise, and strategies they used to raise the issue gently with attention to power in the process. For instance, Charlie no longer brings up the subject of their whiteness across the board during early sessions, but will "slip it in" if a subject comes up where race could be relevant to the client's experience. They describe finding "different ways to talk about it or address it" depending on their relationship with the client and what the client is bringing to the encounter. Riley echoes that they often wait until later in therapy to bring up race because "people are more honest and would hold more complexity around it." They described their process with "Black client who recently was sharing a bit more about her experience of racism." Riley used this as an opportunity to ask, "how it was for her to talk about this and she said that she was nervous at first but it was actually fine." Riley followed up by asking, "were you nervous because I'm white, were you nervous for other reasons?," but noted that in bringing up this question, they are intentional that "the focus is 'you're nervous' the focus isn't 'I'm white'."

Overall, clinicians wrestled with the dynamics of naming difference without centering their privileged identities in the process, with some thinking more critically about this than others. As CWT (Applebaum, 2010; Frankenberg, 1993; Hook, 2011; Sullivan, 2014) indicates, clinicians seemed to struggle to avoid common pitfall of white anti-racism; in naming race, clinicians may unwittingly centering whiteness, positioning

themselves as the "good" white person through the act of naming racial difference, and soothing their own guilt and anxiety about their identity through naming it.

My analysis suggests that most clinicians sought to "walk the line" in their naming of difference—creating a space for power dynamics to be discussed, without asserting their own perspectives or centering themselves in the process. Clinicians' discussions about their acknowledgment of power and oppression in the therapeutic encounter reflect the idea that there is no one way to approach this work, and how identity difference is addressed and handled must be decided through attunement to the client's presentations, needs and context, to the clinicians own emotions, biases and mental models, and with attention to the power dynamics being enacted in the therapeutic space.

Meeting Requirements Relationally and Transparently

As with navigating identity differences, clinicians find ways to use their discretionary power to "walk the line" for optimal spacemaking—doing what needs to be done, while still focusing cultivating safety in the therapeutic relationship and making space for client choice and agency as possible. In situations where clinicians have to participate, and ask clients to participate, in practices that feel unhelpful or oppressive to clients, they sought to strike a balance between relational attunement and meeting agency requirements, and used transparency as a tool to do this.

Laura discussed how she handled a situation where her client, a new mother, was very distraught by having to complete a depression screening as part of an intake. This client was concerned that based on her answers, she would be labeled as having

postpartum depression and her baby taken away. In response, Laura was very transparent and took extra time with the client about what would be done with the information:

It took me like, 20 minutes to, really, like, I ended up opening my laptop and just, you know, covering…'look, this is what happens, I put your information into here. And then I scan this, and I put it into a folder', and I literally showed her my…inbox. 'And that's it. Nobody ever sees this again. And I'm going to shred this.' I was like, 'I'll take you to show the shred box and I'm gonna shred it. Like, I want you to know, I'm not…trying to take your kid.'

Laura took the extra time to walk the client through the process as transparently as possible, reassuring her that in this context, there would be no repercussions to how she answered the questions. Mary, who experienced dissonance around "the screening that we have to do" in CMH to diagnose clients and track their symptoms in measurable ways, treads carefully in her approach to data collection by giving "as much…agency and like sense of what to expect as possible." Mary described doing this by "preparing people (pause) for what's gonna happen…saying you know I'm going to ask a lot of questions and some of them are very personal. Mary then creates space for choice, saying "we can stop when you wanna stop…don't have to answer anything you don't want. Do you feel up for this today? Or do you feel like you'd rather do it next week?"

Charlie described a similar approach to administering assessment, acknowledging that the process of collecting this data "hypothetically…could be an oppressive situation," but goes on to say that they feel able to mitigate this if they try to "honor what people don't wanna share and not like pushing them to share more than they need to." Like Mary, they did this by providing context and choice, telling clients "these are some

sensitive questions but I'd really like to ask you for xyz reasons. Is that okay? How would you feel about me asking these questions so that we can get a sense of what the best next steps are? Just really explaining why I'm doing what I'm doing. Why I'm asking what I'm asking…" Laura, Charlie and Mary all describe how they approach data collection requirements with attention to relational process and from a place of transparency. They give context, ask permission, and make space for the client to voice feelings about what's being asked. In taking this relational approach, clinicians shared that they feel like they are able to avoid stepping into an oppressive dynamic, thus reducing dissonance around meeting these agency requirements.

Clinicians took similar approaches around having to diagnose people. Riley reflected on how she has had supervisors who put diagnoses in clients' charts without discussing them with the client, and is sure not to replicate this in their own practice by being transparent about the diagnosis and what it could mean for clients. Charlie described a similar approach around having to diagnose people:

I did a lot of F43.8s[4] to kind of get around what felt like yeah kind of a crappy decision to have to diagnose somebody…. but again there's way to like mitigate that. Which is like talking to them about it and being like 'yeah, I have to pick something to make sure that you can get these services. So if you have any concerns about that just let me know.'

Here, Charlie used discretionary power to select diagnoses carefully and keep them vague to avoid placing stigmatizing labels on clients that may impact them in other ways

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[4] F43.8: The ICD-10 code for the diagnosis of "Other reactions to severe stress"

outside of treatment. They are also candid with clients about how the system works, and that they are diagnosing because they have to.

Being transparent with clients about systemic requirements also seemed to enable clinicians to distinguish themselves to their clients as separate from the system, which could be understood as a distancing strategy used to reduce clinicians' dissonance (Harmon-Jones & Mills, 2019) by putting the responsibility on the system. Lisa, who left CMH after three years to pursue a degree in a related field, would be similarly explicit about things she had to do that were requirements, saying things to clients like, "hey, this is unfortunately a part of the system that I am in and we have to do this…it's a part of the system, how can we make it useful?" Other clinicians described a similar process of joining with the client around the frustration of some systemic requirements and inviting the client to collaborate with them about how to make the most of therapy within these requirements.

Overall, the theme of transparency emerged as an important relational tool that clinicians used to mitigate the potentially harmful effects of some CMH expectations and requirements. They used transparency and openness not only to mitigate harm toward clients, but to protect and nurture the therapeutic relationship in moments where meeting the requirement has the potential to damage it. Transparency was also an important part of giving clients choice and making them active collaborators on the treatment team— they need to know about all their options and the possible consequences in order to make an informed decision. Many participants described how they attempt to mitigate the impact of their involvement with what Riley referred to as "carceral systems" by being very clear with clients at the beginning of treatment about how what they share could be

used against them. They remind clients of their status as mandated reporters, as people with the power to involuntarily hospitalize them, or in situations of mandated therapy, as people who are required to report back to the carceral system. Clinicians talk about this as a way to give their clients as much information as possible about the reasons that what is said in therapy might be shared outside of the space so they can choose what to share with the clinician based on an awareness of possible outcomes.

When clinicians did feel like they had no choice but to involve a carceral system, they described trying to maintain a focus on maximizing their client's comfort and agency throughout the process. Mary discussed how she tries to "give more agency to clients and do my best to advocate on behalf of a client" within the process of reporting. For instance, Mary described how if she is told to report something by her boss, but she doesn't personally feel concerned about the client's safety, she will emphasize this to the child welfare worker when she makes the call, making her clinical judgment of the situation known in hopes that it will dissuade child protective services from more punitive responses. Mary is transparent with her clients throughout the process:

> I never want to be…a surprise. So if I am gonna call something in and it won't put anyone in danger I will warn them beforehand and say I have to make this call. Here are some things that might happen. I might even have them make the call with me.

When clinicians are put in positions to actively remove a client's agency, they seem to try to mitigate the dissonance around this moment of exerting power-over by giving back agency as much as possible at the same time.

There is a sense throughout clinicians' experiences of using their discretionary power that they are walking a line, trying to find balance, which Dave speaks to very clearly:

> It's not that I wouldn't pay my due diligence and do everything I needed to do ethically ya know as far as documenting and suicide prevention protocol. But I would have to work really hard to walk a line in, in the gray area where I was still relationally connected to the person and sometimes that looked like maybe…putting in the paperwork later. Or ya know different kinds of ways of…managing my own shit.

Ultimately, Dave and other clinicians described being willing to prioritize relational processes over bureaucratic ones. When it feels necessary for their clients' comfort, they may turn in paperwork late or incomplete. While still meeting requirements, they find flexibility.

In many instances, clinicians in this sample reported following agency policies and practices because they have to. As discussed in Chapter 4, their pay is threatened by non-compliance. Yet clinicians also felt that not all of these requirements are simply bureaucratic busy work. As implicated in Chapter 3, clinicians found value in some of the tools used in CMH, but took issue largely with the rigidity of these requirements and used discretionary power to use tools more flexibly.

For instance, Mary, who expressed feeling like screening processes in CMH can be violating, also expressed feeling like she understands why it's important, stating "I think it's complex." Similarly, Lisa expressed that "I think treatment plans can be very therapeutic. I do. I believe in treatment plans. Because you can get really lost in, like,

what are we talking about today?" yet described the protocols around treatment planning as "something that we like had to do but it didn't necessarily feel like something that we should be doing in the way we were doing. It felt like a lot of checkboxes…that didn't necessarily benefit patients." She goes on to say that "when you're kind of forced to do them it doesn't necessarily do…what you're hoping they would achieve." The paternalistic process of forcing and requiring felt to Lisa as if it removed the therapeutic benefit of the tool itself. Riley described similar feelings about the role of diagnosis:

> I think diagnoses are complicated and really important and helpful and valuable for some people, I wouldn't deny one to a client, but the fact that we can just sort of put something that has a huge weight and a huge stigma not only in terms of like, how the client identifies and processes but it's in their record…a label that bears medical and social and legal weight.

Again, a tool that clinicians find has the potential to be clinically useful is rendered oppressive within the bureaucratic context of the clinic and ways that the public mental health system is informed by and complicit in racial capitalism and systemic oppression. Clinicians acknowledge that nestled within this context, there are useful tools that they believe have the potential to actually empower clients. For instance, as discussed in Chapter 3, using diagnosis, psychoeducation, and collaborative goal setting can help clients name the problem and play an active role in their own care—but clinicians have identified these tools as only supportive of the client's agency insofar as the client is given agency in the *process*. Therefore, clinicians use their discretionary power to be relationally intentional in how and when they implement these tools. Again, relational

awareness is used by clinicians as a way to respond to dissonance by attempting to reconcile potentially disparate clinical priorities.

While still beholden to system requirements, clinicians described approaches to meeting those requirements while still giving the client agency and choice wherever possible. In these moments, clinicians manage to make space for clients without necessarily challenging or defying agency requirements. Clinicians attempted to create the most empowering possible experience for clients. Yet clinicians told other stories in which they were not willing to accommodate the expectations and norms of the agency and pushed back more directly.

Leveraging Discretionary Power to Advocate and "Push Back"

Clinicians described some situations in which the dissonance between their values and what's expected by the agency does not feel reconcilable by walking a line—sometimes clinicians pushed against the line more explicitly. This often looked like standing up to authority in the agency to advocate for clients. Riley, who tended to work with clients struggling with suicidality, described a situation where they "flat out refused" to follow their supervisor's instruction to call the police and involuntarily hospitalize their client, stating that "this was a teenager. He was Latino, and he was queer. And there was just no way that I was involving police." They reported that they felt "comfortable" to push back with their supervisor, and they "ended up being able to make an alternative plan with him" in which they would up escorting their client to the hospital to voluntarily admit themselves rather than involving police. Riley further reflected:

I understand that there's a possibility that our client will run away, or something when we're walking with them to the hospital. But it feels so punitive, especially

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for someone who is saying that they will go…we could go with them. We could

get a Lyft with them, like, there were just other ways to do this. And to me it

actually feels like a bigger liability to put them in the hands of police which we

know do harm, rather than just do it ourselves.

Riley's reflections highlight the ways that their supervisor, driven by the threat of

liability, had the immediate response to pursue the most punitive possible path. If Riley

had accommodated to their supervisor, they would have tacitly accepted this as the only

path. Instead, Riley was motivated by their experience of dissonance and in connection

with their anti-oppressive values, was able to forge other options to keep the client safe in

a way that was relational and optimized their agency.

One thing that enabled Riley to do this was that they felt comfortable with their

supervisor. Other clinicians echoed that they felt more capable of advocating for their

clients when they have a "good supervisor." Mary described a good supervisor as

someone "who I can talk things through with." She describes that when the issue of

reporting child abuse arises "if they think I should report and I think that I shouldn't then

I'll push back and say like well here's why." When clinicians felt empowered to use their

voice, they were able to advocate for their clients. Sometimes, this empowerment came

from strong, trusting relationships with like-minded supervisors.

Use of Discretionary Power as a Developmental Process. Clinicians described

"pushing back" as a developmental process, naming that with experience they felt more

confident and connected to their voice. Dave describes how they "got used to pushing

back against the psychiatrists and learning more and more that that was okay." Dave

figured out through experience that "at least no one was gonna give me trouble as long as

I'm doing everything I have to do on my end…I kind of just disregarded the psychiatrist…commands." They described this becoming more comfortable the longer he worked at his agency:

> It did feel good overtime to just develop a kind of confidence around, around…pushing back or sort of advocating, asserting my clinical conceptualizations and suggestions…that felt like it, ya know, an area of development for me that was needed.

Dave described being able to stay connected to their discretionary power, concluding that in many situations, "at end of the day it was okay for me to, to do my own thing, ultimately." They developed this sense over time and through testing the boundaries and limitations of their power and seeing where they are able to push back and use their voice. Other clinicians however did not share this comfort with pushing back. Mary, who has the same number of years of practice experience as Dave, stated that she is more likely to follow her supervisor's recommendations around reporting child abuse "because I'm still early in my career and like…it still matters like if somebody were to threaten to take my license away." Dave and Mary's accounts highlight the ways that clinicians differed around experienced risk and willingness to take that risk when it comes to pushing back with authority figures. One way clinicians approached handling differences in opinion with supervisors around clinical decision making was by being careful about what information they shared, both verbally and in their documentation, with those above them in the hierarchy. Discretionary power in their documentation allowed them to engage in acts of resistance more subtly without necessarily risking their professional status through more explicit resistance.

Discretionary Power around Documentation

One area where many clinicians described having discretionary power was around documentation, and careful navigation of documentation was one way that clinicians were able to "walk the line." Clinicians indirectly spoke to how, at the end of the day, it's only the clinician and the client in the therapy room, and the clinician has complete control over the narrative when documenting or reporting back to supervisors about the clinical encounter, which then becomes the "truth" of the encounter for the agency and funding bodies.

As discussed in Chapter 4, CMH agencies put pressure on clinicians to use short-term, behaviorally focused interventions, and to demonstrate through treatment plan updates and notes that the work is staying focused on treatment plan goals. As the clinicians in this sample tended to value more relational, insight-oriented approaches to therapy, they found ways to practice in these ways while still adhering—on paper—to agency expectations. Dave describes the clinical freedom that comes when you're willing to harness the full discretionary power of how to document clinical interactions, stating that "we really do have a lot more freedom and wiggle room to practice however we want…if we're willing and able to put on the pretention of doing something else." What this looks like for Dave in practice is being strategic about how they used language to describe what occurred in session:

> It's very easy for me to switch between different kinds of languages. Different theoretical orientations…a lot of it is just different language for the same thing and so I found myself increasingly able to sort of produce treatment plans and documentation that reflect a certain way of understanding what happens. And

while also practicing the way that feels in alignment with my values. And

practicing in a way that I feel like centers the best interest of my client.

Dave reflects here a sense of increasing confidence over time in his ability to focus on

meeting his clients where they are, and documenting in such a way that on paper, he is

meeting agency requirements. Candace, who has worked in CMH for over 8 years and

has no intention of leaving, describes a similar approach to meeting these requirements:

"I don't take it too seriously (laughing) when people are like oh you need to like, you can

only do this amount of sessions a week…or like you can only do this type of work. Like

okay. My notes will reflect that for you. It doesn't have to be the reality of the situation."

Here Candace and Dave suggest a more subversive approach to "walking a line" to

accommodate the agency while protecting their clients: saying one thing and doing

another.

Clinicians were acutely aware of how worship of the written word (Okun, 2021)

constituted reality in the CMH setting, and were able to leverage this strategically in

dissonant moments to do what feels best for their clients. Some clinicians talked about

how they leveraged documentation in moments where they were faced with a decision

involving carceral systems. Riley talked about the role of language and documentation in

instances when they made calls to not to hospitalize a client, and to come up with an

alternative safety plan with them instead. They described the importance of detailed

documentation of this alternative plan and knowledge that it was "something I would

need to defend."

When defending this plan to supervisors, Riley was strategic about what was

shared and how, "sharing certain information in supervision, and stating my case

carefully in supervision about how I was doing things and why." Again to the point that the ability and willingness to use discretionary power is developmental, Riley expressed that over time, their supervisors began to develop a great sense of trust in their clinical decision making and discretion, giving them further autonomy.

Mary described using similar discretion when faced with the choice around making a child welfare report, stating that "if I don't think that something needs to be reported…but someone…might have a different opinion, I probably won't include those specifics in my documentation so that there's not a place for somebody to check me on it if I'm sure that it shouldn't be reported." Here Mary is conveying a sense of trust in her clinical judgment, and in these moments, makes use of her discretionary power around documentation to protect both herself and her client from reprimand by the system.

Riley and Mary again are speaking to the power that clinicians have around how they represent clinical interactions after the fact. Overall, the clinicians who spoke about pushing back more intentionally reflected a sense of confidence in their clinical judgment.

The Dissonance of Discretionary Power

In their discussions about pushing back, Dave expressed feeling like they differ from other clinicians in their experience of how much clinical freedom there is in CMH, which could be because Dave is not afraid to use it. Chapter 4 reflected experiences where clinicians felt too disempowered to use their clinical freedom. Some clinicians described pushing back, but not always feeling that sense of confidence that they did the right thing, and would experience further dissonance when they did so.

Laura discussed this in relation to a client with delusions who had a young baby. She did not see any indication of neglect or maltreatment, commenting, "how paternalistic is it of me to think that a person with a mental illness can't parent." Yet she questioned herself, stating "I was really wigged out for about two days after that. Where I was like, am I missing something? Am I trying too hard to give the person like agency and the benefit of the doubt?" Other clinicians reflected similar uncertainty and anxiety after taking more resistant action. In their attempts to find the least restrictive possible solutions in their work suicidal clients, Riley acknowledges:

It makes me really anxious. I feel very anxious. I also have parts that get pretty angry about it but mostly I just feel really anxious…especially in these situations…like okay you have someone who has come very close to ending their life and you feel reasonably sure that they're not going to right now but what if you're wrong? And what if your client fucking dies? I mean that's really scary.

Other clinicians who discussed choosing less restrictive or carceral responses brought up similar anxieties. Clinicians reflected an awareness of liability and the dissonance it creates when they take a risk.

For some clinicians, dissonance comes up in response to even to less explicitly risky resistant action as well. In discussing moments where she feels dissonance between how she is expected to practice and what feels right to her in the moment, Laura described prioritizing the moment-to-moment work, and who introduced the idea of "dropping into a space" and being "in resonance" with clients, but struggling "afterwards where I'm like, you know, writing my notes and processing the session and doing the self-reflection piece where I'm like, that's where I feel the dissonance." While relational

components in therapy are widely understood, even within the medical model, to be an important piece of what creates therapeutic change, relational interventions are not acknowledged within managed care to be mechanisms of change in and of themselves. While clinicians might be able to meet their clients where they are within a session, my analysis suggests that doing so can lead to a further sense of dissonance for clinicians about whether they are doing "enough" or whether they are meeting expectations.

Even Dave, who throughout his interview was an example of confidence in one's own clinical intuition, experienced dissonance at times when reflecting back on his using his discretionary power when implementing a manualized evidence-based practice:

I did it incredibly flexibly…I engaged in the model in good faith but…it just didn't fit for a lot of my cases and so I didn't really adapt it very often…I had to like act like I was doing it while I was in that training, and I had to do it at least for one case and be billing for it and ya know, I would go through some of the stuff with clients when and if at all possible with where they were at….I mean I could have made mistakes there. I'm not sure. I mean maybe…It just, it felt so not resonant with my clinical antennas and um. So I did kind of just put on the pretention of doing the bare minimum with it and then just kind of moved on.

While feeling confident about what aspects of the treatment "resonated" with him, Dave still wonders if he could have "made mistakes" by not sticking more closely to the model.

Some clinicians, like Julie, did not feel as comfortable "putting on the pretension" in her documentation. She describes dissonance that arose for her when the content of her sessions strayed from what is technically billable at her agency. For example, helping clients connect to housing resources "is considered case management. It's not therapy,"

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and therefore if she reflects this in her note, the insurance company could refuse to pay for it.

Unlike Dave, Candace and Riley, Julie felt "really bound" by these limitations. She described a sense of stuckness and dissonance, reflecting that "you don't wanna lie. You never wanna lie. But you also don't wanna address like somebody's ability to use like their deep breathing exercises when they don't have a place to live." She describes generally choosing to meet the client where they are, but like Laura, felt dissonance in how to describe what she did in her documentation.

Candace, who had no qualms with "putting on the pretension" in her notes, acknowledged that this can generate anxiety for her at times, but concluded that "it means more to me to make sure I keep doing it…than to be like…worried." She goes onto speak directly to her connection to her values as something that mitigates dissonance for her:

> I know it's the right thing to do. Like I don't have any value conflict with the actual work so it's like…you lie to people to just make them feel good. You go do the thing that are your actual values. Like that's okay…why would you feel guilty about that? Like, someone needs to hear that so that they can present it to the state in whatever way they need to. And like then you can do the thing that is actually…mattering.

What enables clinicians like Candace to wield their discretionary power, and to tolerate the resulting dissonance in the process?

Candace spoke to how she does not feel guilty about the discretion she takes with her documentation, because she feels aligned with her value to prioritize the client. She went on to reflect on her frustration that other clinicians she has worked with seem to be

unable to tolerate the challenges of CMH, stating "I don't know why…It makes me so mad that more people don't do this work. It makes me…I don't know why people can't do it. I don't know why…I know that sounds really mean. But it's like…come on…(laughing) you have to do this." Candace explicitly named it as part of her values as a social worker to work with the most marginalized populations, and was frustrated by witnessing other social workers in her community leaving CMH for private practice. She went on to articulate how she is able to tolerate ruffling feathers or upsetting people in her agency when she does what she wants to do:

> I don't care if people are…mean to me…like okay. (laughing) Like that's fine.
> That's not like…it's not really my problem…they can be stupid and mean and I
> have a family and friends…who matter more than some boss who's really
> intense…it feels okay to deal with people like that.

Candace seems to express less dissonance than other clinicians in the sample by having a strong commitment to her values around putting the clients' needs first, and placing less importance on the values inherent in neoliberal managed care. Candace also articulates how her relationships out of work support her.

Factors Influencing Sustainable Resistance

In this chapter I have discussed the ways in which clinicians harness their discretionary power for spacemaking. In both subtler, relational ways and in more explicit ways that challenge or circumvent systemic constraints, they attempt to resist practices that don't feel aligned with their values. In some cases, clinicians use their power to "walk the line," attempting to engage in acts of resistance while still meeting requirements. In others, they more explicitly push the line and push back explicitly.

While this ability to locate and leverage these avenues for resistance felt empowering and sustaining at times, it also had the potential to generate further dissonance, characterized by feelings of anxiety and self-doubt. My analysis suggests that in moments when they are able to resist, it is because they are able to remain connected to anti-oppressive clinical values and their own sense of what feels "right." Through this connection, they notice and intentionally address power proactively in their work. Even the clinicians most comfortable with engaging in resistant practices still felt some sense of anxiety around if they did the "right thing" but some seemed more comfortable sitting with this anxiety than others. Candace's story demonstrates the ways that again, a connection to one's sense of "what feels right" can help clinicians mitigate anxiety in response to engaging in resistance, and in turn help them tolerate dissonance. This section will discuss some emergent themes around what factors impact clinicians' ability to both stay connected to and act from their anti-oppressive values. Clinicians' accounts suggest systemic barriers limiting their ability to act from these values, even when they are connected to them.

Community and Collegial Connections

One factor that came up in clinicians' accounts of pushing back was the role of supervision, and particularly a sense of value alignment with supervisors. Mary described the experience of having "one supervisor at [agency] who I really loved…we could speak candidly all the time…and she was definitely somebody who was more allied with the clients than with the agency…and we could also talk about the agency and critique the agency together." She then described having another supervisor later who was "much more…by the book. Like…here to uphold whatever had been put in place." Mary

described greater challenge and dissonance in her work when working under the supervisor who was more aligned with the agency's values than a client centered approach.

Riley, in their descriptions above, felt empowered by the relationship with her supervisor to advocate for themselves and their clients, and felt that their supervisor respected their clinical judgment. In supervisory relationships where they didn't feel this support, Riley described getting outside supervision, stating that "it just feels different to have support who's not also hierarchically above you. And who's also not at your job and can see some of what you see." Riley highlights how supervisors, who carry even more responsibilities for ensuring compliance with agency requirements, may by virtue of their role be naturally more aligned with the agency, and found space with someone outside of this context to stay connected to their anti-oppressive values.

Finding connections, not only with a supervisor but with others as well, seemed to be a motivating force for clinicians attempting to stay connected to anti-oppressive values in this context. For example, Lisa described feeling "grateful for the relationships, the people" in her agency and reflected on "what that means for doing good work…even if the agency wasn't able to provide…was needed to do some of that, um, at least it was like an understanding of what…it could look like and what it's striving to look like." While Lisa is no longer in CMH, she described her work community as aligned with her values and a sustaining force while she was working in this setting.

Connection to Self and Awareness of Emotional Experience

In addition to connection with community, connection with oneself and ability to introspect emerged as a factor in clinicians staying connected to anti-oppressive values in

moments of dissonance. The findings presented above have spoken to the importance clinicians place on being self-aware of their own biases based on their race and social location, which they named as necessary to be able to notice and respond to moments of dissonance by making decisions that prioritize the client's sense of agency. Clinicians accounts suggest that this can be a nuanced and unclear decision point, requiring awareness of one's own emotional responses and moment-to-moment experiences.

The depiction of CMH that has emerged in these findings is one of pressure and anxiety, which pose barriers to making decisions in alignment with one's values. Dave described how their ability to manage their own emotions without acting from them was essential in their ability to remain in alignment with their values. They articulated that through their own personal reflection and work in therapy, they have learned to recognize their own "nervous system activation." This perspective has enabled Dave to "notice stuff that's going on in me that maybe I wouldn't have in the past." Dave describes being somatically attuned to their emotions, noting that "there's something that we can learn in paying attention to them." He describes how "really noticing" their emotional experience "in a very new way and being able to name what was going on for me made it so much easier to like manage it and not act impulsively based on it." In moments of dissonance, this awareness facilitated Dave's "thinking with greater clarity around like decision making in the moment."

In moments where clinicians did prioritize their values over the requirements of the agency in their decision making, they seemed to do so by making an active choice in the moment stemming from their awareness of their own emotional reactions. Clinicians in these interviews have noted the ways that the clinician's own anxiety or fear can lead clinicians to abdicate the clinical freedom they do have to avoid possible negative

repercussions. Without this awareness of how anxiety, fear, and other emotions are impacting clinicians' decisions, they may be more likely to accommodate systemic requirements and constraints rather than pushing against them.

Chloe, who has been in CMH for three years, echoes the importance of emotional awareness and acceptance of her emotions to help her move through the difficult experience of dissonance:

> I'm a big crier, so I'll cry. I'll cry it out. I feel (pause) I feel the feelings the best I can, I let them run through me and out me the best I can. Because it—because it impacts me. I—no one gets into this field to feel like they're doing harm, and it's painful for me to sit with, and I express that through tears, and occasionally journaling.

Again, the ability to "sit with" one's emotions nonjudgmentally allows clinicians to tolerate the discomfort of dissonant experiences.

Time, Space, and Resources for Intentionality

The clinicians in this sample all sought critical, reflexive self-awareness, staying rooted in the present moment, to enable them to remain aligned with anti-oppressive values. However, as has been explored in Chapter 4, the pace and climate of CMH mean that time, space, and resources are scarce, which makes reflection and self-awareness difficult to achieve. Ultimately, the majority of clinicians in this sample, even those that were finding many pathways for resistant work, struggled to do this sustainably.

A factor that may impact the sustainability of working in CMH is privilege/social location of the clinician. Lisa, who described in Chapter 3 being able to be very present and "in the space" with her clients, articulated that "hyper-privilege" is what allows her to have the emotional resources for this. She describes how her social location makes her

work feel more sustainable: "My mom helps with my kids. My husband has a job, and it has health insurance…we have a lot less student debt…so I am able to currently make the choice, I'm able to take on a smaller client load…I can go slower. I can say, oh, hey, 20 is a great number. 27 would break me." As described in Chapter 4, the pressure to have a high caseload to make a living makes it harder to practice in a sustainably present way. This pressure is even more for clinicians who don't have financial security.

Conclusion

In their work, clinicians found ways to push back around oppressive systems, both in smaller ways using moment to moment relational work, and in larger ways that explicitly challenged or refused to participate in practices that did not align with their values. The themes of "walking a line" and "spacemaking" emerged in my analysis, as clinicians discussed ways that they were able to find and leverage the discretionary power they had in order to act in ways that felt aligned with the philosophies of practice they articulated in Chapter 3.

These moments of dissonance, where the clinician experiences tension between their anti-oppressive values and the expectations and values of their agency, offer opportunities for resistant practices. Resistant action taken by clinicians involved intentional choices based on an awareness of power dynamics. This included awareness of the ways they hold power over their clients. It also included awareness of the ways their agency exerts power over them, as well as awareness of and ability to engage the discretionary power they do have.

In some cases, further dissonance results for clinicians when they do betray the norms or expectations of the agency. Rather than necessarily reducing dissonance

completely, clinicians described ways that they were able make it feel more sustainable to take resistant actions and tolerate the discomfort of dissonance. However, many of the clinicians in the sample, and particularly those who practiced more radical resistance, like Riley for instance, who refused to adhere to the recommendations of their supervisors at times, had left CMH at the time of the interview, most of them citing financial motivations for leaving and describing the compensation for CMH unsustainable. Despite clinicians' efforts to remain connected to their values, themselves and their communities, the lack of time, space and resources posed real material barriers to being able to do so sustainably in the CMH context for many participants.

Chapter 7: Interpretation, Discussion and Implications

My research sought to explore how clinicians experience and respond to dissonance related to power and oppression in their clinical work, and to uncover complex processes of resistance vs. acquiescence as clinicians attempt to turn dissonant moments into anti-oppressive practice. In this chapter, I will unpack the findings shared in the previous three chapters through the lens of my critical postcolonial framework. Before I begin this process, I'd like to return to Sullivan's (2014) point that criticism is a vital part of healthy loving. As I bring a critical lens to the participants' narratives, and simultaneously, to my own, it is not with intention to denounce, scrutinize or shame, but to engage in the type of "critically constructive relationship (p. 299)" that Sullivan (2014) describes as necessary for resistance to be genuine and impactful. Working with my data has been a reflexive process of critically examining myself and my own narratives.

Dissonance Within: Internal Contradictions and the Double Bind of Goodness

The original framing of my research question assumed some amount of internal consistency for clinicians—that they had a sense of how they wanted to practice, and dissonance arose when they could not enact these values due to systemic constraints. In reality, clinicians' experiences also reflected internal inconsistencies leading to dissonance. Returning to the theory of habitus (Bourdieu, 1977; Perry, 2012) and neoliberal governmentality (Schram, 2018) is useful in understanding how the priorities of racial capitalism, which have shaped the mental health field writ large, become internalized by the clinician and part of our professional identities and reflected in our philosophies of practice. Overall, my findings suggest that dissonance is inherent when

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clinicians attempt to be anti-oppressive from within both racial and professional identities that make oppression inevitable within neoliberal practice contexts.

The extent of more radical perspectives on therapy varied in the sample. Clinicians fell on a spectrum in terms of how much they aligned with how the field determines and articulates "best practices." Some clinicians reflected the critical, radical views that acknowledged behavioral interventions and diagnoses as tools of racialized social control (Abulhul, 2021; Conrad, 2007; Metzl, 2009), took issue with the "evidence" that constitutes the state of evidence based practice, and named the ways that they have found these practices unhelpful for meeting the needs of a population dealing with the ongoing trauma and violence of racism and other forms of oppression. Others seemed to find more value in the more traditional behavioral approaches that are held as a gold standard, but still viewed these as only helpful when implemented collaboratively and with relational awareness.

No matter the nuances in how they defined good work, the basic principle of doing good and being helpful was an often unspoken throughline in clinicians accounts. From within the habitus of the "good therapist" clinicians assume the position of the expert who ought to be able to help, which shapes how they view their work and show up in the therapy room. This habitus seems to be a core source of irreducible dissonance for clinicians as they struggle to figure out what being a "good therapist" looks like in CMH. They were critical of "best practices" but maintained the importance of adhering to them on some level, of being sure they were offering "good therapy." They are simultaneously critical of the DSM and aware of the harm that diagnosis can cause, but in the same breath they name diagnosis as a helpful step for clients in "naming the problem." In

practice, the tools and "best practices" that are normatively defined as "helpful" are proving insufficient in meeting the complex needs of their CMH clients, which calls their helpfulness into question.

Dissonance reduction theory tells us that both compliance and commitment are a key factor in determining how one might respond to dissonance (McGrath, 2017). What does this look like when one holds two commitments that are at odds? Hinging on the idea of being a "good therapist," clinicians' narratives reflected how they are motivated to hold to their professional commitments not just for the compliance required for job security, but for the sake of their professional identities. Clinicians were also caught in the implicit commitment to goodness that whiteness requires of them, as reflected in my findings around how clinicians handled racial difference—a point that I will expand on later in this chapter. CWT (Applebaum, 2010; Frankenberg, 1993; Hook, 2011; Sullivan, 2014) and the notion of racialized habitus (Perry, 2012) suggest that whiteness is insidious and its norms embodied and enacted outside of conscious awareness, and these theoretical frames help us understand the nuances of clinicians' experiences of and responses to dissonance. In particular, the ways that paternalistic maxims—virtuosity, goodness, charity, and helpfulness—embedded in helping professionals overlap with those of whiteness in such a way that whiteness masquerades as professionalism (Badwall, 2014). In both their racial and professional identities, clinicians carry a belief that they ought to be good and helpful. Even in their attempts to be critical of their whiteness and of their professional expectations, clinicians still find themselves stuck in an attempt to distance and separate themselves from the sins of these identities in service of protecting their sense of themselves as beneficent.

With this framing in mind, I will now turn toward reflecting on my primary question of how clinicians experience and respond to dissonance, exploring the ways that my findings point to how dissonance, and the motivation to reduce it, may serve to both hinder and facilitate anti-oppressive practice.

Powerless Dissonance and Discretionary Dissonance

Clinical work in CMH is rife with different types of dissonant moments, arising both from within and between clinicians' ideal practice philosophies and their practice realities. I began this investigation focusing on the limiting conditions of the neoliberal welfare state and the ways these come into contrast with clinicians' beliefs and values. In particular, given that this study was advertised as a study about power and oppression, there was the assumption that clinicians who opted into this study would hold anti-oppressive values or goals in their practice, and that these values in particular would be in contrast with the conditions and expectations of their work environments. Clinicians in this sample did hold practice values consistent with anti-oppressive practice. In particular, they highlighted the importance of client empowerment, working in partnership, and navigating power dynamics in the clinical interaction through reflexive self-awareness, and found these difficult to enact within their contexts.

I am referring to this as *powerless dissonance*—moments where clinicians feel the limits of their power and agency as they navigate the conditions and professional responsibilities of their role. For instance, clinicians talked about the ways that agency practices limited clients' choice. Clients did not have a choice of provider or even in some cases of the type of treatment they received. The assumption that clients had to take what they can get, and defer to the expertise and mandates of the agency, left clinicians

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feeling like they did not have the power to fully protect clients' sense of agency and choice. Clinicians also felt that the scarcity of resources put them in a position to feel overworked, and thus not be able to enter into the therapeutic space in the intentional ways that they wanted to. Finally, clinicians felt this type of dissonance around their whiteness, expressing an inevitable harm that comes with their racial identity.

Clinicians' descriptions of what it is like to work in CMH are consistent with the theory and literature articulating the challenges of anti-oppressive work within the neoliberal welfare state (Dominelli, 1999; Marston & McDonald, 2012). They described how the market rationality of the CMH clinic, and the ways that the clinic is run like a business, limit their autonomy and their clients' autonomy. They articulated an environment of scarcity in which they did not have the emotional or material resources to do what they deemed to be "good work," and the *powerless dissonance* that results from this experience. However, in contrast to the induced-compliance paradigm offered by dissonance theory, clinicians still experience dissonance even in moments of low-choice. The suggestion offered by the induced-compliance paradigm that low-choice allows for the justification of counter attitudinal behavior (Harmon-Jones & Mills, 2019) is not consistent with participants' accounts in this study, who experience moral distress around the inconsistencies between their attitudes and intentions and their behavior even in moments where they feel they have no choice.

A second type of dissonance emerged in clinicians' narratives, which I am calling *discretionary dissonance*. In these moments, clinicians feel a sense that they do have some power or choice, and are conflicted about how to act, and/or feel conflict about their choices after acting. Importantly, discretionary dissonance seems to arise in some

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cases around some of the same sources in which clinicians describe feeling powerless. A key example of this is around decisions to hospitalize clients. While in many ways clinicians feel that they have no choice but to hospitalize clients given their professional responsibility to protect clients' safety and wellbeing, they also are ultimately the ones to make the choice to take this information the client has shared outside confidential space and make it known. Discretionary dissonance also arises in smaller moments of deciding whether to promote the agency's agenda or prioritize the client's agenda in a session. Moments of discretionary dissonance seem to occur both before, during and after clinicians wrestle with a choice point. As described in Chapter 6, once clinicians have decided to leverage their discretion, they experience self-doubt around whether they made the right choice, or fear and anxiety around risks they might have taken.

The notion that *powerless dissonance* and *discretionary dissonance* overlap has interesting implications, highlights the ways that dissonance does not just exist between values and actions, but within clinicians themselves. Clinicians feel an *internal* sense of powerlessness, for instance hospitalizing clients or completing paperwork, and may feel this even in situations where they technically do have the final say. It is just them and the client in the room. If the client discusses suicide, and the clinician chooses not to document or act on this, they are able to completely evade external pressure to take a specific action. The pressure that they experience here comes from within—from the internalization of and identification with their professional responsibilities, and a value conflict that they experience around these moments where keeping clients safe and giving them agency are not both possible to achieve simultaneously. My analysis suggests ways that the environment of scrutiny and surveillance that characterizes neoliberal practice

environments (Dominelli, 2010; Schram, 2018) is internalized by clinicians as self-surveillance, as we can see in clinicians' anxiety around how they document their sessions.

While some of the professional expectations that feel challenging for clinicians are universal within the field, my findings point to how the context of CMH is still a relevant factor for understanding clinicians internal pressure experience. Given that habitus is built and reinforced through socialization (Bourdieu, 1977), the work environment may shape clinicians' philosophies and ways of being with their clients. As my findings illustrate, the emphasis on liability and consistent messaging around reducing it, as well as various strategies of surveillance and monitoring in the neoliberal clinic may increase clinicians' experiences of professional responsibility and reify their importance. Over time, if clinicians are driven to reduce dissonance, the fuel is there within their context to strengthen cognitions related to the agency's agenda and rationalize any actions taken that are oppressive in nature but aligned with the goals of the agency.

The other implication of my analysis is that while clinicians experience these two types of dissonance and are driven to reduce it, dissonance is never really reduced, but rather one type is exchanged for another. For instance, I found clinicians may move toward reducing dissonance about hospitalizing a client by reminding themself that this is their professional responsibility and feeling soothed by having met this responsibility. This may reduce discretionary dissonance in the moment, but increase *powerless dissonance*, as they sit with their awareness of the fact that their professional roles require them to at times act oppressively. On the other hand, reducing powerless dissonance by

finding discretionary power (Lipsky, 2010) and taking the risk of not hospitalizing increased *discretionary dissonance*—questions around whether the right choice was made come up. Powerless dissonance and discretionary dissonance overlap as clinicians experience a sense of having choice, but there not being any choice that feels positive or fully resonant.

Responses to Dissonance and Attempts at Dissonance Reduction

Given the ways that my analysis suggests dissonance could not be successfully reduced, it feels more useful to understand dissonant experiences as an ongoing process of reckoning. In contrast with the dissonance literature, in which dissonance is felt, and then either cognitive or behavioral change is attempted to reduce it (Festinger, 1957; McGrath, 2017), clinicians' experiences here reflect dissonance as a dynamic process of *moving between* various types of dissonance in their attempts to reduce it.

We can notice clinicians' attempts to reduce dissonance in their stories, even if they prove to be limited in their success or only offer momentary relief. Dissonance reduction strategies not only emerge in clinicians' direct reports of how they attempt to reckon with inconsistencies, but are felt throughout the interviews in between the lines of their narratives. Clinicians were asked to reflect and report on how they've experienced handling dissonant moments, and findings related to their responses are useful. Yet the process of being interviewed about these experiences inevitably activated a felt experience of dissonance during the interview, and we can see the dissonance reduction strategies being employed in real time to reduce inconsistencies. Implicit attempts at dissonance reduction are elucidated through the application of the critical theoretical framework that guides this study.

We can see Dominelli's (1999) paradigm of escapism, accommodation, and resistance playing out as dissonance reduction strategies, and as suggested by the integration of Gibson's (2019) framework, the line between accommodation and resistance in therapeutic practice is blurred. Consistent with escapism, many clinicians felt unable to tolerate chronic dissonance and left CMH. Important to emphasize here is that this was not the sole reason cited for those clinicians who left CMH, with most also naming simply that the work was not financially sustainable for them. Emotional sustainability was named as a large factor in the decision to leave, and we can understand the chronic moral distress and resulting injury engendered by dissonance as a deeply emotionally taxing component of the work. This is consistent with the suggestion that moral injury breeds burnout (Rosen, 2022).

Aligned with Dominelli (1999), clinician's described moments of accommodation, but sometimes these were moments of acquiescing to the agency's interests, while in other moments accommodation was more strategic and subversive. In moments of *acquiescent accommodation* clinicians acted in ways that reified existing power structures in some way without challenging them. These moments overlapped with Gibson's (2019) concepts of both enacting and complying. An example of this is when clinicians described experiences of unnecessarily enacting power over clients described in Chapter 5. Again, consistent with clinicians' white habitus, those that I interviewed described ways that internalized paternalism and pressure from the agency are automatically "metabolized" or enacted with clients if they are not being intentional to resist them. Clinicians told stories that reflected the pressure they felt to be helpful within

their professional roles and their tendency to enact the norms of these roles in moments where they were feeling powerless to help.

As described in Chapter 5, feelings of powerlessness within the pressure of helpfulness led some participants to be more likely to force their definition of the problem on clients so as to make it a problem that their professional tools can solve. Again, while ultimately these moments only engender further dissonance, in the moment they can be understood as an attempt to reduce dissonance by allowing the clinician to play the ascribed role of the "good therapist" according to professional expectations. Within this role, clinicians give strength to the cognition that the therapist holds the solution. From this place, when the solution doesn't work, the clinician instead begins to blame the client. This tendency in itself reflects the way that clinicians need to hold on to the notion that they are helpful to maintain their own sense of self. As Hook (2011) writes, "after all, if one is not narcissistically invested in one's own image as benefactor, then what is so offensive about the refusal of the gift?" (p. 16)

On the other hand, clinicians described moments of *strategic accommodation*, in which they attempt to make maximal space while still adhering to their professional rules and guidelines. Strategic accommodation approaches consisted of a mixture between compliance, compromise, and concealment in Gibson's (2019) terms. Strategies they described for "walking the line" and leveraging discretionary power for spacemaking within existing constraints can be understood as an intentional use of strategic accommodation in the service of resistance. Strategic accommodation allows clinicians to maintain their professional standing while they utilize their discretionary power more subtly. Clinicians broke the rules in subtler ways that allowed them to accommodate

publicly and resist privately, utilizing their discretion around documentation to enable this.

To this point, clinicians' approaches to "walking the line" pointed to ways that strategic accommodation, even in the form of compliance (Gibson, 2019), can increase discretionary power (Lipsky, 2010) and their ability to resist in more significant ways. For instance, clinicians discussed how over time their work performance and adherence to guidelines positioned them as a "good employee," which allowed them to "fly under the radar" and receive less scrutiny. Some described how over time, as their supervisors came to trust their clinical decision making, they were allowed more clinical freedom to advocate for clients and resist oppressive practices. In this way, moments of compromise, and even of compliance, may be leveraged in the interest of resistance.

Finally, clinicians also engaged in *explicit resistance*, by pushing back against guidelines and practices that were not in alignment in vocal, above ground ways that directly challenged institutional norms—more closely aligned with Dominelli's (1999) concept of resistance, and Gibson's (2019) notion of influencing. They described appealing to higher ups to change policies or ask for other structural changes at their agencies. Clinicians' accounts were consistent with Gibson's (2019) findings that clinicians may experience shame for violating the norms or expectations of their professional identities in moments of outward resistance, or risk being actively shamed or denounced in their professional communities. One strategy clinicians used to decrease this discretionary dissonance was to seek consultation and community with other clinicians who share their anti-oppressive goals. Creating professional relationships where their resistant actions will be validated allowed clinicians to access new consonant

cognitions and shift focus off of the dissonant ones. In doing so, clinicians bolstered their anti-oppressive identities, allowing them to disentangle their sense of self from oppressive professional norms.

This section has highlighted the various responses to dissonance demonstrated by analysis as they map onto both Dominelli's (1999) and Gibson's (2019) frameworks, which are summarized in Figure 2. Overall, clinicians' accounts suggest that when they are able to stay connected to the power they do have in their roles, dissonance can inspire clinicians toward anti-oppressive actions.

Figure 2: Responses to Dissonance
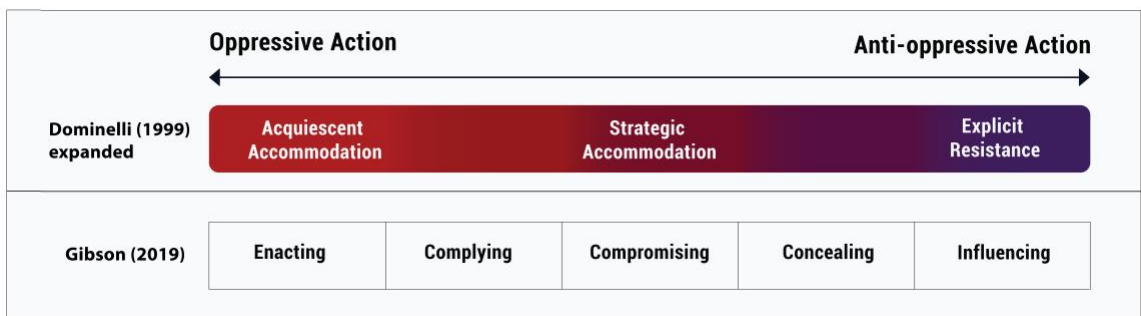
I will now turn toward a more critical examination of clinicians' reports of these anti-oppressive efforts, exploring how clinicians in my sample may change or reprioritize cognitions in the interest of self-soothing. Dissonance theory tells us that we can't necessarily take clinicians' accounts of resistant practices at face value, given that these accounts themselves are in part shaped by an intrinsic motivation to reduce dissonance to maintain a consistent internal sense of themselves as moral actors (Steele, 1988), and their narratives reveal important patterns within dissonance, and as us to consider whether strategies for "walking the line" are as resistant as they might be.

Aligned with the induced-compliance paradigm (Harmon-Jones & Mills, 2019)., clinicians seemed to emphasize the notions of "I had no choice" and "I did what I could"

as a way to reduce dissonance around their role in oppression; reminding themselves of the limitations of their power offered some relief. We can see this clearly in Chapter 5 as clinicians combat the felt sense of powerlessness by reminding themselves of the limited control they have over larger systems and accepting the ways that they lack power, and in Chapter 6, as they distance themselves from the systemic requirements when describing these requirements to clients, making sure it is known that they are not in charge and are simply doing is being asked of them.

Consistent with the free-choice paradigm (Harmon-Jones & Mills, 2019), we can see in clinicians' narratives the ways that they rationalize their clinical decisions and approaches. For example, clinicians' discussions of the importance of transparency in Chapter 6 can be interpreted as a way to increase the importance of consonant cognitions while shifting focus off of dissonant ones, which is a common dissonance reduction strategy (Harmon-Jones & Mills, 2019), and one that prior studies have found to be utilized by social workers to assure themselves that their interventions are useful (Burke et al., 2017). Clinicians in my study emphasized the usefulness of transparency for helping clients feel as in control as possible in moments where they were actively taking control away from their clients. By emphasizing the utility and anti-oppressive efforts of transparency, they reduce the discomfort of having to act in power-over ways. Clinicians do the same thing regarding the therapeutic relationship, really emphasizing the ways that a strong relationship and the safety that may be created in the room may act as a buffer between the client and the system.

When examining dissonance reduction strategies through the lens of CWT (Applebaum, 2010; Frankenberg, 1993; Hook, 2011; Sullivan, 2014), we can see the

ways that clinicians may be engaging in distancing strategies to separate themselves as the "good" white person, or more generally, the "good" therapist, and how this drive leads clinicians to fail to properly reckon with the impacts of their whiteness and of their power. This is particularly apparent in their discussions about whether to address race and other power-laden identity differences in the therapy room. Many clinicians spoke of bringing up their whiteness with BIPOC clients as a way to subvert the white supremacy value of the right to comfort (Okun, 2021), and make the unspoken explicit, which as CWT would suggest, is necessary for deconstructing whiteness. However, declaring whiteness is not the same as subverting it. At the level of content, the act of naming it may be useful, but on a process level, it serves to recenter and reify whiteness. By alerting the client to it, the clinician is able to set themselves apart—their ability to declare their badness makes them "one of the good ones," and their right to comfort is met.

It would follow that this same process was happening intersubjectively in my interviews with clinicians. As I gave them a platform to make declarations about the ways that they think critically about power and oppression, we provided each other unspoken reassurance that we are both one of the good ones. I believe this because reflecting back, I can see the narcissistic gains that I achieved from this research process, and the validation I received from hearing my experiences reflected in theirs. When reflecting on clinicians' narratives to understand the role dissonance plays in motivating anti-oppressive practice, we ought to consider what is at stake for their self-concept, both as they navigate dissonance, and as they recounted their experiences to me.

Dissonance Reduction: Facilitating or Hindering?

The goal here is not to shame clinicians for wanting and attempting to reduce dissonance, but to be curious about the impacts of these reduction strategies, and their implications for anti-oppressive practice. Of course, we can't actually know what clinicians are doing in the room. More importantly though, this data says nothing about how *clients* feel about these practices. Ultimately, research about anti-oppression without the voice of the oppressed can only allow us to draw conclusions about the experiences of the oppressor. Still, within the limitations of this research allows us to, we can consider the possible blind spots and pitfalls that clinicians may fall into in attempts at anti-oppressive practice, and how the motivation to reduce dissonance plays a role.

As reflected in the dissonance literature, the drive to reduce dissonance can be a powerful source of motivation for behavior change and value-based action, but can also lead to rationalization and justification of unethical behavior in the service of reducing discomfort and guilt (McGrath, 2017; Steele, 1988). With this in mind, I work here with my data to explore two questions: Is it a problem for clinicians to engage in strategies to reduce the discomfort and guilt of dissonance? In what ways can the drive to reduce dissonance facilitate or hinder anti-oppressive action? These questions emerged as important to consider as I analyzed my data, as they help us understand what allows dissonance to be generative and lend itself to resistance, and when it can instead motivate accommodation (Dominelli, 1999). Gibson's (2019) work examining how the threat of moral injury impacts social workers professional behaviors, along with CWT literature on the role of white guilt and shame (Hook, 2011; Spanierman, 2022; Sullivan, 2014), suggest that it's important to consider how guilt and shame impact how clinicians respond in moments of dissonance.

First, my data reflects that feelings of powerlessness and resulting moral injury (Rosen, 2022) tend to breed moments of *acquiescent accommodation*, which are counter to the goals of anti-oppressive practice. The capacity to be reflective and intentional rather than reactive seems to be a necessary component of leveraging dissonance in the service of resistance. In reactive moments, clinicians' white habitus goes uninterrogated and shapes clinicians' behavior, often outside of their awareness, whereas their intentionality allows them to notice their embodied instinct to align themselves with harmful aspects of their professional identities, and choose to instead realign with anti-oppressive values.

My findings point to how, in moments of *strategic accommodation,* attempts to reduce dissonance through intentional action in alignment with values can be generative and facilitate anti-oppressive practice approaches. Clinicians use these moments as cues that their professional requirements or expectations are not aligned with what is most useful for the client. Their dissonant experiences indicate that they are remaining connected to the importance of maximizing client autonomy, and they are aware in many cases of the ways that their power in their professional role is inherently at odds with promoting client agency. In effort to reduce dissonance, they find ways to betray, subvert, or find the flexibility within their professional roles in the interest of aligning instead with anti-oppressive values.

However, we have to consider the ways that *strategic accommodation* is still accommodation, and could be just as much in service of protecting the clinician from retribution as it is in service of anti-oppression. The majority of spacemaking strategies employed by clinicians fell under Gibson's (2019) category of *concealing*, where

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clinicians did not have to risk professional scrutiny for non-compliance. Spacemaking strategies that "walk the line" can be seen as a way to avoid moral injury from both directions, and being able to feel that one did a "good job" both in the agency's eyes, and from an anti-oppressive framework.

As Gibson (2019) suggests, clinicians are motivated by the threat of moral injury to practice in alignment with their values. For the clinicians in my study, we can see examples of the moral injury that can result when they feel that they are not able to do so, and how this is counterproductive to anti-oppressive work. However, as Gibson (2019) suggests, the drive to avoid moral injury can also motivate compliance, as clinicians are driven to avoid the guilt and shame of possible professional scrutiny. As dissonance reduction is related to maintaining self-concept (Aronson, 1969; Steele 1988), it's important to consider how much clinicians' self-concept is linked to doing a "good job" as defined by the agency, and to what extent their self-concept is reliant on the external validation that comes with compliance, when considering whether dissonance reduction will move them toward accommodation or resistance.

I am reminded here of Candace's reflections about lying in her documentation: "I don't have any value conflict with the actual work…you lie to people to just make them feel good. You go do the thing that are your actual values…why would you feel guilty about that?" Candace also reflected that she didn't feel bothered by professional scrutiny in instances where her boss was unhappy with her clinical choices. Candace seems to be an example of a clinician who is able to divest from professional norms, constructing her own professional identity that does not require the external validation of her professional setting. From this place, she reduces dissonance without accommodating, and is able to

feel like she is doing a "good job" (Gibson, 2019) even in moments of non-compliance. Other clinicians seemed to hold more internal conflict around compliance, as seen in Chapter 6 as clinicians discuss anxiety around breaking the rules. In sum, dissonance reduction to reduce the threat of moral injury could lead clinicians toward accommodation over resistance. They may miss opportunities for more explicit *influencing* in Gibson's (2019) terms if their professional identities depend on compliance. In other words, threat of professional moral injury may lead clinicians to "walk the line" rather than push the line.

In terms of these spacemaking approaches, it's important to also critically reflect on dissonance reduction strategies that may have been at play in clinicians' narratives. We can hear the ways that clinicians engage in justification and rationalization of their behavior so as to be assured that they are doing everything in their power to resist oppression, which doesn't mean that they necessarily are resisting it. These narratives may point again toward how needing to reduce dissonance to maintain self-concept can lead clinicians astray from anti-oppressive practice, even in moments where they believe they are engaging in it.

Clinicians' emphasis on the usefulness of their spacemaking strategies could lead them to miss opportunities to be critical of these strategies, and could lead to subtle forms of *acquiescent accommodation*. For example, clinicians talked about the importance of giving clients choice and options, and their use of transparency. At the same time, there were other points where clinicians reflected on how they are the arbiters of power and professional authority within the therapeutic space, and how this dynamic intensified when the white clinician is working with a BIPOC client. Yet there didn't always seem to

be a critical connection between these two realities—clinicians assured themselves that offering space and choice was empowering, as if this offering meant that clients believed them and took them up on the offer. Interestingly, when talking explicitly about discussions of race, this limitation was acknowledged by some clinicians, who noted that inviting discussions about race did not necessarily make the client feel comfortable to do so, but this consideration did not extend to more general discussions about collaboration and offering choice. On the subject of navigating identity, we can see how clinicians may engage in naming their whiteness with clients, not necessarily from a place of attunement with the client, but out of a desire to set themselves apart as "good" white people. Here, the centering of whiteness and right to comfort may actually prevent clinicians from being curious whether the client wants to have a conversation about race, and taking cues from the client around when and how to do so.

Reducing dissonance by emphasizing the impact and usefulness of their spacemaking strategies could drive clinicians away from resistance. For example, transparency with clients during moments of taking power away could be seen as again getting stuck in declaration rather than action (Ahmed, 2004). If clinicians are comforted that transparency mitigates the harmful impact of a practice, they may be less likely to challenge or protest that practice. Of course, this is assuming that the attempt at dissonance reduction is successful—there seemed to be some variation in how much solace clinicians were able to find in focusing on what they could control and accepting what they could not.

Acceptance without Complacency. The question here is whether this acceptance engenders complacency, or whether it opens further emotional resources to motivate a

striving for maximal resistance. A finding that arose from clinicians' accounts was that falling into guilt, shame and despair around dissonance is not a useful motivator for action, and in fact rendered clinicians less intentional in their practice and more likely to acquiesce to oppressive expectations. We also know from CWT that white guilt is more likely to facilitate empty actions that are more about assuaging guilt than about the needs and priorities of BIPOC (Spanierman, 2022; Sullivan, 2014).

Being able to focus on the areas where they do have power and not be stuck in despair around areas they do not may be important for their ability to engage in and sustain resistance long term. Yet this same strategy of accepting powerlessness could easily be used as justification to abandon resistant practices in moments where they *do* actually have disruptive discretionary power. The "good therapist" habitus can subtly shape clinicians' awareness of and willingness to engage with this power, and coax them toward the comfort of compliance.

It is possible for an action to do two things at once—clinicians may receive secondary narcissistic gains from dissonance reduction, while simultaneously engaging in actions that have anti-oppressive impacts in their work. Hook (2011) points to this inevitable contradiction in white anti-racism—that avoiding narcissistic gains in trying to dismantle and reckon with one's whiteness is perhaps not possible. Yet ultimately, if clinicians are *reliant* on these gains, if they cannot tolerate the dissonance, it will impede their anti-oppressive goals. As Sullivan (2014) suggests, we become reliant on narcissistic gains when operating from the "narcissistic self-loathing…at the heart of white people's racial quest for moral goodness" (p. 284). Inability to tolerate guilt,

shame, and other unpleasant emotions that come with dissonance will make it more difficult for clinicians to make decisions that actually center anti-oppressive values.

When Dissonance Can't—and Shouldn't—be Reduced

Ultimately, both given the internal contradictions held within clinicians' "good therapist" habitus, and the limiting conditions of the neoliberal CMH center, dissonance is not reducible—or at least, it shouldn't be, if one's goal is to remain committed to finding opportunities to resist oppression. To find complete acceptance and be free of negative emotions around the complexities of the work would indicate complacent acceptance rather than ongoing reckoning. The clinicians in this study, even throughout attempts to reduce dissonance, do offer stories and examples of what this reckoning could look like. While many described moments of succumbing to powerlessness and despair around dissonance, there were also examples of instead surrendering—sitting with painful feelings and asking themselves difficult questions about their role in oppression.

Returning to the concepts of double consciousness (Fanon, 1963/2004) and structural dissociation (Nijenhuis et al., 2006) and sitting with multiplicity can offer a way forward. This requires clinicians to sit with the guilt, shame, despair, fear and other negative emotion states that are bound to arise in their work. De-identifying with the need to be "good," and constructing a sense of self that is not reliant on the virtues of whiteness (Sullivan, 2014) may actually be a way not necessarily to reduce negative emotions, but to transmute them into emotional states that are more geared toward action. For example, a common therapeutic distinction between guilt and shame is that guilt tells you that you *did* something wrong or bad, whereas shame is feeling that you *are* wrong or bad. The former offers the opportunity to change one's behavior, whereas the latter

engenders hopelessness and futility. Similarly, sadness is an appropriate response to witnessing pain, and can facilitate empathy and ability to *be with* someone in their pain. Despair, on the other hand, renders one frozen again in hopelessness and futility. Shifting from goodness to wholeness creates room for clinicians to leverage the wisdom of their painful emotions without being taken down by them. This is an important shift in the interest of developing the "stamina" and resilience necessary for ongoing anti-oppressive work (DiAngelo, 2018).

What possibilities open up when clinicians are able to *tolerate* dissonance, and fight the urge to reduce it? First, if clinicians are able to tolerate the dissonance of contradicting their professional identity, letting go of the need to "be good" by being compliant, it opens us up to lean into risk and break the rules, which is a requirement for disruptive practice (Carey & Foster, 2011; Stanford 2010). We also need to be able to tolerate the discomfort of acknowledging their power and privilege as a result of both their racial and professional identities. As Hook (2011) articulates, resistance from within a white identity requires sitting with the "wounding of whiteness (p. 19)." If we are able to tolerate the guilt of being a "bad" white person, we may be more free to engage in more radically critical self-appraisal. Embracing dissonance begins to enable a self-interrogation that is radically honest because it is not in the interest of maintaining a coherent self-concept. If dissonance can be tolerated and multitudes embraced, we need not reassure ourselves with "I did what I could" and end there. Instead, from a place of curiosity and openness, we can always be asking the question, "what more could I do?" Through this process of open communication, the clinician can learn from the part of self that did not do enough rather than exiling it in shame, asking "what stopped me from

doing more?" and being genuinely able to hear the answer. The ability to do this can make dissonance generative, turning moments of conflict into opportunities for ongoing commitment to anti-oppressive practice.

Limitations and Opportunities

Modeled after the dialogic space described above, I will discuss the limitations of my study alongside opportunities for future research, finding paths forward from missteps. A major limitation in this research comes from the ways that I did not always successfully engage in this type of non-judgmental dialogue with myself. As I reflect on my research process, I can see my own attempts to reduce dissonance even while interrogating it. Even though my theoretical framework pointed to the inevitability of internal contradiction, my data collection focused on the difference *between* rather than within. In reflecting on this now, I think I was driven by a desire to pin possible oppression on the agency, the system, the external limiting conditions, rather than owning my own tendencies toward oppression.

When I go back to my interview guide (See Appendix G), I can see that I avoided asking clinicians to take responsibility for oppression and instead externalized the problem. I asked, "where have you seen oppressive dynamics operating" in CMH, about how "the therapeutic relationship can become oppressive," and about "a moment where you experienced an oppressive dynamic play out in a session." All of these questions paint the clinician as a passive observer rather than an active participant in oppression, to create distance and avoid responsibility.

As the arbiter of the interview space, I cannot expect my data to reflect levels of self-interrogation and responsibility taking that I did not model or create room for. What

norms did I project into the interview space from within my own "good white therapist" habitus? I noticed, for instance, that while clinicians described painful experiences, they did not become emotional in retelling them, and I wonder whether they felt that their shameful parts were even welcome in the space. On a content level, if I had more directly asked about moments when clinicians were active participants in oppression, I may have elicited richer, more emotionally charged stories.

Another limitation is in how I approached and analyzed the data, focusing largely on shared experiences rather than interrogating disparate ones. In general, there was variation *between* clinicians that could have been examined more systematically, and the complex interplay of individual-level variables were not properly explored. One variable was location, which impacts the conditions of the clinicians work environment (See Chapter 2: Methodology). Furthermore, the sample came from interdisciplinary backgrounds, with social workers, professional counselors, psychologists, and clinicians with education degrees all represented. Though as helping professionals they share a lot in common, these various disciplines have differences between ethical codes and practical guidelines that inevitably impacted clinicians' philosophies of practice, professional identities, and their level of commitment and exposure to anti-oppressive pedagogy, all of which would impact how they experience and respond to dissonance. Similarly, while clinicians were all white, many held different marginalized identities. As a whole, this research is missing an intersectional framework, which would have shed light on how clinicians' and clients' identity-based power intersect to shape dissonant moments. In particular, examining class as a clinician-level variable and how this impacts clinicians ability to take risks that might impact their job security would be an interesting

question to explore. All of these individual-variables could be areas of future research in terms of how they shape experiences of and responses to dissonance.

A final, crucial limitation to note is that this research, in its exploration of how clinicians try to engage in anti-oppressive practice, and its interrogation of what being "helpful" actually means, says nothing about what *clients* find helpful. This is arguably the most important perspective, and it is not represented here. When talking about what constitutes "successful" anti-oppressive practice, we ought to start by asking what the client wants from therapy and if they are getting it.

Conclusion and Implications

This qualitative study (N=13) employed a critical phenomenological and autoethnographic approach to explore how white clinicians experience and respond to dissonance related to power and oppression in their CMH work. I sought to uncover processes of both resistance and acquiescence to the oppressive neoliberal norms of the CMH center, and locate the role of dissonance in these processes.

My analysis revealed the ways clinicians' experiences and responses to dissonance are impacted by their experiences of and relationship with their own relative power/powerlessness in their role—they experienced both *powerless dissonance* in moments where they felt they had no choice, and *discretionary dissonance* in moments when they do. These dissonant experiences are often coexisting, overlapping, and exchanging as clinicians reckon with them, but ultimately dissonance cannot be fully reduced. In response to dissonance, clinicians often found themselves succumbing to powerlessness. This led them to either burnout and leave the field entirely, or relinquish their remaining discretionary power and engage in *acquiescent accommodation* of

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oppressive agendas. In other moments, clinicians were able to stay connected to their discretionary power, either for the purpose of *strategic accommodation* to find maximal space for their clients, or *explicit resistance* to push back against harmful practices. As clinicians navigate dissonant moments, they also reckon with their sense of self and professional identity as these moments call into question what it means to be a "good therapist" in CMH.

My analysis has suggested that dissonance can be generative for clinicians if we do not need to necessarily reduce it—and as we have seen, we generally can't in spite of efforts. Being able to tolerate the emotional experience of moral distress in dissonant moments may enable clinicians to act with intentionality around it rather than reacting from a place of self-protection. However, some strategies for dissonance reduction may be more aligned with anti-oppressive goals, while others may enable complicity. This research has implications for how clinicians can be supported in learning to sit with dissonance from a place of critical self- and other- awareness, thereby enabling more authentic engagement and meaningful resistance.

My research supports the well-established importance of professional communities and ongoing mentorship opportunities that support anti-oppressive practice goals (Lynch & Forde, 2016). The role of critical consciousness-raising in facilitating resistant practice is argued in anti-oppressive practice literature (Dominelli, 2002; Lynch & Forde, 2016), and consciousness-raising is an inherently collective process (Lynch & Forde, 2016). Consciousness-raising can begin in training programs, with greater exposure to critical practice theory and opportunities for experiential practice of critical

consciousness. However, it needs to continue throughout practice to resist the pull of accommodation and make resistance sustainable.

Beginning in training and throughout our careers, clinicians need collective support to go deeper than traditional diversity, equity, and inclusion programs. We need to be exposed to critical theories that enable us to interrogate the contradictions within our role as a helping professional. Some of the theoretical concepts supported by this research offer useful lenses that training programs and practice communities alike can use in their consciousness raising efforts. Acknowledging the role that emotion tolerance and regulation plays in determining how people respond to dissonance (Cancino-Montecinos et al., 2020; Gibson, 2019) points toward the importance of consciousness-raising practices that prioritize working experientially with moment-to-moment emotions. Theories of multiplicity like structural dissociation theory (Nijenhuis, Steele, & van der Hart, 2006) are not only necessary for clinicians working with complex trauma, but can be integrated into anti-oppressive practice frameworks to deepen clinicians' self-awareness of their own identity-based splitting. Practice frameworks ought to normalize questioning and challenging professional standards from a place of critical consciousness, and interrogate within a frame of CWT what's at stake for clinicians' sense of self in trying to be a "good" therapist.

However, knowledge and intentions toward self-awareness are not enough. The emotional presence and tolerance required for open and critical self-interrogation is not possible to maintain in an environment of material and emotional scarcity. Connecting with community requires that you have time and emotional resources to invest in this work. The financial structure of the CMH center and the ways that it necessitates carrying

high caseloads means that clinicians don't have the time and space to put anti-oppressive strategies into action, nor to spend energy cultivating them. In order to retain clinicians in CMH, and support them in sustaining anti-oppressive action, we need to be more fairly compensated. In particular, the fee-for-service billing structure which prevents us from being compensated for any work we do for a client outside of the session greatly limits our ability to more creatively and resourcefully address the issues that are most immediately pressing to the client.

In that vein, the strictly defined guidelines often imposed by managed care around what is considered therapy worth paying for ought to be challenged. First, the line between clinician and case manager may be blurred at times, and more practical support that involves connecting clients to resources needs to be considered billable practice when working with clients who are economically oppressed. As Julie put it, you aren't going to work with your client on "their deep breathing exercises when they don't have a place to live." Second, if clinicians receive training in more relationally based practice models, we may feel that we have a more diverse set of tools than the standard behaviorist best practices offer, and can use traditional tools in more relational and flexible ways. Again, connecting with supervisors who can encourage and guide the use of these models may help clinicians stay connected to a more expansive definition of what "helping" might look like in therapy rather than feeling trapped by normative definitions of what makes for effective therapy.

As discussed previously, high turnover in CMH practice negatively impacts clients, preventing them from being able to form the stable, long term treatment relationships that are most beneficial for clients with complex trauma (Herman, 2015).

However, my findings suggest that longevity in the field is also important because developing comfort with resistance may be a developmental process. Some clinicians' accounts suggested that as they became more established in their agencies and in their careers, they developed a greater capacity to navigate bureaucratic requirements through minimal accommodation, while finding maximal discretionary power. If CMH practice was more sustainable for clinicians long term, they would have the chance to hone anti-oppressive strategies in their setting.

The participants in this study, as well as myself, despite the barriers, challenges and inevitable pitfalls, make efforts to stay committed to anti-oppressive practice values and are able to engage in meaningful resistance; *and* we struggle to do this consistently, and there are ways that we still actively participate in oppression. At times, actions we think are most liberatory for our clients may be both helpful and harmful at the same time. Ongoing commitment to anti-oppression in our work means sitting with the duality of both helping and harming as a reality of our role as a white clinician.

Appendices

Appendix A: Study Flyer (Original)

Outpatient clinicians needed for research study

If you are a community mental health clinician working with clients 18+, I want to hear from you!

Study looking at power and identity in clinical practice

I am interviewing community mental health clinicians about challenges they confront in their work and how they navigate issues of power and identity.

Why Participate?

- Have an opportunity to reflect on clinical decision making around issues of power and identity.

- Contribute towards a movement for social justice in clinical practice.

- Be part of improving the quality of public mental health services for marginalized groups.

Logistics

- Interviews will take place either in person in ✕✕✕✕✕ or over secure Zoom connection
- Duration of interview will be 60-90 mins
- Interviews will be confidential

Eligibility

- Provide out atient thera
- Work in a ✕✕✕✕✕✕✕✕ funded agency
- Work with adult clients 18+

Interested? Have Questions?

- Contact:

Maisy Hughes, LMFT
Doctoral Candidate and Primary Investigator
Bryn Mawr College Graduate School of Social Work and Social Research

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Appendix B: Recruitment Emails (Original)

Agency Director Contact Email

Subject: CLINICIANS NEEDED: Research Study looking at power and identity in clinical practice

Dear [insert name],

My name is Maisy Hughes and I am a doctoral candidate in the Graduate School of Social Research at Bryn Mawr College. I am a licensed marriage and family therapist and have been working in community mental health for over five years. This work has inspired my curiosity about the experiences of clinicians working in community settings —specifically, how they navigate issues of power and identity in their practice. Through involvement in this project, clinicians will have an opportunity to reflect and contribute toward a movement for social justice in clinical practice.

Your staff's experiences offer invaluable insight that can inform future research and intervention development with the goal of improving the quality of public mental health services, and I would really appreciate your assistance finding clinicians who might be interested in participating. Participants will take part in an individual interview and potential focus group. Each will last about 60-90 minutes, and will be conducted either in person or via a secure Zoom connection, and your agency will not be named in any publications or presentations related to this project and will not identify that the research was conducted in Philadelphia, but rather that it took place in a major urban setting in the United States.

Please find a flyer attached, and an email blurb below. I hope you will promote this opportunity for clinicians at your agency to participate. Please feel free to email or call me with any questions or suggestions.

Thank you very much!

Maisy Hughes, LMFT
Doctoral Candidate (bio)
Graduate School of Social Work and Social Research
Bryn Mawr College
████████████████████
██████████

Contact Email for Clinicians

Subject: CLINICIANS NEEDED: Research Study looking at power and identity in clinical practice

My name is Maisy Hughes and I am a doctoral candidate at the Graduate School of Social Research at Bryn Mawr College. I am interviewing community mental health clinicians about challenges they confront in their work and how they navigate issues of power and identity.

You are eligible for this study if you:

> • Work as an outpatient clinician in a community mental health center (a [MCO] funded agency)
> • Work with adults (18+)

If you elect to participate in this research, I will ask general questions about challenges you confront in your clinical practice, how you cope with them, and what you need to feel more supported in your work. I am inviting you to participate in this research because I believe your experiences in the field offer invaluable insight that can inform future research and intervention development with the goal of improving the quality of public mental health services for marginalized groups and contribute toward a movement for social justice in clinical practice.

Participation in this study will consist of one confidential open-ended interview either in person or via a secure Zoom connection lasting approximately 60-90 minutes, and the option of participating in a follow up focus group. Participation is completely voluntary, and you can stop the interview or end participation at any time. Your agency will not be informed of whether or not you elect to participate.

If you'd like to be involved or have any questions about the study, please email or contact me at ▆▆▆▆▆▆▆▆▆ or ▆▆▆▆▆▆. Thank you for considering being part of this research.

Sincerely,

Maisy Hughes, LMFT
Doctoral Candidate (bio)
Graduate School of Social Work and Social Research
Bryn Mawr College
▆▆▆▆▆▆▆▆
▆▆▆▆▆

Appendix C: Study Flyer (Revised)

Clinicians Needed for Research Study

Current /former community mental health clinicians: I want to hear from you!

Study looking at power and oppression in clinical practice

I am interviewing community mental health clinicians about how they've experienced power and oppression in the clinical encounter

Why Participate?

- Have an opportunity to reflect with fellow therapists about how intersectional aspects of identity impact the therapeutic relationship

- Contribute towards a movement for social justice in clinical practice.

- Be part of improving the quality of public mental health services for marginalized groups.

You're eligible if you…
- Currently or formerly have been a clinician in a mental/behavioral health agency that accepts Medicaid

Logistics
- Interviews will take place over Zoom
- Duration of interview will be 1hr
- Option to participate in focus group with clinicians across the country

Interested? Questions?

Contact:

Maisy Hughes, LMFT
Doctoral Candidate, Primary Investigator
Bryn Mawr College Graduate School of
Social Work and Social Research

Appendix D: Social Media/Listserv Post

Subject (if applicable): Interviewing current/former community mental health clinicians for research study- "Power and oppression in CMH practice"

My name is Maisy Hughes and I am a doctoral candidate at the Graduate School of Social Research at Bryn Mawr College. For my dissertation research, I am interviewing clinicians about how they have experienced and navigated issues of power and oppression in community mental health (CMH) practice, and am inviting you to share your thoughts and experiences. My interest in this topic arose from my own work in community mental health in Philadelphia as a white clinician working primarily with low-income clients of color. Working on this project has offered me the chance to reflect with other clinicians on how oppressive dynamics related to intersectional aspects of identity show up in the clinical encounter. I hope you will consider joining me in this reflection!

Participation would consist of one confidential open-ended interview via Zoom lasting approximately 60 minutes, and the option of participating in a follow up focus group with other current and former community mental health clinicians across the county. You are eligible to participate if you currently, or have ever, been a clinician at a behavioral/mental health agency in the United States that accepts Medicaid.

For more information about the study and what participation entails, please see the consent form here: shorturl.at/ehACZ

To sign up for an interview, please follow this link: calendly.com/maisyhughes/interview

If you have any questions, please email me at ▨▨▨▨▨▨▨▨

Thanks for your time!

Maisy Hughes, LMFT

Appendix E: Recruitment Email (Revised)

Subject: Interviewing current/former community mental health clinicians for research study- "Power and oppression in CMH practice"

My name is Maisy Hughes and I am a doctoral candidate at the Graduate School of Social Research at Bryn Mawr College. For my dissertation research, I am interviewing clinicians about how they have experienced and navigated issues of power and oppression in community mental health practice, and am inviting you to share your thoughts and experiences. My interest in this topic arose from my own work in community mental health in Philadelphia as a white clinician working primarily with low-income clients of color. Working on this project has offered me the chance to reflect with other clinicians on how oppressive dynamics related to intersectional aspects of identity show up in the clinical encounter. I hope you will consider joining me in this reflection! Your experiences in the field offer invaluable insight that can contribute toward a movement for social justice in community mental health practice.

Participation would consist of one confidential open-ended interview via Zoom lasting approximately 60 minutes, and the option of participating in a follow up focus group with other community mental health clinicians across the country. You are eligible to participate if you currently, or have ever, been a clinician at a behavioral/mental health agency in the United States that accepts Medicaid.

If you elect to participate in this research, we will discuss:

- · Your beliefs about therapy.
- · Dynamics of power and oppression in community mental health setting.
- · Dynamics with clients related to intersectional aspects of identity.

I am inviting you to participate because I believe your experiences in the field offer invaluable insight that will contribute toward a movement for social justice in community mental health practice. I hope you will find it useful to reflect together about these important issues.

For more information about the study, what participation entails, and your rights as a participant, please see the full consent form here: shorturl.at/ehACZ

Interested in being interviewed? Find a time that works for you here: calendly.com/maisyhughes/interview

If you have any other questions about the study, please email or contact me at ▨▨▨▨▨▨▨▨ or ▨▨▨▨▨.

Thank you for considering being part of this research.

Sincerely,

Maisy Hughes, LMFT
Doctoral Candidate (bio)

Graduate School of Social Work and Social Research
Bryn Mawr College

Appendix F: Oral Consent Form

Power and Oppression in Community Mental Health Practice

Bryn Mawr College Graduate School of Social Work and Social Research

1) **Title of Study:**
The title of this study is "Power and Oppression in Community Mental Health Practice"

2) **Purpose and General Description of the Study**
This is a research study conducted by Maisy Hughes, LMFT, a PhD candidate at the Bryn Mawr College Graduate School of Social Work and Social Research. This study is a PhD dissertation, and the faculty advisor overseeing this project is Cindy Sousa, PhD. I am conducting qualitative research, using open ended interviews and focus groups, to explore how clinicians experience and navigate power and oppression in their work in community mental health. I will be recruiting clinicians across the country for this study by sharing recruitment materials using social media, listservs and other online forums where mental health providers connect. It is estimated that a total of 10-15 clinicians will participate and data will be collected until August 2023.

3) **What does participation involve?**
Participation in this research involves participation in one open-ended interview that will last around 60 minutes via a secure Zoom connection and will be audio recorded. I will be interviewing clinicians who currently work or have worked in community mental health about how they experience and navigate issues of power and oppression in their clinical work. Following your individual interview, you may choose to be contacted in the future to participate in a focus group exploring the same topics.

4) **Confidentiality:**
This is a confidential interview. Neither your name nor your agency name will be attached to your demographic form or part of the interview transcript. I will not reveal any responses that could possibly be linked to specific individuals. I will not share information about whether you have participated in this project with anyone.

I will be recording the audio from your interview via Zoom and recordings will be recorded onto my computer, not on Zooms servers. The data will then be uploaded to the Bryn Mawr OneDrive, a password protected account accessible only by me and system administrators, and deleted from my computer. Audio recordings will be retained until they are transcribed and transcripts are verified for quality and accuracy, then the recordings will be deleted.

All data, including demographic forms and interview transcripts, will be stored in a password protected account accessible by only the researchers and system administrators. While no absolute guarantees can be made regarding security, these measures provide safeguards against outside agents accessing the electronic data.

The transcription resulting from the audio recording will not be linked to your name or any identifying information. Any report or publication that results from this research will not include any identifying information of yourself or your agency, unless the agency would like to be identified in the acknowledgements or as a co-author. However, the possibility of being identified exists. No absolute guarantees can be made regarding the confidentiality of interview data. If you feel your participation will put you at risk, you may opt out of the study.

5) Risks of participating in the study

The risks of participating are minimal. The ways that confidentiality will be protected have already been described. You may experience some temporary discomfort while being interviewed. Some people feel invaded or self-conscious when speaking in an interview. We will be discussing issues of oppression in our work, which may also bring up challenging feelings such as shame, sadness, hopelessness or anger In the event that discomfort following the interview persists, then be in touch with me and I will provide suggestions and referrals.

6) Benefits of participating

You will likely not directly benefit from taking part in this research, although I hope you will find it useful and compelling to reflect on your practice experience and knowledge. Findings will be used to further understanding the ways that oppression operates within mental health services for marginalized individuals.

7) Compensation

There will be no compensation for participating in this research.

8) Deception

There is no deception used in this study.

9) Voluntary Participation

Your participation is completely voluntary. You can withdraw from the study at any time by informing me (contact information below). You do not have to answer any questions that you don't want to answer. If you choose not to participate, there will be no penalty or loss of any benefits for not participating.

10) Questions about the research and rights of research participants

If you should have any questions about the research, please feel free to call or email the Principal Investigator, Maisy Hughes, LMFT, at ▨▨▨▨▨▨▨▨▨▨, ▨▨▨▨▨▨▨. You may also contact the faculty advisor of this project, Cindy Sousa, at ▨▨▨▨▨▨▨▨▨; ▨▨▨▨▨▨. If you have questions about your rights as a

research participant, please be in touch with Gary McDonogh, Professor and Chair, Bryn Mawr College IRB (███████████; ███████).

For Interviewer:

Are you 18 or older? Yes _____   No_____

Have you read this consent form or had it read to you?   Yes_____   No_____

Were all of your questions about the study answered to your satisfaction? Yes____   No

Have you been given a copy of this consent form? Yes_____   No_____

Do you agree to participate in this research? Yes_____ No_____

If the researcher has questions or needs clarifications after data collection is completed the research might contact you. You are not obliged to respond. Yes_____ No_____

Do you give permission to audiotape the interview? Yes___ No___

Date of interview: _____

Interviewer name (printed): _____

Interviewer signature: _____

Appendix G: Semi-Structured Interview Guides

Interview Guide- Current CMH Clinician

The larger goal of this study is to look at dynamics of power and oppression as they play out in the therapy room, and how you as a clinician manage these challenging dynamics. I'm going to start with some more general questions about your experience as a clinician, and then move into talking specifically about power and oppression.

- I want to hear a little bit about your beliefs about what makes effective therapy
- What comes to mind when you think about what makes for an ethical and empowering therapeutic experience with clients?
- In what ways do you feel that these beliefs and priorities align with the priorities of your agency? In what ways do they diverge?

Now we're going to shift to discussing power and oppression in therapy. There's a growing acknowledgment in all fields, particularly professions oriented toward care, of the ways in which institutional racism and systemic oppression shape the systems we work within and influence the context of our work, and I'd like to explore what that looks like in community mental health.

- First, I'm interested in any identities you hold that you're comfortable sharing
    - How do you see these identities enter the room with you?
    - How do you navigate identity differences with your clients?
- Where have you seen oppressive dynamics operating in community mental health agencies? (Specific examples)
- In what ways can the therapeutic interaction become oppressive?
- Tell me about a moment where you experienced an oppressive dynamic play out in a session
    - What did you do?
    - What was that like for you to hold that tension?
    - How do you feel now reflecting on how you approached that situation?
- Tell me about an ethically challenging clinical decision you have had to make
    - What did you do?
    - What was that like for you to hold that tension?
    - How do you feel now reflecting on how you approached that situation?

Debriefing Questions
- Is there anything else you would like to share about your experience?
- What was this interview like for you?
- Would you be interested in participating in a focus group with other clinicians to continue this discussion?
- Is there anyone you know who may want to participate?

Interview Guide- Former CMH Clinician

The larger goal of this study is to look at dynamics of power and oppression as they play out in the therapy room, and how you as a clinician manage these challenging dynamics. In particular, I am interested in how these dynamics look in a Medicaid-funded setting. So for this interview, I'll ask you to draw from your work in community mental health in answering these questions. I'm going to start with some more general questions about your experience as a clinician, and then move into talking specifically about power and oppression.

- First, I want to hear a little bit about your beliefs about what makes effective therapy
- What comes to mind when you think about what makes for an ethical and empowering therapeutic experience with clients?
- In what ways do you feel that these beliefs and priorities aligned with the priorities of the CMH agency you've worked for? In what ways did they diverge?
- Why did you leave CMH- tell me about this decision-making process for you

Now we're going to shift to discussing power and oppression in therapy. There's a growing acknowledgment in all fields, particularly professions oriented toward care, of the ways in which institutional racism and systemic oppression shape the systems we work within and influence the context of our work, and I'd like to explore that that looks like in community mental health.

- First, I'm interested in any identities you hold that you're comfortable sharing
  - How do you see these identities enter the room with you?
  - How do you navigate identity differences with your clients?
- Where have you seen oppressive dynamics operating in community mental health agencies? (Specific examples)
- In what ways can the therapeutic interaction become oppressive?
- Tell me about a moment where you experienced an oppressive dynamic play out in a session:
  - What did you do?
  - What was that like for you to hold that tension?
  - How do you feel now reflecting on how you approached that situation?
- Tell me about an ethically challenging clinical decision you have had to make:
  - What did you do?
  - What was that like for you to hold that tension?
  - How do you feel now reflecting on how you approached that situation?

Debriefing Questions:
- Is there anything else you would like to share about your experience?
- What was this interview like for you?
- Would you be interested in participating in a focus group with other clinicians to continue this discussion?
- Is there anyone you know who may want to participate?

Appendix H: Demographic and Work Information Form

Please provide a response for each of the following questions:

Age: _____

Gender identity and pronouns: _____

Race/Ethnicity/ cultural background: _____

Degree(s) held: _____

Years of Experience: _____

Years in community mental health (Medicaid funded agencies): _____

Avg community mental health caseload: _____

Please list any evidence-based practices below that you have formal training in:

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