Sponsoring Change in Self and Others:

Female Sponsors in the Cultural Context Model

A Thesis

Submitted to the Faculty

of

Drexel University

by

Eunjung Ryu, MSW

In partial fulfillment of the

requirements for the degree

of

Doctor of Philosophy

May 2010

DEDICATIONS

This dissertation is dedicated to all my friends and colleagues who are working toward bringing social justice for all people and to my loving husband, Inhyok Cha, and my daughter, Na Yoon.

ACKNOWLEDGEMENTS

Many individuals have played vital roles in my completing this process and have supported me by giving me strength, clarity, inspiration, and perseverance. I would not have completed this process without their presence in my life.

I would first like to thank the members of my dissertation committee, Drs. Andrae L. Brown, Kathleen Fischer, Pilar Hernandez-Wolfe, Cheryl Litzke, and Carolyn Y. Tubbs, for their guidance, generosity, and support. Special thanks go to my dissertation committee chair, Dr. Carolyn Y. Tubbs, for her commitment to supporting me from the beginning to the end. Dr. Tubbs spent countless hours to advise me in many different aspects of dissertation process, both academically and personally, and provided me with clear direction that enabled me to move forward and keep focus on my dissertation. Dr. Tubbs has been an exceptional role model and mentor for me.

Special thanks go to my husband Inhyok Cha, who has been showing me such love and patience throughout this long process. He has done more than his share of childrearing and household responsibilities and provided me with a space where I could concentrate on my career and dissertation. For that, I would like to dedicate this dissertation to him for his selfless acts and supports. I would also like to thank my family, especially my parents, for their loving support and belief in education and my ability to complete the program whenever I had doubts about myself. My sisters, Kyung Na, Soo Jin, and Soo Min, are my lifetime friends who always helped me grounded and appreciate my roots. My nieces and nephews have a special place in my heart who brought happiness, joy, and laughter whenever I felt heavy. In addition, I would like to thank my parents-in-law and the other members of my family-in-law for their support as well.

My sincere gratitude goes to the participants from the Institute for Family Services who were willing to share their life stories with me during interviews. Their willingness to share their time and insights has made it possible for me to complete my dissertation. In addition, I would like to extend my thanks to Dr. Rhea Almeida, Judith Lockard, Caroline Haan, Lisa Dressner, and members of Alliance for Racial and Social Justice for their work in bringing social justice. They are the ones who make difference in people's lives without much recognition from others but are will willing to make themselves available for others who need their support. Dr. Almeida is a visionary and has been a role model for me for many years. Her courage and vision of bringing social justice in family therapy field has inspired me to become a better therapist. She has shown me the way to care for others in ways that no one has shown ever before.

Lastly, I would like to share my joy with my colleagues, Moneida Elzy and Carol Kahn who had been there for me whenever I needed good ears to express my feelings and exchange ideas about figuring out the exit in the 'dissertation maze.' I thank them for their support.

Many other people have supported me in completing the process that I cannot mention their names due to limited space here. However, I am eternally grateful for all the people who have inspired me to become the person who I am today. I thank you for giving me the opportunity to getting to know you and for sharing your life with me!

Sponsoring Change in Self and Others:

Female Sponsors in the Cultural Context Model

by

Eunjung Ryu, MSW

Chair:	Carolyn Y. Tubbs, Ph.D.
Committee:	Andrae L. Brown, Ph.D. Kathleen Fisher, Ph.D. Pilar Hernandez-Wolfe, Ph.D. Cheryl Litzke, Ph.D.

TABLE OF CONTENTS

List of Tables

List of Figures

ABSTRACT

Sponsoring Change in Self and Others:
Female Sponsors in the Cultural Context Model
Eunjung Ryu, MSW
Carolyn Y. Tubbs, Ph.D.

In recent years, the field of family therapy has been increasingly influenced by social constructionism and has explored methods to utilize clients' experiences of change into the treatment process. These developments have led to the cultivation of new views on therapeutic relationships, social contexts, and processes of change. The Cultural Context Model (CCM), a family therapy approach based on social justice principles, therapeutic communities, and a unique form of sponsorship to facilitate change, emerged in this context. This study aimed to understand the experiences of female sponsors within the CCM and to fill a gap in the clinical literature on the CCM sponsorship. It employed a phenomenological research design to examine female sponsors' perspectives of the process of therapeutic change. Critically-informed, progressive transformation emerged as the essence of the female sponsorship experience. Importance of community and critical consciousness were two of four themes fundamental to critically-informed, progressive transformation. Findings suggest that a community- and social justice-informed therapeutic context and set of relational skills remain powerful and untapped resources in the field of family therapy.

Chapter 1: Introduction

The introduction of social constructionism to family therapy since 1990 brought to the profession new perspectives on therapeutic relationships, social contexts, and processes of change (McNamee and Gergen, 1992). Clinical researchers who share social constructionist views have become more collaborative with clients in therapies (Christensen, Russell, Miller, & Peterson, 1998; Helmeke & Spenkle, 2000; Kuehl, Newfield & Joanning, 1990; Sells, Smith, & Moon, 1996; Sexton, Ridley & Kleiner, 2004; Singer, 2005; Wark, 1994). For example, research inquiries into clients' perceptions of therapy in individual or couples therapy and their perceptions of change processes have emerged (Heatherington, Friedlander, & Greenberg, 2005; Helmeke & Spenkle, 2000; Sells, et al., 1996; Singer, 2005; Wark, 1994). This shift in emphasis has also involved building a client-based description of family therapy utilizing qualitative research methods (Berg, 1998; Denzin & Lincoln, 2005; Marshall & Rossman, 2006; Maxwell, 2004; Moon, Dillion & Sprenkle, 1990; Silverman, 2005). Feminist therapists, for example, are now focusing on integrating gender issues in family therapy (Goodrich, Rampage, Ellman, & Halstead, 1988; Rosewater & Walker, 1985; Silverstein & Goodrich, 2003), and feminist practices have adopted a renewed focus on clients' own interpretations and perceptions of gender realities and ensuing therapeutic processes.

More recently, therapists who have perspectives that go beyond gender to social justice have engaged their clients in more non-traditional ways. Social justice approaches in family therapy address the importance of "just" relationships as indicators of health and sanity, and expose how mainstream cultural norms often work against justice. In the

context of these discourses, the term “just” means being fair and equitable in the allocation of bargaining power, resources, and burdens (Prilleltensky & Nelson, 1997). Therapists with social justice orientations believe that the traditional psychotherapy literature makes generalizations based on a particular group – one of white, middle-class, urban-dwelling, and educated individuals – as if its characteristics apply to “people in general” (Hare-Mustin & Marecek, 1997). In this view, mainstream psychology and traditional family therapy roundly dismiss ideology, power disparities, intergroup relations, and other issues related to social justice (Taylor & Moghaddam, 1994). Thus, traditional methods help people adjust to their circumstances rather than transform the very circumstances that often contribute to the core of their problems (Hare-Mustin & Marecek, 1997). Social justice approaches, on the other hand, emphasize and advocate for the integration of race, gender, class, ability, ethnicity, and other contextual issues into family therapy, thus leading to the transformation of the circumstances that contributed to the “problem” in the first place (Aldarondo, 2007; Fox & Prelleltensky, 1997).

In social justice approaches to family therapy, clients are not viewed as customers who need therapists’ help and counseling to address their personal problems (Prilleltensky, Dokecki, Frieden, & Wang, 2007). Rather, they are seen as individuals who can benefit from socio-education and counseling on the social manifestations of the issues and oppressions they face so that they are not perpetuated. Ultimately, social justice-based approaches in therapy allow therapists to view their clients as people who can, with counseling, become active in their own communities, question existing power structures in society, and become advocates, or even agents, for social change.

Therapists who are currently using social justice-based approaches assert that these approaches are more effective in advancing change in their clients' lives. In large part, this is because they have helped their clients form "just communities" for support against mainstream norms (Almeida, Dolan-Del Vecchio, & Parker, 2007). Just Therapy (Waldegrave, 1990; 2005), Community Family Therapy (Rojano, 2007), and the Cultural Context Model (CCM) (Almeida & Lockard, 2005) are few examples of social justice-based family therapy approaches. Although Just Therapy and Community Family Therapy are social justice-oriented approaches that are actively practiced, this study will focus solely on the CCM and the research question related to this form of therapy.

The Cultural Context Model (CCM) is a social justice-based family therapy approach in which client participation in a therapeutic community is central to the process of change. In the CCM, sponsorship provides eligible, more experienced clients opportunities to work with newer clients in specific areas and at various points in time; it also provides non-clients similar opportunities to collaborate in mentoring and support. The CCM approach seeks to facilitate changes not only in individual clients but also in a community of clients. On a broader scale, the model also seeks to institute changes in the field of psychotherapy (Almeida et al, 2007; Almeida, Dolan-Del Vecchio, & Parker, 2008).

The CCM (Almeida, et al., 2007) places client participation in a therapeutic community as an avenue for change. Within the model, a subset of clients transition into what the model defines as 'sponsors', i.e., they participate as co-facilitators of therapy, mentors to newer clients, and also form a peer support group among themselves. Clients, who achieve significant changes in their presenting issues, as well as in other areas of

their lives, are encouraged to actively sponsor new clients. Sponsor has a set of tasks that include narrating stories, mentoring, sharing resources, and providing insights into the therapeutic process. The CCM allows therapists to cross-verify their assessments of any individual's change process with assessments on the same individual made by the individual's peers or sponsors in the therapy group. In all of these ways, the model systematically monitors change of clients in their therapeutic processes.

Despite the fact that the CCM has been practiced for more than a decade and that sponsors constitute a major support for change in the therapeutic methodology of the CCM, there is little systematic research to date that has explored how sponsors in CCM therapy perceive and interpret their own change processes. Rather, the existing research on the CCM, in relation to change processes, is largely based on observations and assessments made by therapists and researchers (Hernández, Bunyi, & Townson, 2007; Hernandez, Richard, & Giambruno, in press; Hernandez, Siegel, & Almeida, 2009; Parker, 2003). The existing research has not employed the clients' direct input as lived and experienced by the clients.

Purpose

General Goal of the Study

The purpose of this study was to understand the lived experience of sponsorship from the perspectives of female sponsors in CCM therapy. The study examined female sponsors' perspectives on the therapeutic change process through an inductive analysis of the sponsors' rich description of their experiences. For this study, sponsors were defined as former clients in CCM therapy who are currently offering feedback to other members in the therapeutic community through interactions inside or outside of the on-site

therapeutic setting. Sponsors have been selected by clinical staff to take on and maintain voluntary roles of leadership within a CCM therapeutic community.

Existing research on the CCM suggests that the change process occurs when clients exhibit several, early, observable behavioral changes, including accessing emotional experiences that underlie problematic and rigid interactional positions, and subsequently re-synthesizing such experiences to create new and more equitable interactions (Almeida et al., 2008). While not all clients respond to the therapy equally (some fare well and some do not), clients who are considered to have made some initial changes as explained above are likely to become sponsors who then play roles distinguishable from those of the therapists or the non-sponsoring clients in the treatment process. Despite the uniqueness and assumed importance of the sponsorship role in therapy, there is no known work of research, which examines sponsors' overall experiences, specifically their processes of change and especially from their own perspectives. This study attempted to fill this void by using a phenomenological research method to explore the lived experiences of the female sponsors in relationship to their therapeutic change processes in CCM therapy.

Research Question

Based on the stated goals of this proposed study, the primary research question, which guides this research is: *What is the lived experience of female sponsors engaged in the therapeutic change process promoted by the CCM?* From this central question, several sub-questions emerge:

- What language best describes the change processes?

- What are the sponsors' understandings of the relationship between their own therapeutic change experiences and their role of interacting with therapists, other sponsors, and clients? And how did these relationships facilitate change?
- What were some of the critical points in their change processes, and how did they affect others?
- What is the essence of change facilitated by the CCM, and how do the sponsors contribute to it?

Overview

This study illustrates a study of the lived experience of sponsorship by a particular group of therapeutic clients referred to as *sponsors* within a relatively new family therapy model, the Cultural Context Model (CCM). CCM is a social justice-based therapy paradigm that emphasizes the role of sponsors in therapeutic communities. In this study, I used a phenomenological research methodology to capture and analyze female sponsors' accounts of their lived experiences of being sponsors in relationship to their therapeutic change processes in CCM therapy.

The structure of this manuscript is as follows:

Chapter Two presents a review of literature relevant to the phenomenon of interest, i.e., sponsors experiences within the CCM, using the following outline:

- Traditional contexts for change
- Emergent context for change related to the CCM
- Theory of the CCM
- A detailed description of change process espoused by the CCM

- Sponsorship in the CCM
- Research conducted on the CCM
- The gaps in research

Chapter Three is a description of my location as the researcher relevant to understanding who I am in reference to the phenomenon of interest and how this location shapes the conduct of the research. Chapter Four provides a detailed description of the methodology of the study (e.g., phenomenological qualitative research, the sampling method, and strategies for data collection and data analysis). Specifically, I describe transcendental phenomenology, providing a brief historical background, along with my arguments in favor of its use. Chapter Five provides findings of this study; and finally, Chapter Six includes a discussion of the study's findings, its limitations and suggestions for further research, followed by the reference list and the appendices.

Chapter 2: Literature Review

Literature On The Change Processes

Traditional Context for Change

Before the advent of systemic family therapy, psychodynamic therapy considered the individual person as the basic unit of diagnosis and treatment. Diagnosis consisted of classification of a person into a type, and therapy attempted to change individual behavior. The individual, along with her (note: the female gender is used throughout this dissertation to reflect the focus on female sponsors) own cognitions, emotions, and beliefs were considered the motivating agents for change (Haley, 1971; Nichols, 2008). Therefore, emphasis was placed on the individual in isolation, unaffected by perceptions of her situation as important to change. Therapy largely centered on making a person consciously aware of her motivations and inner dynamics, with an eye toward seeking to change the perceptions and response behaviors learned from past experiences (Haley, 1971).

Group therapy was introduced as a practice after World War II as a means to treat traumas experienced by veterans, and as a more economical alternative to traditional individual psychotherapy (Corey & Corey, 1992; Yalom, 2005). In group therapy, a number of persons - ordinarily strangers to one another - participated together regularly in therapy sessions, and a perception of group membership evolved during these sessions. Participants learned to deal with one another, and jointly explore tensions and relationships that emerged within the group (Corey & Corey, 1992; Schaffer, Wynne, Day, Ryckoff, & Halperin, 1971; Yalom, 2005).

The group formed and functioned with a common purpose of supporting its members. However, this support was limited by time as contracted, after which group members would be expected to become strangers again. Such artificial time constraints were thought to facilitate self-disclosure, because the members could use their interaction with the group to help them solve their issues, but do so with the keen awareness that the support relationships they had formed would not extend beyond the termination of the sessions. This understanding guaranteed confidentiality (Haley, 1971; Glick, Berman, Clarkin, & Rait, 2000). Groups utilizing this form therapy typically did not evolve into sustainable communities, and long-term efficacy of the change brought about by group therapy was questioned. In addition, as the economic impact of the war subsided, people seeking therapy could once again afford – and indeed preferred – individualized therapy.

In the 1950's, two major changes took place in the field of psychotherapy: individual therapy became newly defined as an interchange between two people, and therapists began to try to change individuals' relationships rather than just the individuals themselves (Haley, 1971; Glick, et al., 2000). This change became especially prevalent in couples therapy, which viewed and treated the couple as a unit (Glick, et al., 2000). Therapists began to bring two persons - usually marital couples, but sometimes - other types of related individuals such as a parent-child or sibling pairs – into treatment sessions. With this shift, the goal of therapy moved from attempting to change individuals to transforming behavioral exchanges between intimates (Haley, 1971).

Family therapy started in the 1950s as a new therapeutic modality (Guerin, 1976). In family therapy, at least three persons – a therapist and two or more additional people who are usually intimates in family relations – are present and participating in sessions.

From its inception, family therapy has focused on the fact that family members tend to form long, natural histories and often share assumptions of the future as an ongoing social system. The discontinuities inherent in traditional group therapy are absent (except with regard to the therapists) because the family's association with one another continues between sessions and after they are terminated (Schaffer, et al., 1971).

As previously stated, family therapy defined the focal unit of diagnosis as two or more people, usually related within family relationships (Berg-Cross, 2000), Family therapy influenced the definition of the "therapeutic client" and, with that came a change in the therapeutic goal, including changing the ways people interact with one another. The communication sequence between intimates was the focus of change (Glick, et al., 2000). With this focus, the client's individual perceptions – her own repressions or emotions as well as the ways that she dealt with people in larger, non-family systems – became peripheral matters (Haley, 1971; Glick et al. 2000). Another distinctive characteristic of family therapy was that it worked from the principle that abnormal behavior was a maladaptive response to a systemic change. Therefore, clients were encouraged to shift from using rigid, maladaptive behavioral responses (i.e., first order change) to using context-specific, adaptive behaviors in new situations (Becvar & Becvar, 2008).

Transtheoretical model. The transtheoretical model is a framework for explaining how people change within and between therapy sessions. It is also useful in identifying stages of change by integrating principles and processes across multiple theories of intervention (Prochaska, 1999). The model was originally developed by Prochaska and DiClemente (1982, 1983) and named "transtheoretical" because its

concepts are derived from a number of theories of human behavior. Prochaska (1979) initially conducted a comparative meta-analysis of 18 leading theories of psychotherapy and behavioral change. He discovered what he viewed as common pathways to change, regardless of treatment modalities. They include affective, behavioral, cognitive, psychodynamic, existential, humanistic, interpersonal, and medicinal models. When Prochaska and DiClemente (1982) conducted their first research of the transtheoretical model with people who attempted to overcome smoking, they learned that nearly 80 percent of them had resumed smoking within a year of completing therapy. Studying this particular change process among the population was thought to be a good model, since the relapse rates of smokers were similar to those of addicts.

Prochaska and DiClemente (1982) viewed the stages of change as representing specific coordinates of attitudes, intentions, and behaviors related to an individual's position or state in the cycle of change. The body of this research indicates that behavior change is an ongoing process that unfolds over time in a commonly occurring sequence of six stages (Appendix A): *precontemplation, contemplation, preparation, action, maintenance*, and *termination* (Prochaska & DiClemente, 1982; Prochaska & Norcross, 1994).

Precontemplation is the stage in which individuals are not intending to change or take action in their foreseeable futures – usually defined as six months prior to their present situation. Individuals may be in this stage due to ignorance, avoidance, rationalized defensiveness, or being uninformed or under-informed about the consequences of their behavior. Individuals in this stage tend to underestimate the benefits of changing and overestimate the costs.

Contemplation is the stage in which individuals intend to change in their foreseeable futures. They have become more aware of the benefits of making appropriate changes, as well as the costs associated with them. The length and duration of contemplation vary with the severity of the person's problem and/or the amount of introspection and understanding that has occurred prior to the individual's going to therapy.

Preparation is the stage in which individuals intend to take action more immediately, within a month or so from their present situations. A key indicator of this stage is the presence of a plan of action. People in this stage are best suited for brief action-oriented treatment programs.

Action is the stage in which individuals have made specific and overt modifications of behavior. In this stage, clients not only exhibit a commitment and a plan, but they have also taken action within the past six months. Not all behavioral modifications are considered action. Rather, Prochaska identifies sufficient clinical improvement as a signifier of action.

Maintenance is the stage in which individuals work to prevent relapse. Even if they are not making significant changes at this point, clients in this stage are more confident and conscientious about their efforts. Identifying this stage points to the importance of developing plans to help clients take active roles in averting relapses. Maintenance includes identifying and encouraging people to continue on their paths to change. This stage may last from six months to five years.

Termination is the final stage. In this stage, individuals experience no temptation to relapse and exhibit 100 % self-efficacy.

The body of Prochaska's research also asserts that processes of change are the covert and overt activities that people engage in to alter effect, thinking, behavior, or relationships in the context of a particular problem or more general patterns of living (Prochaska & Norcross, 1994). In order to help individuals progress from one stage to the next, therapists need to apply the specific processes and principles of change at each stage of treatment as well as outside of therapy sessions (Prochaska & Norcross, 1994). Prochaska (1999) presented nine processes of change:

1) *Consciousness raising* involves increased awareness and information about the causes, consequences, and cures for a particular problem.
2) *Dramatic relief* involves emotional arousal about one's current behavior and the relief that can come from changing it. Fear, inspiration, guilt, and hope are some of the emotions that can move people to contemplate changing.
3) *Environmental reevaluation* combines both emotional and cognitive assessments of how one's behavior affects one's social environment and how changing it would affect that environment.
4) *Self-reevaluation* combines both cognitive and affective assessment of one's self-image free from a particular problem. As clients progress into the *Preparation* stage, they begin to develop more of a future focus as they imagine how their lives might be, free from the problem that brought them to therapy.
5) *Self-liberation* includes both the belief that one can change and the commitment and recommitment to act on that belief. Techniques that can

enhance such willpower make greater use of public rather than private commitments.

6) *Counterconditioning* requires replacing problem behaviors with healthier ones. Counterconditioning techniques are specific to a particular behavior and include desensitization, assertion, and cognitive counters to irrational, distress-provoking self-statements.
7) *Contingency management* involves the systemic use of reinforcements and punishments for taking steps in a particular direction.
8) *Stimulus control* involves modifying the environment to increase cues that prompt healthier responses and decrease temptation. Avoidance, environmental reengineering, and attending self-help groups are some of the ways of reducing risks for relapse.
9) *Helping relationships* combine caring, openness, trust, and acceptance as well as support for changing. Rapport building, a therapeutic alliance, counselor calls, buddy systems, sponsors, and self-help groups can be excellent resources for this process.

The integration of the six stages and the nine processes of change is considered essential to a therapist's work, in order to determine a client's progress. (Prochaska & Narcross, 1994).

Although the stages identified by Prochaska and his collaborators present a unique contribution to the field of psychotherapy, these categories are only based on individual change processes and do not capture the impact of systemic change on the therapeutic system. Examples of such systemic change impacts include clients'

relationships with significant others, family systems, and communities.

Systemic family therapy. Human behavior occurs in context. Systemic family therapy pioneered the field of family therapy by considering the individual's behavior connected to the context of one's family dynamics. Prior to systemic thinking's being embraced as the dominant meta-paradigm within the field of family therapy (Bishop, 1984), psychotherapists suggested that the motivation of the individual actor is internal; the exterior merely provides a background (O'Connor, 1977). According to systemic family therapy thinking, the family is a uniquely obvious and immediately accessible ongoing system. Therefore, instead of isolating the client from the family system, clinicians should consider the client within that context in order to fully understand and assess the behaviors (Wilkinson & O'Connor, 1982).

Systemic thinking in family therapy was influenced by cybernetics (Nichols & Schwartz, 1998), which was founded in the 1940s by the famed applied mathematician Norbert Wiener. Cybernetics attempted to explain processes of dynamical systems through the lens of feedback loops, and it was Gregory Bateson who first introduced this concept into family therapy (Nichols & Schwartz, 1998; Nichols, 2008). Bateson also introduced a shift in systemic thinking where causal relationships are considered in circular ways as opposed to traditional, linear ways (Becvar & Becvar, 2008).

Systemic family therapists' views on the change process of clients are influenced by the cybernetic view of dynamic systems (Becvar & Becvar, 2008). In dynamic systems, the behaviors of the actors are best understood by the concepts of phases (or states) and their transitions through feedback loops. In the cybernetic view, three factors – the external input, the current internal state, and the feedback loop – collectively

describe both the outwardly observable output and the internal mechanism of a system. The external input is the stimuli from outside of the system, while the internal feedback loop determines how the current state of the system is influenced by its past history. Finally, the internal state of the system is a 'view' of the system that is not visible to the outside but indicates an internal 'picture' of the system. In summary, cybernetics views that an individual's future behavior, her future 'view' of the world, and her view of herself are determined by the external stimuli she receives, the internal feedback mechanism from her history, and where she stands right now. Sometimes, the collective effect is a relatively stable equilibrium in behavior or homeostasis in a system. This means that the system the person belongs to tends to maintain its homeostasis. If change requires greater deviation from her familiar system, her behavior will likely to be self-regulated and will eventually revert to the previous homeostasis. At other times, more significant changes can occur based on certain combinations of external inputs, internal feedback loops, and the present state of the individual. Such changes can result in the individual's motivation to attain a new and different phase, and the result can be a much more significant change in her behavior - which may indeed stick, and become a permanent behavior of the individual. Influenced by cybernetics, systemic family therapists consider clients' behavioral changes in terms of the transitions between several distinct phases of the system. Specifically, they cite two different types of behavioral change: the *first-order change* and the *second-order change*.

Systemic family therapists have considered change in behavior as the primary condition for resolving problems and have emphasized *second-order change* (Watzlawick, Weakand, & Fisch, 1974). Watzlawick first defined *first-order change* as a

change in a system that does not result in change of the system's state itself. *Second-order change*, on the other hand, involves a change in the system or the process of change itself (Watzlawick et al., 1974). In other words, second-order change is considered a "*change that makes a difference*" (Watzlawick et al., 1974).

In the context of family therapy, Watzlawick notes that an individual's attempt to change the given rules of his external system can be described as first-order change; he notes such an attempt, i.e., a first-order change in behavior, would leave the system essentially unchanged (Watzlawick et al., 1974). First-order change is a symptom relief and associated with causes and solutions that lie outside of the person. Second-order change, on the other hand, is an individual's attempt to change her response to rules, which effects a change in the family system itself.

The following four principles are associated with second-order change (Watzlawick et al., 1974):

1) Second-order change is applied to what appears as a solution to an individual in the first-order change process. In the second-order change process, such a solution actually reveals itself as the root of the problem.
2) While first-order change always appears to be in line with logical conclusions or reactions, second-order change usually appears unexpectedly and outside the realm of common sense. There is a puzzling, paradoxical element in the process of this level of change.
3) Applying second-order change techniques to the solution concocted in a previous first-order change attempt means that the paradoxical situation is dealt with in the here and now. These techniques primarily focus on the

effects of the problems and not their presumed causes; the crucial question is *what,* not *why?*

4) The second-order change process frees the actor by placing the situation in a different frame of reference.

Systemic family therapists consider second-order changes in behavior the primary condition for resolving problems. They also believe that by seeing the results of altering rigid behavioral responses, clients become more flexible in their problem-solving strategies (Nichols & Schwartz, 1998). Some systemic family therapists also argue that transitions from one stage of the family life cycle to another require second-order changes, while problems within stages can usually be handled with first-order changes (Nichols & Schwartz, 1998).

The distinction of first-order and second-order changes has been considered a useful tool in conceptualizing the change process in therapy and in formulating intervention strategies (Nichols & Schwartz, 1998). In family therapy, especially among the systemic and Milanian therapists, the primary condition for resolving problems is to achieve second-order change, as this was the foundation for their clinical models (Palazzoli, Cecchin, Prata, & Boscolo, 1979). These principles also influenced other schools of psychotherapy. For example, second-order change is often the focus of community psychology, where clients are encouraged to help themselves in their communities and to collectively strive to bring about changes in their social and economic conditions (Nelson & Prilleltensky, 2005).

With its distinction of first-order and second-order change, systemic theory shifted the focus from individual psychotherapy to family systems. However, its focus

has remained largely within the boundaries of the individual family system, which has been viewed effectively as “unrelated to its environment” (Mannino & Shore, 1982). Nevertheless, even from the early days of family therapy, there has also been awareness (e.g. Haley, 1971) that the family was but one of multiple social groups that must be considered in the therapeutic process. Since the 1970s, some researchers have noted the limitations of individual-oriented assessment procedures and treatment modalities that minimize the contribution of systemic factors (Moos & Fuhr, 1982). Individual-oriented causal attributions have been thought to result in assessment techniques, intervention strategies, and program evaluation criteria that focus on person-centered variables. As a result, many investigators have developed new treatment modalities that consider systemic factors such as the context of individuals (Moos & Fuhr, 1982).

Emergent Context for Change

Traditionally, the goal of therapy has been viewed not only to resolve presenting issues or narrowly defined short-term problems, but also to help clients achieve long-lasting transformations. However, the transformation advocated by traditional therapy has often been too self-centered, individualistic, and oblivious to larger social issues, as though individuals’ transformations occur in isolation to larger societal influences. Advocates of social justice- based approaches in family therapy believe that promoting narrowly focused individual life satisfactions often plays accomplice to the continued oppression of the less powerful and privileged members of society. They assert that traditional therapy has helped individuals change themselves and achieve their personal goals, but often at the cost of less power and lower social location for others (Fox & Prilleltensky, 1997). In contrast, social justice-based approaches in therapy view change

as not only for personal satisfaction or transformation, but also for the systemic transformation of individuals and their societies. These approaches aim to expose the ways that mainstream cultural norms and institutional practices work against social justice, and consequently, prevent clients from challenging socio-cultural contexts and the status quo. Instead, these clients become resigned to living with their (oppressive) circumstances. The impetus for change in social-justice approaches inspires clients to get involved with larger social change through activism. As a result, social justice encourages agency and action on the part of people of lesser power and privilege.

Family therapy from a social justice approach. The origin of social justice legacies in the mental health professions can be traced back to the work of feminist therapists and community psychologists that began in the late 1970s. For more than two decades, these two groups have consistently emphasized the need for mental health professions and scholars to understand people's lives as a reflection on the social contexts in which they develop, to highlight the political nature of mental health problems, and to take up an activist stance in their work (Aldarondo, 2007).

Feminist therapists were the first to challenge the field of family therapy for failing to consider the lived experiences of women and children raised in contexts characterized by power imbalances and social inequality (Hare-Mustin, 1978). They were joined by feminist scholars who made calls to address sexist biases in family therapy and promote a more equitable and just society (Aldarondo, 2007). These scholars also asked family therapists to evaluate the structure of society, the ways in which it supports the status quo, and the responsibility of all concerned to help challenge these structures (Aldarondo, 2007).

Community psychologists were the second group of therapists who emphasized social justice as an integral factor in the mental health field (Aldarondo, 2007). They strove to create change in people within their environs, focusing on the strengths of individuals and communities who were surviving and prevailing despite adverse and often unjust social conditions (Nelson & Prilleltensky, 2005; Rappaport, 1977). By advocating for the use of narratives (Nelson & Prilleltensky, 2005) and by facilitating solidarity with other communities (Moane, 2003), these psychologists tried to help individuals resist domination and oppression and thereby revitalize their communities.

Within the framework of family therapy, one could also argue that the emergence of multiculturalism along with culturally competent theories and methodologies were also precursors to social justice- based approaches. Therapists familiar with these approaches stress that sensitivity and competency are necessary qualities for therapists wishing to deal effectively with clients representing diverse ethnic groups and various cultural norms (Atkinson, Morten, & Sue, 1979; Lee, 1997; Locke, 1992; McGoldrick, Giordano, & Pearce, 1996; Vargas & Koss-Chioino, 1992). As important and relevant as culturally competent approaches are, there is a risk associated with them. Namely, therapists may accept certain practices of clients as justifiable (from multicultural or postmodern stances), even when those practices are, in fact, oppressive (Nelson & Prilleltensky, 2005; Smith, 1999). An example of such behavior would be the therapist who does not screen clients for intimate partner violence unless the clients themselves bring up the issues. Adopting a post-modern stance, a therapist may justify her inaction by believing that the clients are ‘the experts’ in their own lives. Another example would be the therapist’s accepting serious power imbalances and resulting oppressive behaviors among family

members in Asian families, doing so under the precept of "respecting different cultural norms."

Social justice approaches in family therapy have attempted to expand on the work initiated by feminist therapists and community psychologists by realizing that both an individual and a family's mental health are inextricably linked to the health and justness of larger social contexts. These approaches view social justice as a defining factor of health and sanity, recognizing that there is injustice in the world. Some groups of people are privileged and others are disadvantaged – on a consistent basis. In this context, a "just" society is viewed as one where the bargaining power, resources, and burdens are allocated in fair, equitable, and accountable ways (Prilleltensky & Nelson, 1997). A "just" relationship, therefore, would be viewed as one where the virtues of fairness, equity, and accountability are encouraged and upheld. Therapists with a social justice orientation believe that "just" relationships – at both the individual and larger social levels – are essential to achieving positive therapeutic outcomes.

In addition, therapists with social justice orientations believe that therapy conducted without raising the critical consciousness of their clients enables oppressive discourses to continue unchallenged (Waldegrave, 2005). When these dominant discourses are supported, those with a social justice approach further believe that these therapists end up becoming a part of the societal oppression maintaining the status quo (Charmaz, 2005; Dolan-Del Vecchio & Lockard, 2004; Fox & Prilleltensky, 1997; Waldegrave, 1990). Examples of this approach in family therapy include Just Therapy, Community Family Therapy, and the Cultural Context Model. Therapists practicing these models shift the blame for problems from families to culture, convincing their

clients that they are dominated by oppressive practices from which they need liberation. On the other hand, family therapists with social justice orientations are engaged in the work of building community and creating social change (Aldarondo, 2007). Although the CCM has some commonalities with Just Therapy and Community Family Therapy, it offers a unique way of dealing with clinical issues. Therefore, the rest of this chapter will be devoted to describing the model and its own change process.

Overview of the Cultural Context Model (CCM). The Cultural Context Model (CCM) is a family therapy paradigm rooted in social justice principles. The CCM framework enables therapists to guide clients into an awareness of the societal patterns that contribute to their presenting difficulties and to view families as subsystems of their communities. As such, racism, sexism, heterosexism, classism, able-ism, and other oppressions are seen as inherently piercing through family boundaries (Almeida, et al., 2008). Such intersections of power and oppression can cripple family relationships, and thus healing and transforming them requires substituting more just patterns (Almeida, et al., 2008). Before presenting the historical development of the CCM and discussing its critical concepts, a brief summary and introduction of the model will offer a helpful foundation for understanding the Cultural Context Model's specific components.

A defining characteristic of the CCM is its unique definition and emphasized use of the *therapeutic community*. In essence, therapists practicing the CCM seek to provide families with connections to a community whose function is to promote liberation (i.e., change) through critical consciousness, empowerment, and accountability (Hernandez, Almeida, & Del-Vecchio, 2005). As clients gain knowledge and support from this community, they are encouraged to work together to challenge the systems of power,

privilege, and oppression that are the foundation of many presenting problems (Almeida, et al., 2007). Therefore, individuals and their families are supported in the context of the community, rather than solely by individualized therapy. One of the main roles of the community is to hold the individual accountable for her actions and possible consequences in the more public setting of the therapeutic community. Individuals are expected to grow as they change their behavior, and this transformation will reveal itself not only in regard to their primary relationships, but also in terms of their impact on and contributions to the larger community.

Cultural Context Model - Theory

The Cultural Context Model (CCM) is influenced by critical scholarship and social constructionist theory, both of which center on issues critical to diversity and social context in families (Almeida, 1994; Almeida, 1998; Almeida & Durkin, 1999; Almeida, Wood, Messineo, & Font, 1998). Almeida and a team of clinicians at the Institute for Family Services (IFS) developed the CCM based on their understandings of postcolonial scholars in various disciplines (Appendices A and B). The main postcolonial scholars were F. Fanon (1963), P. Freire (1971), G. C. Spivak (1988), and K. Crenshaw (1997). These scholars' philosophies heavily influenced the backbone of CCM in terms of its organizing philosophy, clinical approach, and practice. The model offers an expanded family therapy paradigm based on an analysis of societal-based patterns that contribute to the social inequalities organizing family and community life (Hernandez, 2003).

Theoretical Underpinnings of the Cultural Context Model

Traditional family therapy uses the individual family as the focal unit, but this myopic focus has been criticized by many researchers for the following theoretical and practical limitations: (1) traditional family therapy does not necessarily lead to the assessment and utilization of social resources outside the boundaries of the family (Bishop, 1984), (2) it may not elicit data regarding social constraints, which may be crucial in understanding the family (Hume, O'Connor, & Lowery, 1977, p. 36), and (3) it may lead to an inappropriate focus on intra-family dynamics when the problematic phenomenon is arising from interactions within larger socio-contexts (Mannino & Shore, 1982; Bishop, 1984).

The Cultural Context Model (CCM) attempts to address the shortcomings of traditional family therapy by integrating an inquiry of social justice issues into the diagnosis and treatment of individuals (A history of the CCM can be found in Appendix B). The CCM bases its theoretical framework on a diverse array of theoretical approaches in general social science, psychology, and family therapy that all share a common element of an emphasis on the role of larger societies in considerations of therapeutic diagnoses and interventions. These approaches include critical theory and intersectionality, critical pedagogy, critical psychology, community psychology, and network theory. In the following subsections, these various approaches will be briefly reviewed (See Appendix C). Preceding this exploration, however, is an introduction on social constructionism, as social constructionism provides a common epistemological foundation for these approaches.

Social Constructionism. Constructionism is an epistemology embodied in many theoretical perspectives (Crotty, 1998). Such perspectives include interpretivism (Hyde, 1994), phenomenology (Husserl, 1964), and hermeneutics (Gadamer, 1989). Constructionism contends that truth becomes possible and is made meaningful only as a result of how people experience the realities of their worlds (Crotty, 1998). Meaning is not discovered, but constructed in conversation with others. In this understanding of knowledge, it is clear that different people may construct meaning in different ways, even in relation to the same phenomenon (Crotty, 1998).

Constructionism as a philosophical discipline is sometimes thought to derive from Georg Hegel and Karl Marx (Crotty, 1998). In fact, the concept goes back in history as early as Giambatisttia Vico (1968-1744), a 17th century Italian philosopher whose seminal work was largely forgotten until the 20th century (Grassi, 1990). Vico noted what he called the *verum factum* principle (Grassi, 1990), which states that truth is verified through creation or invention and not through observation as was traditionally thought. Vico argued that truth is established because people have made it so with their minds. He further argued that what people regard as truths in how societies should be, and how people should behave within these societies are wholly constructed - just as mathematical truths are wholly constructed (Grassi, 1990).

In the 20th century, a number of sociologists developed the basic truth-as-construct concept of constructionism as applied to social phenomena and meaning making. For example, Hungarian-born German sociologist, Karl Mannheim (1893-1947) applied this basic concept to develop a theory that scientific knowledge evolves through social process. His work influenced later theories of scientific knowledge by thinkers

such as Thomas Kuhn (1962). Later, Berger and Luckmann contributed *The Social Construction of Reality* (1966) in which the truth-as-construct concept developed into a kind of sociology of knowledge (Crotty, 1998).

Social constructionism holds that "all knowledge, and therefore, all meaningful reality as such is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context" (Crotty, 1998, p. 42). Effectively, social constructionists emphasize that society is actively and creatively produced by human beings and that social worlds are "interpretive nets woven by individuals and groups" (Crotty, 1998). The "social" in social constructionism references the mode of meaning generation rather than a kind of object, such as the society itself, which has meaning. Therefore, social constructionism deals largely with the process of how humans in social settings and contexts *make* meaning in their worlds and establish truths, rather than the more limited scope, which is concerned with how humans make sense out of their societies (Crotty, 1998).

Social constructionists are also historicists and contextualists, in the sense that they hold that the meaning-making process of any group of humans depends on the particular historical and other contexts (e.g. geographical and cultural) of the people who engage in this process. It can thus be argued that the world held no meaning at all before humans acquired consciousnesses capable of interpreting the world (Crotty, 1998), and that truths or meanings are contextually bound by the culture or beliefs of a particular society or a group of people.

Theoretical Approaches

Critical Scholarship. ***Critical Theory.*** Critical theory is concerned with empowering human beings to transcend the constraints placed on them by race, gender, class, and sexual orientation (White & Klein, 2002). The critical theoretic view of knowledge is that all theories are value-laden, and such values and beliefs should be exposed and challenged if the aim is to create opportunities for change (White & Klein, 2002). Therapists with critical theoretic views believe that by prioritizing individual life satisfaction, traditional therapists have often become accomplices in the perpetuation of oppression. They have criticized traditional therapy for allowing individuals with more power and higher social locations to advance at the cost of others of lesser power and lower social positions (Fox & Prilleltensky, 1997).

The concept of *intersectionality* is central to critical theory. *Intersectionality* refers to an analysis of the dynamic interplay of one's gender identity, ethnicity, sexual orientation, religion, age, disability status, and other diversity characteristics upon multiple aspects of one's identity, including the resources and lack of resources. These differences are conveyed upon the individual within his or her current social context. (Crenshaw, 1997; Crenshaw-Williams, 1995). Intersectionality is a concept that feminists within a post-colonial and critical theoretic paradigm (Fox-Genovese, 1991; Molina, 2004; Williams, 1993) first used extensively to analyze power. They argued that power is located within the intersectionalities of class, race, culture, ability, sexual orientation, gender identities, and religion. Specifically, Spivak (1988) posits that the experience of dominance is as relentless as the experience of oppression. As dominance is normalized, it is rarely questioned. Individuals do not see their role in the structures of

dominance. Spivak (1988) sees a great need for people to be critically aware of the occurrences of internalized dominance in their daily lives so that they can find ways to resist and interrupt the perpetuation of oppression.

Critical Pedagogy. Critical pedagogy owes its founding to Paulo Freire (1921-1997). In his best-known work, *Pedagogy of the Oppressed*, Freire defines and uses such concepts as critical consciousness and critical thinking (Freire, 1972). Furthermore, Freire defines critical consciousness as "thinking which discerns an indivisible solidarity between the world and men." Critical thinking, Freire adds, "perceives reality as process and transformation, rather than as a static entity" (1972, p. 87). Drawing from phenomenology, Freire emphasizes people's intentionality and trust in their intuitive experiences of phenomena, both of which are viewed as essential for resisting attempts to rationalize the status quo. Freire (1972) also asserts that liberation is a praxis, the action and reflection of men and women upon their world in order to transform or humanize it.

In the context of pedagogy, Freire notes (1972) that subordinate groups always know the groups in power because that knowledge is crucial for survival. Moreover, oppressed groups learn self-denial as another means of survival. In therapy settings, critical pedagogical views support the notion that analysis of power relations is the key to correct assessment and formulation of intervention strategies. Therapists espousing this school of thought are essential to understanding, rather than pathologizing, the oppressed.

Post-colonial Scholarship. Colonialism, in the context of therapy, can be defined as an inter-group dynamic within which one group - the colonizers- holds power and control over another group, the colonized (Dolan Del-Vechio & Lockard, 2004). Post-colonialism addresses the specific issues encountered by societies affected by the

historical phenomenon of colonialism (Crenshaw, 1997; Foucault, 1975; Said, 1978; Spivak, 1988). The prefix "post" does not imply that colonialism is a past phenomenon, but rather, an ongoing "meta" perspective (Alva, 1994). Said (1978). Said is often credited as the literary founder of post-colonialism, with his seminal work *Orientalism* (1978). Said describes how the colonial expansion of the European powers justified their aggressiveness toward others, such as people of the Middle East. He and later post-colonialist scholars have articulated discourses that oppose colonization and subordination across the globe. These discourses focus on the pluralities of personal and community histories elucidated alongside larger social dimensions such as migration, education, economics, health, and the environment (Loomba, 1998). In the therapy setting, a post-colonial view suggests that these therapists consistently focus on these dimensions as a fundamental part of the therapy process.

Critical Psychology. Critical psychology (Bartky, 1990; Bulhan, 1985; Moane, 1999; Parker, 1999; Prilleltensky & Nelson, 2002; Sloan, 2000; Wakerdine, 1996; Young, 1990) is an approach that attempts to address the pervasive influence of power and the roles of psychologists in therapy, research, writing, consultancy, education, program development, and evaluations. Critical psychologists analyze how power permeates professional discourse and action; they consider that people may be oppressed in one context and may act as oppressors in others. These psychologists identify three primary ways that an individual uses her power: (a) to strive for well-being, (b) to oppress, and (c) to resist marginalization and strive for liberation (Prilleltensky & Nelson, 2002). It’s important to note that power is viewed not only as multifaceted and omnipresent, but critical to opposing injustice (Parker, 1999; Sloan, 2000).

Moreover, critical psychology denies the premise that research is neutral and that psychologists are merely healers (Prilleltensky & Nelson, 2002). Rather, psychologists are viewed as colleagues of clients in liberation. Critical psychologists advise therapists to be trained in the following principles: tuning into multiple sources of oppression, learning to collaborate and empower clients, de-emphasizing psychopathology in assessment and treatment, strategizing, and being willing to work in natural, *in-situ* settings (Prilleltensky & Nelson, 2002). Practitioners are also advised to be attuned to how the concepts of power, well-being, oppression, and liberation play out at societal, community, familial, and individual levels. Therapeutic change, according to critical psychology, is made possible by a cyclical practice of vision-portraying inquiry, understanding of cultural contexts, exploring needs, and engaging in action (Prilleltensky & Nelson, 2002).

Clinical Contributions. ***Community Psychology.*** Community psychology is a sub-discipline of the larger discipline of psychology that, despite having started in Europe, expanded at a rapid rate in the U.S. during the 20th century. Community psychology is an action-oriented field that strives to address problems and create change in people within their community contexts (Nelson & Prilleltensky, 2005). Community psychology tends to focus on the strengths of people and communities who are surviving and prevailing despite adverse conditions, rather than focusing on individual or community deficits or problems (Rappaport, 1977). Community psychologists believe that focusing on strengths enables people to build upon their pre-existing resources, capacities, and talents (Nelson & Prilleltensky, 2005).

Community psychology seeks to promote competence and well-being through self-help, community development, and social and political action (Nelson & Prilleltensky, 2005). People are viewed as adapting to oppressive conditions as best they can, and are not to be pathologized (Nelson & Prilleltensky, 2005). Unlike traditional psychology in which the client has a passive role, community psychology assigns clients active participation, choice, and self-determination in any intervention, assuming that people know best what they need and that their active participation in bringing about change is healthy and desirable (Nelson & Prilleltensky, 2005). Community psychologists also deny the traditional role of the helper as the authoritative expert. Instead, therapists typically function as resource-collaborators, who bring their knowledge and social activism to their community work (Nelson & Prilleltensky, 2005).

Community psychologists also make extensive use of the narratives provided by members of the communities, relying especially on those produced by people who have been survived oppression by chronicling of their experiences (Nelson & Prilleltensky, 2005). Instead of reinforcing mainstream society's biased stereotypes – which Rappaport (2000) calls dominant cultural narratives - community psychology works on the premise that listening to these stories of resilience and strengths is a first step towards empowering marginalized people and disadvantaged communities and undoing damaging labels that society has constructed, such as identifying them as "those people" (Nelson & Prilleltensky, 2005). Finally, Community psychology emphasizes connecting clients with others in the community in mutually supportive and power-sharing relationships. The aim is to help the community itself regain power. Solidarity with others is viewed as a vehicle for collective resistance and social action (Moane, 2003).

Network Theory and Therapy. A social network can be defined as a group of people who maintain ongoing significant relationships with each other, and through which they fulfill specific human needs (Speck & Rueveni, 1969). A person obtains two types of essential support from within her network: emotional sustenance and instrumental aid (Greenblatt, Becerra, & Serafetinides, 1982) Social networks for most people include nucleic families, extended families, friends, work associates, and others with whom they maintain relationships. In short, social networks provide a sense of belonging.

Social network theory, or network theory, provides a framework for exploring relationships between clients' issues and their social environments as well as an appropriate approach to the study of social support (Bishop, 1984; Mueller, 1980; Tolsdorf, 1976; Wellman, 1981). Social network analysis seeks to explore "how ties between [the] people are arranged and how such arrangement influences the behavior of [the] people" (Bishop, 1984, p. 126). Social network research has typically addressed one of two perspectives: (1) the individual's manipulation of the network to achieve certain ends, or (2) the use of network characteristics to explain individual attributes (Mitchell, 1974).

In the clinical setting, network theory-based therapy approaches seek to utilize the client's network as her support system so that she can maintain her psychological and physical integrity (Greenblatt, et al., 1982). Speck and Rueveni (1977) also define network therapy as an approach that aims to solve crises by mobilizing family and friendship support systems in a collaborative fashion. In this approach, the therapy system extends its boundary to include large numbers of social network members in face-

to-face interaction (Bishop, 1984). Network therapy works to stimulate, reflect, and focus the potential within the network to solve the client's problems. Therapists attempt to strengthen or loosen bonds, open new channels, facilitate new perceptions, activate latent strengths. They also help to ventilate - excise- pathology, with an aim towards enabling the client's network to become a life-sustaining community for her (Speck & Attneave, 1971).

The practice of network therapy is closely related to many social support groups that seek to help individuals cope with crises and lead better lives despite hardships (Greenblatt, et al., 1982). These social support groups vary in constituents, the problems they try to address, and social acceptance. A few of the better-known groups include Alcoholics Anonymous, Narcotics Anonymous, Gamblers Anonymous, and Recovery Incorporated. Some of these organizations rely on more experienced members who have learned to cope with their own problems. They often asked to serve as *sponsors* for other, usually newer, members. Sponsorship is considered an essential element of twelve-step program such as Alcoholics Anonymous.

Network theory approaches have also been adopted in family therapy. One of the first to introduce social network theory into family therapy was psychiatrist, Mansell Pattison (1981). He pioneered the social network paradigm developed in social anthropology as a construct for analysis of social relationships. Pattison also presented clinical questions that arose out of applying social network theory to family therapy. Clinical results of applying network theory to medical family therapy have been reported, often in the context of addictions (Galanter, 1993; 1999). In these cases, family and friends were actively recruited and encouraged to form networks to lend support to

addicts in their journey to recovery (Galanter, 1993; Goolishian & Anderson, 1981).

Cultural Context Model – Clinical Model

According to Almeida (Almeida & Durkin, 1999; Almeida et al., 1998), the family therapy field should address historical and contemporary experiences of oppression affecting family life, including but not limited to racism, sexism, class-ism, homophobia, and colonialism. The health of an individual or family is not a closed entity and is not isolated from larger societal or global influences (Beech & Goodman, 2004). In order to address underlying issues of power, privilege, and oppression, the model uses collaborative systems theory that includes trans-generational, structural, strategic, solution-focused, feminist, narrative, and social justice therapy approaches (Parker, 2003). Community-based resilience is also emphasized as the model seeks to support a collective consciousness of healing and liberation by developing knowledge necessary to dismantle linkages of power, privilege, and oppression (Hernandez, 2003, p.2).

Intervention occurs at multiple systems levels outside and around the family system. The model deals with cultural contexts that lie at the heart of the most pressing problems in the community-based group setting - racism, gender oppression, homophobia, and class-ism. Moreover, it approaches issues with individuals and families from a multifaceted, community-based perspective that addresses gender, ethnic background, and socialization factors (Almeida et al., 1998). Sponsors are selected based on their connections with other participants both inside and outside of the on-site therapeutic setting (Almeida & Bograd, 1991).

The group – or therapeutic community – holds the memory of each member's individual story, thereby enabling collective maintenance of truth telling and

accountability. Confidentiality is viewed in a justice-promoting sense, with the individual code of silence re-interpreted as the code of oppression. The CCM is focused on raising consciousness regarding the power and privilege of men and the diminished role of women in intimate relationships. Inter-relationships of power and privilege in the historical and sociopolitical contexts of culture are emphasized. The model utilizes paradigms that are "larger and beyond" the couple system (Almeida & Durkin, 1999). As indicated earlier, the CCM was initially implemented for adults - perpetrators and victims - who had court-mandated referrals due to domestic violence, but later its use was expanded to include adults and children in the general population.

The CCM uses power and liberation as foundational concepts in the development of practicing therapy and training mental health providers. Specifically, the CCM addresses families' health by including structural and societal issues that create situations that may be unsafe, thus limiting opportunities or exacerbating conflicts for those who depend on their social location (Almeida, 1993). The model puts those issues at the core of therapeutic change and works through the intertwined ways in which discourses about gender identities, ability, class, religion, sexual orientation, and ethnicity play out in a family's life.

Process of Change in the CCM

In the CCM, the change process is viewed as comprising two broad stages of treatment facilitated by three critical change processes. The two stages of treatment are intake/socio-education and culture circles (with sponsorship or activism occurring as outcomes of change). The processes are critical consciousness, empowerment, and accountability, and they interface with the stages of the model in several ways. In the

first stage of treatment, clients' changes manifest by the development of critical consciousness through socio-education. In the second stage, empowerment and accountability are processed in culture circles. In the optional outcome stage, clients' changes contribute to the therapeutic process for themselves and others as they either become sponsors or get engaged in community activism. Throughout this process, clients (and especially sponsors) are encouraged to participate by supporting members within the community and taking leadership in community advocacy. Some examples include voter registration drives, food drives for flood victims, and testimony in legislative settings on behalf of victims' rights (Almeida, et al., 2008).

The three key change processes - *critical consciousness, accountability*, and *empowerment* - are fostered through the examination of how familial and cultural legacies shape the ways people understand, experience, and represent themselves and others. Change is also fostered and through relational safety and development of collaborative learning processes within therapeutic communities. I will provide an explanation of these processes in the following section, followed by a second section outlining the stages of treatment.

The processes of critical consciousness, empowerment, and accountability are practically implemented to effect second-order change in family systems. They are woven into the particular issues and solutions that families create in the culture circles (Almeida & Lockard, 2005). For example, in group therapy sessions, therapists might be working simultaneously with such concerns as relationship issues in parenting, addictions, domestic violence, and depression. As might be expected, clients' changes are reflected in all aspects of their relationships – couple, family, work, community. A built-in

feedback loop, facilitated by sponsors who interact with clients both inside and outside of the culture circle, aids in accountability, and serves to report changes (Almeida, 2004; Hernández, et al., 2005).

Critical Consciousness. Developing critical consciousness, i.e., awareness of personal dynamics in social and political context (Freire, 1972), is seen as an essential component of the change process in the CCM. It is considered second-order change because it alters the fundamental organization of the family system (Hernandez, et el., 2005). Critical consciousness presupposes that the causes and consequences of some clinical problems reflect political, economic, and psychological oppression. Furthermore, it is assumed that these experiences of oppression require public, institutional, and internal family process solutions. Oppression is the principle target of critical consciousness (Watts, Griffith, & Abdul-Adil, 1999) and is defined as the unjust exercise of power as well as the control of ideas and coveted resources in a way that produces and sustains social inequality (Watts, Abdul-Adil, Griffith, & Wilson, 1996).

The initial process of raising critical consciousness is centered on issues of oppression, including but not limited to institutional racism, male dominance, homophobia, capitalism, and class discrimination (Hernandez, et al., 2005). Multiple socio-educational materials are used to address the intersections of power, privilege, and oppression in personal and public life. Group discussions draw attention to the notion that although one may be oppressed in one context, that same individual may be the oppressor in another situation (Hernandez, et al., 2005). These multiple roles and levels do not manifest themselves when the focus is exclusively on racism or white supremacy. True sociopolitical development occurs only when the individual is able to integrate

experience in different power relationships into a multi-leveled understanding of oppression. Discriminative attitudes and practices such as sexism, homophobia, and other "isms" in African American communities, for example, cannot be ignored in the process of self and community development (Watts, et al., 1999). Thus, developing critical consciousness is considered the first and most important step toward empowerment and accountability (Hernandez, et al., 2005).

Empowerment. Empowerment in the CCM refers to a process of reconstruction of one's life story in such a way that acknowledges one's location in the social world in terms of gender, race, class, ethnicity, and sexual orientation (Hernandez, et al., 2005). Hernandez et al. (2005) defines empowerment as a postcolonial and liberating stance, because it expands the traditional understanding of nuclear-family dynamics to include community, and links therapeutic community conversations to social action.

Accountability. Almeida and Lockard (2005) define accountability as a fluid and relational concept that informs a way of being in relationship to others. Accountability begins with the acceptance of responsibility for one's actions and the impact of those actions upon others. It goes beyond a single act of repentance, an apology, or even complete reparation. Rather, accountability is a patterned way of relating to others that acknowledges the existence of rigid social norms, seeks to make amends for their harmful influence, and regrets any personal contribution toward maintaining the status quo of oppression (Almeida & Lockard, 2005). Accountability questions the integrity of multiple institutions that maintain and perpetuate racism, sexism, classism, and homophobia. It also illuminates the ways in which these forms of oppression are manifested in the client's personal, family situation, and other relationships (Hernandez,

2003).

Accountability moves beyond blame and guilt and results in genuine reparative actions. It also demonstrates empathic concern for others, and makes changes that enhance the quality of life for all involved parties. In addition, reparative action based on accountability takes into account the reparation-doer's level of access to resources and privileges. For example, when addressing second-shift imbalances between a middle-class heterosexual couple and a working-class heterosexual couple, the difference in economic resources will create different paths toward accountability. The middle-class male client might offer generous reparations to his wife, whereas, before being held accountable, he chose to limit full partnership with her. Reparations could include helping her cook, shop for groceries and other necessities, and arranging for childcare. On the contrary, a working-class male client might learn to invite other men into his life to help with tasks that he might be unable to afford or incapable of doing, but are essential to the wellbeing of his family. For instance, he might ask the men in his culture circle to help him tutor his young children. He might also learn to nurture his wife in ways that call for expanded norms (Appendix H; Hernandez, et al., 2005).

According to the CCM, the process of accountability is not limited to the boundary of family life; it engages conversation about the misuses of power in the public context toward people of color, people with lower socioeconomic status, and people of different sexual orientation. Through this process, clients begin to think about systems of privilege and oppression in contexts other than their intimate lives. Once their awareness has shifted, clients are encouraged to bring positive changes to the system of privilege and oppression found in the particular contexts of their lives (Almeida, et al., 2008).

Stages of Therapy. ***Initial session.*** A diagram of the treatment process in the CCM, as described in the following section, can be found in Appendix D. Initially, when a client (individual, couple, or family) comes in for an initial consultation, the client is introduced to a minimum of two therapists. At least one therapist stays in the room with the client(s) while the other therapist moves to an observation room separated by a one-way mirror. Beginning with the first interview with the client(s), there are several assessment tools utilized: a genogram is used as one of the tools to record, illustrate, and interpret family patterns, processes, and communications; wheels of power & control (Appendix E) are also used to assess the private context of abuse and misuse of power in heterosexual or lesbian/gay relationships.

Socio-education. After the initial consultation, clients join same-sex socio-education groups that convene weekly for eight weeks. The socio-education component enables clients to develop a critical consciousness around issues of gender, race, culture, and sexual orientation (Almeida, et al., 2008). Tools such as the *Traditional Norms Of The Female Role* illustration (Appendix F), *Traditional Norms Of The Male Role* illustration (Appendix G) and *Expanded Norms Of The Male Role* illustration (Appendix H), for example, are used to assess and/or raise clients' critical consciousness about social influences on gender identities and behavior (Almeida, Dolan-Del Veccchio, & Font, 1998; Font, Dolan-Del Vecchio, Almeida, 1998). In addition, a combination of video clips, books, articles, and music lyrics are presented to activate discussions that expand the understanding of clients' presenting problems.

Culture circles. Raising clients' critical consciousness occurs not only in socio-education groups, but also in small, same-sex groups called *culture circles* where there is usually a sponsor of the same gender. This way of establishing connection between client(s) and sponsors serves to mentor new clients into the process of building a critical consciousness as well as different ways of receiving therapy. After the initial eight weeks of socio-education, clients are then invited to larger culture circles; one is a same-sex group and the other is a mixed-gender group in which clients discuss the issues being presented in therapy. It is within these circles that large parts of the therapeutic intervention processes are accomplished. This type of structural intervention supports the possibility of the client system (individual, couple, or family) as an open system. Therapeutic change within this context is community-driven at multiple levels, not solely at the personal level (Almeida, et al., 2008).

The term *culture circle* used in the CCM is a borrowed term from Freire. Culture circles are heterogeneous helping communities, or groups, comprised of members of families who seek therapeutic treatment, sponsors, and a team of therapists (Almeida, et al., 2008). Healing circles practiced among Native Americans have a similar component to culture circles, where a community of people gather together to build a sense of dignity and respect for other members in the community (Vick, Smith, & Herrera, 1998). By sharing with each other, people can feel a sense of safety and healing.

Unlike these Native American healing circles, culture circles often invite a cultural consultant to facilitate therapeutic change processes for members of the therapeutic community. Cultural consultants are individuals who have a highly developed consciousness of race and gender issues, and who can offer alternative

interpretations of various religious customs and different cultural practices (Almeida, et al., 2008). They play a role similar to that of sponsors, but participate only as needed and for a more specific purpose. Cultural consultants can be police officers, clergy members, or persons of a particular race, ethnicity, or religion (Almeida, et al., 2008). At appropriate junctures of the therapeutic process, cultural consultants can provide education to clients. For example, such education may emphasize the inter-relationships of power and privilege to the historical and sociopolitical contexts of specific cultures (Almeida, et al., 2008).

The culture circle gives and receives support in a unique way, most importantly, through a form of collective accountability that allows each group member engage in his or her own behaviors and responses. For example, men who support traditional male norms are challenged by men in the group to be accountable to different norms that promotes gender equity within diverse cultures, and prescribes an ethic of caring that is relational. Therefore, change occurs through opportunities to embrace a form of masculinity which emphasizes equity for women, and expands options for men to be more relationally and emotionally ethical in their interaction with them (Almeida, et al., 2008).

Sponsorship in the CCM

As noted earlier, a potential third stage of therapy in the CCM involves contributing to the therapeutic process as a sponsor and/or as someone who engages in community advocacy and activism. Throughout this process, clients - especially those selected as sponsors - are encouraged to participate by supporting members within the community, as well as providing leadership in activities promoting social change. It is on

these efforts by the CCM that I focus the remainder of this chapter, since they are directly relevant to the research I have studied. Specifically, I will describe the role of sponsors in the CCM, how they are trained, and how their roles compare to those of sponsors in other programs.

Role of the sponsors. Sponsors are men and women invited into culture circles in different capacities who act as mentors to clients in the program. They can be graduates of the program or clients who are in the latter stages of therapy; graduate-level mental health students who serve as cultural consultants; or church or civic leaders interested in doing activist work that support non-violence relationships within their community (Almeida, 2004). Sponsors can also be individuals from within the culture circles who are former clients who have addressed their own issues in a CCM therapy program, and now want to give back to others while continuing to work on their own issues. In addition, some sponsors are people who have been asked to participate as sponsors because of their unique perspectives or expertise (Almeida, et al., 1998; Almeida, et al., 2008).

In these varied capacities, sponsors establish partnerships with clients in culture circles with the aim of mentoring a life of accountability and empowerment. They serve to break down the secrecy surrounding violence and/or oppression, expanding conversations about family life to a community process, and breaking the isolation that informs the relational choices of people with power and privilege. Sponsors model respect for people who are different from themselves (Almeida & Durkin, 1999; Almeida & Lockard, 2005). Sponsors also commit to holding each other accountable in their work with clients in culture circles as well as their relationships with each other.

Sponsor training. Training for sponsors is isomorphic to the treatment format for the CCM. There is a socio-educational component as well as a group-meeting component that mirrors the culture circle. In terms of socio-education, sponsors start with a group, consciousness-raising experience focused on the very real benefits and costs of each person's social location, the real-time impacts of social location on self and others, and the fluidity and complexity captured in each person's multiple experiences of power, privilege, and oppression (Almeida & Lockard, 2005). This exercise, along with others in the sponsors' training, is accomplished through group discussions aided by videotapes, role-plays, selected readings, and illustrations of the wheels of power and control (Appendix E). Sponsors are encouraged to express their views and ask questions about descriptors of power and control. As part of the training, discussions are structured to elicit information about the sponsors' lives and personal values, and sponsors. Sponsors are also invited to address their personal experiences of racism, sexism, classism, heterosexism, and other oppressions.

In addition to socio-education training, bi-monthly sponsors' meetings are held in which individuals may seek additional support from other sponsors and therapists to deal with particular issues around mentoring clients and/or issues within their lives. Sponsors serve one-year terms and assist in training new sponsors as their term ends; they may also commit to a new term (Almeida, et al., 2008). As they get involved with clients in the culture circles, they become an integral part of the therapeutic context.

The therapeutic staff based on the following criteria chooses prospective sponsors. They have:

(a) attended weekly, two-hour group sessions for a minimum period of nine

months, (36 sessions total)

(b) consistently kept appointments and been punctual for sessions

(c) openly and honestly participated in group discussions with other members of the community

(d) shared information about his/her own family

(e) acknowledged past use, misuse, and/or abuse of power and privilege

(f) taken responsibility for categories of power and control: physical abuse, sexual abuse, economic abuse, intimidation, isolation, triangulation of children, treats, using male privilege, and/or immigration status

(g) maintained a safe home for self and family members

(h) maintained sobriety and attended AA/NA, if needed

(i) demonstrated a willingness to resolve conflicts in a nonviolent manner

(j) written either a letter of accountability or empowerment in the context of their treatment process

(k) reached out to other sponsors and maintained contacts consistently by phone, email, or in-person communication

(l) engaged in community activities both inside and outside the therapeutic sessions

(m) offered feedback to other members in their interactions inside and/or outside of the on-site therapeutic setting.

Clients with histories of severe violence, mental illness, or heavy involvement with drugs or alcohol are excluded from becoming sponsors until they have worked on their own issues and have basic understanding of the intersections of gender, race, class,

sexual orientation, and colonization (Almeida, et al., 2008). Similar exclusion criteria are applied to male sponsors who have had major difficulties in their relationships with their partners (for example, current ongoing custody issues, recent separation or divorce, severe cutoffs with their families of origin, and/or unresolved recent loss, etc.). Other clinical judgments can be used to assess which sponsors become mentors for new clients (Almeida & Bograd, 1991) and to screen candidates based on their levels of willingness to consider alternatives, vulnerability, and respect for diversity.

Sponsors - CCM, AA and NA models. ***AA and NA models.*** As illustrated earlier, sponsorship is not unique to the CCM. Sponsors play essential roles in both the Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) programs. Sponsors in AA and NA are selected by un-sponsored individuals in the program. As a policy, sponsored persons act in accordance with the 12-step model, a set of codified procedures designed to promote abstinence, improve relationships, and inspire fundamental changes in life-style (Crape, Latkin, Laris, & Knowlton, 2002). AA and NA sponsors provide peer counseling, crisis intervention, guidance and life direction, encouragement and spiritual advice for sponsored persons going through the 12-step process (Crape, et al., 2002).

Despite dismal critiques by some health professionals (Lamb & Zusman, 1979), many sponsored individuals in other self-help groups endorse sponsorship (Crape, et al., 2002). There is evidence that having a sponsor, in addition to attending regular meetings and participating in them, correlates with an increased likelihood of successful abstinence (Caldwell & Cutter, 1998; Morgenstern, Frey, McCrady, Labouvie, & Neighbors, 1996). Some studies also found that providing help as a sponsor is a predictor of improved

psychosocial adjustments (Crape, et al., 2002). Other studies claim that sponsorship has an advantage over professional therapy because 12-step sponsors are recovering addicts and alcoholics themselves (Condelli & De Leon, 1993), which is not always true of trained helpers. It is believed that this shared experience provides for better insights into the problems particular to addicts (Condelli & De Leon, 1993).

Similarities – CCM, AA, NA. There are similarities between 12-step sponsorship and CCM sponsorship (See Table 1). The underlying principle of 12-step programs- the community-based mutual aid- is compatible with the philosophy of the social justice framework underpinning the CCM. Almeida et al. (2008) points to both the aspect of healing within a community context and the concept of sponsorship as profound strengths of 12-step recovery programs. Despite these similarities, however, notable differences also exist between social justice sponsors and 12-step sponsors (Almeida, et al., 2008).

Differences – CCM, AA, NA. The concept of power is fundamental to both the 12-step sponsors and social justice sponsors, but in significantly different ways. Twelve-step programs emphasize the overwhelming power of addiction over the recovering individual and posit that recovery cannot begin until the addict acknowledges powerlessness over his or her compulsion to use substances and/or has *fallen hard* as a result of destructive behaviors. Twelve-step sponsors seek to convince program participants to acknowledge their powerlessness over their addictions and relinquish their relationship with the substance or behavior with which they have been struggling. Fundamentally, discussions about power focus on the relationship between the addict and the source of the addiction (Almeida, et al., 2008). Concerns about power are limited to the addict-addiction source dyad.

In the CCM, **power is viewed less dyadically and more contextually**. Sponsors of the CCM, accordingly, seek to identify the ways power affects personal, social, and work relationships at every level of a person's life as the fundamental interpersonal/intergroup dynamic. Sponsors emphasize how human differences such as race, gender, class, and sexual orientation have been manipulated by the powerful to create hierarchies of privilege and oppression. Discussions on power within the CCM therapy emphasize the benefits of leveling these hierarchies and encourage action aimed at spreading equality within human relationships. A CCM sponsor supports the recovery process but also encourages accountability of the person being sponsored at multiple levels. For example, a person's addiction is not prioritized over domestic violence or child abuse, lest such prioritization dilute the accountability of the person's harmful behavior toward family members. Similarly, the addiction is not privileged as an excuse for lack of accountability for other behaviors. A CCM sponsor brings all issues into discussion in a single integrative, healing circle (Almeida, et al., 2008).

Rules of confidentiality and privacy are also handled differently in the CCM versus the 12-step model. In the CCM, sponsors encourage and participate in dialogue and inquiry that challenge abuses of power and privilege. On the other hand, 12-step sponsors would view such challenging dialogues as "cross-talk," which is discouraged in 12-step group meetings (Almeida, et al., 2008). In addition, adult CCM sponsors provide support to adults and children, individuals and families, not merely the addict.

As a rule, **male and female social justice sponsors are encouraged to work to balance the relational context of gender, race, class, and sexual orientation**, issues that are not in the domain of AA sponsorship. Unlike some 12-step programs, the CCM

does not support a rigid hierarchy between sponsors and new clients. Sponsors continue to work on their own issues in the same circles as the new clients. **This approach creates an open and flexible identity for sponsors and ensures that sponsorship does not get equated to privileged power.** In addition, in the CCM, newer members of the client community are offered **multiple sponsors**, rather than the one sponsor assigned in 12-step programs. Multiple sponsors avail themselves to the newer clients for making connections, which increases the potential for creative solutions as well as opportunities for cross-verification of sponsor interventions (Almeida, et al., 2008).

Table 1

CCM Sponsors vs. AA/NA Sponsors

	CCM	AA or NA
Similarities	Sponsors make themselves available for contact by non-sponsors, and provide guidance to non-sponsors	
Differences	a. Each non-sponsor has equal access to all sponsors b. Focuses on giving support by holding people accountable c. Multi-level power analysis d. Fluidity in hierarchy of relationship e. Sponsors held to same standards of accountability	a. Each non-sponsor primarily has access to one sponsor b. Focuses on the overwhelming power of addiction over individual c. More dyadic than contextual d. Relatively rigid "sponsor vs. non-sponsor" hierarchy e. Little public accountability held of sponsors

Research On the CCM

The CCM, as a relatively new family therapy model, does not yet have a large body of research available in family therapy literature. Most published articles on CCM and its historical development have been works authored by R. Almeida, Almeida's co-therapists at the IFS, or researchers and therapists who have gone through CCM training at the IFS (Almeida, 2004; Almeida & Bograd, 1991; Almeida, et al., 1998; Almeida, et al. 1994; Almeida & Lockard, 2005; Almeida, et al., 2007; Almeida, et al., 2008). Most of these works, although valuable as sources of knowledge about the CCM, along with its philosophies and methods, primarily deal with the theoretical and clinical components of the CCM. However, two qualitative research studies do exist that have looked at the efficacy of the CCM, and these two studies are reviewed in this section (Hernandez, et al., 2007; Parker, 2003).

Hernandez, et al. (2007) examined how therapeutic change among couples is facilitated in the CCM as practiced at the IFS. Three couples of diverse and ethnic backgrounds were investigated in this study. Two couples were heterosexual (one biracial – Latino and Caucasian – and one Jewish), and the other participant was a lesbian (Caucasian) couple. The inclusion criteria for the couples included the following: they had spent at least 12 months receiving services at the IFS, attended at least 80% of appointments, and sought out family therapy services to resolve relational issues. Data collected for the research included case summaries, phone consultations with the IFS therapists, videotaped sessions, letters, and emails. A total of 17 two-hour video tapes were analyzed by a research team of six investigators utilizing grounded theory and aspects of a consensual qualitative research methodology (Hill, Thompson, & Williams,

1997). Consensual qualitative research refers to a data analysis process where multiple investigators code the same data separately to ensure that the categories developed by each investigator are equivalent with the others and that a consensus process continues until no new additional markers for change occur (Hill, et al., 1997).

Hernandez et al. (2007) identified model-consistent narrative shifts in the therapeutic conversations in eight (8) areas: 1) questioning social beliefs of self and others, especially as related to past and current behavior; 2) understanding the impact of one's actions on others and pointing it out to them; 3) acknowledging wrongdoing and holding others accountable for change and reparative actions; 4) discussing social location issues as they pertain to involvement in the community; 5) problem-solving and advice; 6) challenging the partner; 7) supporting others in and outside the culture circle; and 8) writing and reading letters of empowerment and accountability. Of particular relevance to this study was the change process of one of the male clients who demonstrated critical consciousness by supporting other men in a manner that consistently reinforced these relational responsibilities: vulnerability, nurturing, gentleness, civic empathy, and compassion for others. This shift was observed in his role as a sponsor, since participating in this role required a level of critical consciousness that had been validated by therapists, sponsors, and other clients.

Parker (2003) studied the CCM utilizing a single case study design. This was performed to investigate how a family therapy program at the IFS addressed issues of power and privilege in therapeutic processes with families. She found making use of sponsors, gender therapy groups, and social education a fundamental and unique aspect of the CCM model as practiced at the IFS (Parker, 2003). As with Hernandez et al.

(2007), Parker (2003) collected information from multiple sources: interviews with clients, staffs, and sponsors, observation of all aspects of the program, field notes, and review of program documents. Snowball sampling was applied to recruit participants from the program, and 22 female and 13 male clients volunteered to be interviewed. The clients interviewed were from various socioeconomic and ethnic backgrounds and different sexual orientations. Likewise, they also presented diverse problems that brought them to therapy. Interviews with clinical staff and clients as well as sponsors were audio taped, transcribed, and analyzed using a computer software program (NUD.IST[1]) along with field notes. Furthermore, the researcher obtained feedback from the participants and verified descriptions, interpretations, and themes developed in the open coding process.

According to Parker (2003), sponsors broadened the base of diversity in the therapeutic program by being presented as resources in each session and serving adjunctively to ensure that new clients were integrated into and supported by the larger IFS community. They also served to level power and to reduce dependency between clients and therapists. In addition, therapeutic influence was found to be expanded as sponsors contributed to facilitating a context of accountability and support within the therapeutic encounter. On a personal level, sponsors expressed interest in giving back to the culture circle as mentors to new clients who struggled with issues of equity and nonviolence in relationships. Some also wanted to promote social justice within their own communities, or get involved with larger social advocacy projects.

[1] Non-numerical Unstructured Data Indexing, Searching and Theorizing

The Gaps in Research

As the reader will note, research on the CCM has been limited. This is largely due to its status as an emergent model, as well as philosophical positions that lend themselves more to qualitative research. In an attempt to further develop the research base on the CCM, this study is an initial effort to analyze the experiences of sponsors, specifically female sponsors. Such sponsors have a central and unique place in the CCM therapeutic model – as co-facilitators of a community-based therapeutic process, and as mentors to new female clients with whom they develop relationships reaching beyond in-session interactions. In short, these sponsors play a vital role in CCM therapy.

The significance of the role of sponsors has been discussed in a case study of the Institute for Family Services (Parker, 2003). However, no research has been conducted on the experiences of sponsorship from the perspectives of the sponsors themselves – information that could assist CCM therapists in formulating effective intervention strategies and encourage other practitioners to use the Model.

In this study, participants were limited to female sponsors for several reasons. Most significantly, I believe that it was particularly important to honor the voices of women as they are immersed in the therapeutic model that empowers their voices. To the best of my knowledge, the majority of the female sponsors have overcome - as part of their therapeutic process in CCM therapy - their own histories of oppression from the white-, heterosexual-, male-centric norms of the larger society as well as their own couple and family relationships. By giving and receiving rigorous support in the community setting of the culture circles, these women have not only prevailed over their personal hardships, but have also made significant positive impacts on the lives of their

peer sponsors and other clients.

A second and more practical reason for researching the experiences of female sponsors relates to my own experience with the CCM process, along with my observations of male and female sponsors exhibiting different ways of supporting their peer sponsors and newer clients. In many cases, male sponsors focused their efforts on stopping the violent and life-endangering behavior of newer male clients who were often abusive to their partners and children. Ending the obvious violence was the highest priority, but many newer male clients did not make sufficient positive behavioral changes in the first six to nine months of therapy. Therefore, they tended to discontinue therapy, leaving male sponsors frustrated and disappointed that they were unable to form lasting relationships with them. Female sponsors, on the other hand, appeared to be able to develop longer-lasting and richer relationships with newer female clients. This difference – and other differences I witnessed between the male and female sponsors' processes, respectively – indicates to me that the most reasonably way to manage the scope and focus of this project was to select only the female sponsors as the target population of this study. In my view, a study of the male sponsors' unique experience deserves another, separate work of research.

Due to the complexity of the CCM process and its focus on more intangible forms of change, I felt that a qualitative inquiry was the most relevant research method for understanding the female sponsorship experience, while continuing to build knowledge about this approach in a discovery-oriented study. In addition to anecdotal evidence, I had observational and participatory experience that suggested to me that the experiences of female sponsors were unique. However, to date I have not discovered one study that

specifically examined the lived experiences of female sponsors in relationship to their change processes.

Chapter 3: Location/Self Of The Researcher

I am a 44-year-old, married, Korean immigrant with a toddler, living in a suburb of Philadelphia, Pennsylvania. Economically, I am a member of the upper-middle class, yet I do not feel fully integrated into – or socially accepted by - that class. I ascribe my feelings to my identity as an immigrant of color. I was trained in the CCM for many years and had participated in CCM therapy as a supervisee to examine the intersection of race, gender, culture, class, sexual orientation, and ability. This training ultimately helped me work with clients more affectively, and gave me a framework of power, privilege, and oppression.

Before being exposed to the CCM and trained in this model at the Institute for Family Services (IFS), I had educational and professional experience in social work, with a MSW from the University of Pennsylvania. I also have many years of work experience as a clinician, and completed a multi-year, post-graduate family therapy training from the Multicultural Family Institute (MFI) in Highland Park, NJ. The latter training at the MFI provided some understanding of cultural practices from different parts of the world, as well as an appreciation of my own Korean culture and heritage. However, that training did not give me the framework of power, privilege, and oppression I needed to deal with differences among people in intimate relationships, and to address common presenting issues raised by clients, such as “communication problems.”

Asian families, particularly, have family systemic rules and practices that are strictly governed by power differences and positions of family members within the hierarchy of the extended family, which includes family members related by blood or by

law. I had noticed that therapists made the mistake, often unintended, of allowing the oppression of the powerless within family systems to continue. They were not aware that these oppressions were disguised as merely "different" cultural norms and practices. Multicultural perspectives, which did not challenge oppressive cultural practices, did not provide effective solutions for dealing with rigidity around family systems. I continued to look for answers only within family systems, not realizing the influence of larger social forces on these systems.

Then, in 1997, I attended a workshop dealing with racism entitled "Undoing Racism" given by the People's Institute of Survival and Beyond. It really opened my eyes about institutional racism and how it affects all people, especially people of color. Coming from a relatively homogeneous society of Korea - one where I had not experienced overt racial discrimination - it came as a shock to me to learn how institutional racism manifests itself in the society of the American nation in which I had chosen to live. Racism was not a common part of discussions about social issues in Korea. Therefore, to my limited understanding, it was about individual and personal prejudice or bias against African Americans and other foreigners - not a systemic oppression that insidiously takes away opportunities from people of color just because of their skin color. Until that time, I did not even think I belonged to the group "people of color," thinking Asians were somewhat of a different group who were just "different" from Whites or Blacks.

During the workshop, its leaders noted that acknowledgement of oppression toward people of color was very critical for the privileged group, i.e., Whites, in order to understand the power dynamics in society. However, it was not the place for an Asian to

be affirmed in her own struggle in this racially divided society, nor was there space to talk about it, as the workshop was geared primarily toward issues between Whites and Blacks.

Experiences with the CCM

Starting in 1998, exposure to the CCM finally provided answers to the questions I had about dealing with relational issues within and outside of family systems. I was able to use my new awareness of relational power dynamics and larger social issues to look at the intersectionality of race, gender, class, culture, and sexual orientation. Thanks to the CCM, I had a larger framework for helping clients as well as addressing personal issues.

I have also witnessed both as a supervisee and later as a practitioner of the CCM at the Affinity Counseling Group (ACG), the power of a therapeutic community for both therapists and clients. I had opportunities to collaborate with sponsors from IFS to provide family therapy at the ACG, and saw how the model saved time and energy for the therapists. As opposed to individual therapy, therapists did not have to repeat the same process over and over again, for a different individual, addressing essentially same issues with each client. Instead, while the clients were in the room together, the therapists could facilitate an intervention that would apply to all of them.

The benefits of this multiple-client approach went beyond saving time, especially for the therapists. They discovered that clients often got powerful motivation from observing how other clients responded to interventions conducted on essentially the same issues. After watching the therapists advise their clients, these other clients felt empowered to offer their own experience and insights to others who were addressing such issues as parenting, intimate partner violence, and marital problems. Transparency

of the intervention process was another advantage of this model I noted. It is a benefit for both therapists and clients. In individual or family therapy, which I had subscribed to as a therapist before I adopted the CCM, it was hard to measure progress beyond the client's self-reporting. The only opportunities for cross-verification came when other family members attended and made testimonials, but these were rare in practice. It was hard to know what happened once the client left the sessions. In CCM therapy sessions, other clients were able to witness and share any changes they observed by clients within the community, because clients were encouraged to interact in supportive ways outside of the therapy sessions. Hence, in CCM therapy, it became much clearer to both clients and therapists how each of the clients progressed in her therapy inside and outside the sessions.

Another advantage for therapists that I observed from my experience with the CCM was that the therapists also worked in a group setting and were able to cross-verify assessments and come up with intervention strategies cooperatively. Typically, most sessions had multiple therapists working in a group behind a one-way mirror. They also frequently asked for and got support from the sponsors during sessions, too. With diverse expertise, therapists supported each other to expand their knowledge base. In addition, with a more sophisticated critical consciousness, sponsors were able to give appropriate feedback to clients, and clients were often times more receptive to feedback from sponsors than from the therapists themselves.

Another core benefit to the clients that I observed was that they received support from multiple sources. Since sessions were usually longer than 45 minutes, clients were able to witness how others in the group, including sponsors, interacted with and

supported each other - without necessarily receiving direct feedback from the therapists. Clients seemed to be able to reflect on themselves and their own issues during the sessions while observing the groups' treatment of the other clients' issues. In addition, they continued giving and receiving support among each other outside of the therapeutic sessions. Thus, the total amount of time during which the clients received support seemed to far exceed the usual 45 minutes per week that traditional individual family therapy sessions offered to any one client.

Relationship to CCM and Sponsorship/Researcher Bias

Having experienced the effectiveness of the CCM therapy as a therapist and also as someone who applied its methods and principles in addressing her own personal issues, I can attest that I am a strong advocate of the CCM. I am acknowledging this fact clearly here as an important component of the self/location of the researcher.

In addition, I have always been very passionate and curious about the sponsors' experiences in this model. My personal goal in doing this research was to bring women's voices front and center in order to elevate their experiences, and use their own words to tell the world how they have been marginalized, silenced or pathologized by society. Even though some of the female sponsors had gone through life's hardships, they were nevertheless able to empower themselves and others through the support of a therapeutic community; later, they became sponsors in order to continue to give back. I would like to shine light on these stories if I can.

Chapter 4: Methods

I used a qualitative research methodology for this study on female sponsors' lived experience of sponsorship in relationship to their therapeutic change. Qualitative research is an interpretive, naturalistic approach based on distinct methodological traditions of inquiry that explore social or human phenomena (Denzin & Lincoln, 2000; Patton, 2002). This methodology attempts to obtain an in-depth understanding of human behavior, social phenomena, and the causal relationships governing them rather than obtaining statistically significant findings by looking at large, random samples (Silverman, 2005; Wolcott, 2001). The qualitative research paradigm draws on traditions rooted in anthropology and sociology, and provides an alternative to the quantitative research paradigm for exploring social science phenomena (Daly, 2007; Lincoln & Guba, 1985; Vidich & Lyman, 2000). Compared to quantitative research, qualitative research typically uses smaller - but more focused - samples with emphasis given to detailed descriptions of narratives, stories, and archival data. Qualitative research also emphasizes social context, multiple perspectives, complexity, individuated differences, circular causality, recursion, and feedback along with holistic views of systems (Denzin & Lincoln, 2000).

In the last two decades, family therapists have increasingly promoted the use of qualitative research methodology to assess, monitor, and evaluate their practices systematically (Chenail, 2005; Chenail, Somers, & Benjamin, 2009; Sprenkle & Piercy, 2005). More recently, family therapists have also started to support qualitative research

methodology to capture the full complexity of systemic phenomena inherent in the therapeutic processes and within family systems (Couture, 2007; Daly, 2007). This occurred because, increasingly, traditional research methodology derived from linear, reductionist paradigms was considered inadequate (Duffy & Chenail, 2004; 2008). For example, Singer (2005) utilized phenomenology to examine clients' experiences of the processual components of therapy, clients' perceptions of therapeutic helpfulness, and clients' descriptions of therapists' abilities to help them bring about change in their lives throughout the study. Similarly, qualitative research methodology was effective in capturing clinical clients' perceptions of therapy and the change process in multiple studies (Bohart, 2007; Gallegos, 2005; Helmke & Sprenkle, 2000; Rogers, 2003).

Based on this existent body of knowledge on the strengths and limitations of qualitative research cited above, as well as the nature of my research question, I chose a qualitative research methodology for this study. Four reasons, in particular, were important to me as I began to conceptualize the data collection and analysis components of my research design. First, qualitative methodology provided better opportunities than a quantitative methodology to examine the topic of this study, which was situated in the complex, context of multi-actor family therapy settings. Second, IFS' therapeutic approach addressed more than a single client and her interactions with her family system, therefore qualitative research methodology erected fewer constraints to describing and analyzing systemic change. Third, qualitative methodology permitted me to systematically analyze the experiences communicated through fluid and rich narratives. Finally, since there has been little research to date on sponsorship and sponsors within the CCM, learning more about these topics would require collection and analysis of

naturalistic data (Grinnell, Unrau, & Williams, 2007). Therefore, systematically examining these phenomena seemed best served utilizing a discovery-oriented, phenomenological qualitative design that allowed me to cull the essence of sponsors' lived experience of sponsorship and change from detailed descriptions of these processes. phenomenology was the qualitative method, or set of techniques, that I employed for identifying, collecting, analyzing, and interpreting data.

Phenomenology and Phenomenological Methods

Philosophy of Phenomenology

Phenomenology originated from the thinking of German philosopher and mathematician Edmund Husserl (1859-1938), and was further developed by philosophers, Heidegger, Sartre, and Merleau-Ponty (Creswell, 2007). Phenomenology influenced the development of European neo-Marxist philosophy, and later, praxis-oriented discourses and movements such as anti-colonialism (Fanon, 1963), critical pedagogy (Freire, 1972; van Manen, 1990), and post-colonialism (Said, 1978).

Phenomenology is the study of "phenomena," which phenomenology defines as that which "appears of things" or, equally, "things as they appear," in human experience. Central to a phenomenological method is the concept of *lived experience,* or the individual experiences of people as conscious human beings in relation to a specific phenomenon (Moustakas, 1994). Phenomenology studies the ways that phenomena are experienced by people who are conscious beings. Thus, in philosophical terms, phenomenology encompasses both ontology (the study of being) and epistemology (the study of knowledge and consciousness) (Larkin, Watts, & Clifton, 2006).

Husserl believed that in order to uncover meaning and essence in knowledge, one

must understand the sharp contrast that exists between facts and essences, and between the real and the non-real (Moustakas, 1994). He called for a return to that which can be experienced apart from "formal" theories and preconceived beliefs. Husserl's method was based on the premise that every day experience is a valid and fruitful source of knowledge (Singer, 2005). Husserl intended that the researcher distance herself from hidden assumptions and unquestioned interpretations of events, and obtain findings that are, to the extent possible, uncolored by her own biases (Singer, 2005).

Phenomenologists after Husserl used different and divergent philosophical arguments for the use of phenomenology. Martin Heidegger, heavily influenced by Husserl's original thoughts, articulated a transcendental method of the study of human existence in the temporal context in his seminal work *Being and Time* (Heidegger, 1962). Merleau-Ponty (1962), on the other hand, emphasized the unique role of the human body ("body subject") in the process of an individual's perception and the phenomenon of "meaning-making." Despite these and other differences, major phenomenology theorists emphasize common elements such as the study of lived experiences, the view that lived experiences are conscious experiences, and the importance of description - rather than explanation or analysis- of those experiences (Moustakas, 1994).

A phenomenological study describes the essential meaning of a lived experience as it happened for a number of persons (Creswell, 2007). "Lived experience" is an English translation of the German word *Erlebnis*. Phenomenologists use this term to indicate experience as we live through it and recognize it as a particular type of experience (Makkreel, 1992). Among early phenomenological scholars, the 19th century German philosopher and sociologist Wilhelm Dilthey used this term extensively to

demonstrate the existence of a common, shared pattern of meaning - or a certain unity - in how people experience the world (Makkreel, 1992). Dilthey asserted that language can be understood as a vast linguistic map that shows the existence of distinct, identifiable patterns, which can be interpreted as the 'essences' of human lived experiences (Dahlberg, 2006; Makkreel, 1992).

Phenomenologists seek to find a description for the way a phenomenon is experienced – one that will have meaning for each individual participant. Thus, phenomenological research is fundamentally reductionist in that it aims to reduce individual experiences to a description of an universal essence (van Manen, 1990). To this end, phenomenological researchers first identify a phenomenon, which is often interpreted as a quanta or "object" of human experience (Smith & Osborne, 2003; van Manen, 1990). Researchers then collect data from individuals who have experienced the phenomenon and devise a composite description of the essence of the experience as lived and experienced by all. Essence is described in terms of "what" persons experienced and "how" they experienced it (Giorgi & Giorgi, 2003; Moustakas, 1994). A primary tool that phenomenologists use in their quests for essence is critical and systematic self-reflection. Through it, phenomenologists attempt to identify and set aside - or bracket - any preconceptions that could color their descriptions of the participants' experiences and thus the derivation of the common essence of the phenomenon. Thus, the phenomenologist must always ask what she might be taking for granted (Singer, 2005). Broadly categorized, phenomenological research is defined by two approaches: hermeneutic or interpretive phenomenology, and transcendental or psychological phenomenology (Creswell, 2007).

Phenomenological Methods

Hermeneutical phenomenology. Hermeneutical phenomenology research is oriented toward descriptions of lived experience (phenomenology) and interpretation of the "texts" of life as stated in such descriptions (hermeneutics). Hermeneutically oriented researchers identify "abiding concerns" by reflecting on the essential themes constituting a particular lived experience (van Manen, 1990). To hermeneutically oriented researchers, phenomenology serves not only a descriptive purpose, but also an interpretive one in that the researcher draws upon her own lived experience to synthesize an interpretation of the text of her topic. Thus, the researcher is seen as someone who "mediates" different meanings of the lived experiences (van Manen, 1990). Hermeneutic phenomenology maintains that truth about a statement or phenomenon can be determined from its text. Therefore, careful reading and structured interpretation is important. In the lineage of Western philosophy, hermeneutic phenomenology is found in the works of such thinkers as Gadamer (1989) - who was Heidegger's student - and Ricœur (Simms, 2003), whose main focus was narrative identity of the human self.

Transcendental phenomenology. Transcendental or psychological phenomenology focuses less on structured interpretations of the researcher and more on the free-flowing imaginative descriptions by participants (Dahlberg, 2006). Philosophically, both Husserl and Heidegger are considered transcendental phenomenologists. Moustakas (1994) highlighted the utility of transcendental phenomenology for human and social science research. According to Moustakas (1994), to be "transcendental" means to be in a state "where everything is perceived freshly, as if for the first time."

For the purpose of this study, I chose transcendental phenomenological approach because in this study my objective is to uncover the common essence of the lived experience of sponsorship experience. This is to say that, instead of attempting to perform detailed interpretation of individual accounts, I rather strove to extract common themes from free-flowing descriptions of experiences given by many participants. Transcendental phenomenology is thus better suited to my objectives for this study.

Epoché

A central strategy in phenomenological research is that of epoché or *bracketing*. Epoché (*επoχη*) is a Greek word, which can be translated as 'age' or 'period' in English. In phenomenology, the term signifies a process of examining one's existing knowledge, assumptions, presuppositions, and opinions about the phenomenon being investigated while refraining from judgment (Moustakas, 1994). Among phenomenologists, Husserl (1973) developed the notion of "phenomenological epoché," where the world is "lost in order to be regained." Husserl's epoché provides a systematic method of suspending judgment - a way to let the phenomenon speak while the investigator is 'bracketing' the usual presuppositions that are in force in any given situation (Hut, 1999). With epoché, the investigator first steps out of the complexity of the real world, and retreats into a small controlled environment where analytic contemplation can be performed and greater insight obtained (Hut, 1999). Subsequently, that newly obtained insight can be applied by the investigator to understand her world better. Epoché is thus an attempt by the researcher to increase rigor and to gain clarity in phenomenological studies, thus reducing the impact of her own perceptions while avoiding the temptation to impose meaning too soon in the process of analysis. The process of epoché occurs throughout the entire

research project (Patton, 2002).

Bracketing

Bracketing relates to phenomenological epoché and involves dissecting and inspecting the phenomenon closely – away from its context, so that its essential constituents can be extracted and examined (Moustakas, 1994; Patton, 2002). Bracketing, unlike epoché - which can happen during any investigation of any phenomena - occurs specifically in relation to data analysis (Patton, 2002). In bracketing, the researcher suspends all belief in the real world temporarily, in order to focus on the data at hand without any pre-conceived ideas. Afterwards, those beliefs are then recovered. By *bracketing*, a phenomenologist hopes to gain a firmer grounding in her own consciousness in relation to the given data. The ultimate aim is to determine what an experience means for the persons who have had the experience and provided the data, in order to provide a comprehensive description of the experience (Moustakas, 1994), and to obtain a fresh perspective toward the phenomenon under examination (Creswell, 2007). From individual descriptions, general or universal meanings are derived, and the essences or structures of the experience emerge (Moustakas, 1994).

Bracketing in phenomenological research also means coming to know things, perceiving things as they appear, wondering about ways in which they do not appear, and then returning to the world, free of preconceptions and biases (Gearing, 2004). By bracketing, the researcher attempts to put the focus of the entire research process solely on the topic and question. Bracketing is considered the first step in "phenomenological reduction," the process of data analysis in which the researcher sets aside - as far as is humanly possible - all preconceived experiences in order to best understand the

experiences of participants in the study (Moustakas, 1994).

Research Design

The research design for this study addressed the components of research methods that would yield a methodologically consistent whole. These components included data collection and participant selection using criterion sampling, successively performed semi-structured interviews, use of multiple data sources, use of computer software for descriptive coding and cluster identification, bracketing, and trustworthiness-building measures including triangulation and peer debriefing. The following will describe in detail each of these components of my research design.

Data Collection

Recruitment. The Institute for Family Services (IFS) in Somerset, New Jersey is an agency that has implemented the CCM in its work with clients. After I secured permission from the Director to recruit at IFS for the study, she announced the study during weekly therapy sessions, and collected information on female sponsors interested in learning more about the study. After the Director submitted the list of names of potential participants to me, I had no additional contact with her about the study except for member checking toward the end of data analysis.

According to the research protocol approved by Drexel University's Institutional Review Board, I contacted potential participants individually via phone or email (Appendix J), sharing information about the study and confirming their intention to participate. I contacted each person a second time to set up an interview date. Data were collected at IFS, where sponsors attended weekly culture circles and sponsored other clients during therapy sessions. I also met with participants' at their residences when

requested.

Participant selection. Criterion sampling is a purposive sampling technique where samples are chosen according to a pre-designated criterion (Patton, 2002). This sampling technique is used in phenomenological studies where specific phenomena are explored and a systematic method is needed for selecting participants (Silverman, 2005). Criterion sampling was used for this study in order to identify context-rich cases to inform the phenomenon of interest, i.e., sponsors' perceptions of change within the CCM.

The primary inclusion criteria for the study were designation as a sponsor by IFS, and being a female. Criteria for sponsors were reviewed in Chapter 2 and are also listed in Appendix I. Women who were not IFS-designated sponsors, or had not sponsored for at least 12 months; those who were younger than 21 years old; those who had become sponsor(s) as community members or graduate students; and those who had served as cultural consultants or church or civic leaders were excluded from the study.

Another consideration for this study was sample size. Sample size in qualitative research may refer to numbers of persons interviewed, but also to numbers of interviews conducted or numbers of events sampled (Sandelowski, 1995). Different types of purposeful sampling require different minimum sample sizes. With a guiding rule of theoretical saturation (Patton, 2002), I chose a sample size that was small enough to ensure deep, case-oriented analysis and large enough to result in new and richly textured understandings of experience. Although Morse (1994) recommended a sample size of six (6) for phenomenological studies, I recruited 12 potential participants for the study. However, two dropped out: one due to concerns regarding confidentiality, and the other due to scheduling conflicts.

Consequently, ten female sponsors participated in the study. All participants were current or former clients in CCM therapy at IFS, and had been sponsoring a minimum of nine to twelve months at the time of recruitment. Initially, the inclusion criteria included completed sponsor training. However, when asked, none of the potential participants reported that they had 'completed' any formalized sponsor training. Rather, all participants had gone through sponsor training in a gradual process that had also been tightly embedded in their own therapeutic processes. In other words, rather than being formally inducted into training as sponsors, they had transitioned into the role of sponsor while actively going through their own therapeutic processes. Therefore, this inclusion criterion had to be altered in order to be congruent with the reality of becoming and being a sponsor. In addition, I was intentional in my attempts to recruit participants with diverse background in terms of race, ethnicity, education level, marital status, socioeconomic status, and presenting problems.

Informed consent and confidentiality. Before each interview, I reviewed the purpose of the study, Institutional Review Board (IRB) guidelines, and the consent process (See Appendix K). Afterwards, I obtained each interviewee's informed consent, and provided her with a copy of the consent form for her records.

Throughout this process, Dr. Tubbs was involved and informed of any changes before I moved to the next stage of research. Upon IRB approval, I checked in with Dr. Tubbs before I scheduled interviews with participants. Following the first two interviews, I contacted Dr. Tubbs again, and together, we strategized about how any changes to the interview process and guide that would enhance participants' ability to share their experience and continue to prevent any potential harm issues for participants. After the

fourth interview, we talked once more in order to ensure that I was following IRB guidelines, and that the interview protocol did not raise any concerns or questions by participants.

To ensure confidentiality and anonymity, I created a pseudonym for each participant (after each interview), and referred to her by pseudonym throughout the study. In addition, measures of confidentiality were revisited throughout the process and all research materials were kept in a locked file cabinet, in a secured room for safety. In an additional attempt to ensure confidentiality, I encrypted all material involving the participants, or findings from our interviews, before sending the material to the dissertation committee chair via email. I used WinZip (WinZip Computing, 2010), a software compression and encryption program, for this purpose.

Interviewing. ***Semi-structured interviews/Participants' drawings.*** I used a semi-structured interview guide consisting of an ordered set of interview questions to learn more about participants' experiences (Appendix M). Phenomenological data are best collected through in-depth interviews with a relatively small number of individuals describing the experience and meaning of the phenomenon of interest (Creswell, 2007). The guide was designed to elicit rich and detailed information from respondents and to facilitate discovery of their experiences related to the study. Special emphasis was given to personal accounts in order to elicit female sponsors' narratives, beliefs, and emotions about the process of therapeutic change. At least one question asked participants to engage in a drawing activity designed to provide additional detail about the participant's narrative, as well as an additional data source for triangulation (van Manen, 1990). (See Appendix O for an example drawing).

The goal of each interview was to create an atmosphere in which participants' perspectives about their experiences could unfold unscripted and unhindered (Marshall & Rossman, 2006). The interviews were structured in such a way that the diversity of participants' experiences emerged. In addition, I explored and probed other domains that participants brought up during the interviews. On some occasions, I also attempted to elicit information about experiences of sponsorship, so that participants could make those connections for themselves.

On average, each interview lasted up to two hours, and I conducted each interview in person. Seven out of the ten interviews were held at participants' home, per their requests. The remaining three interviews were held at IFS, a study room in a local public library, and a participant's workplace, respectively. Participants did not receive any monetary or nonmonetary compensation for conducting the interviews, in compliance with Institutional Review Board (IRB) approval.

All interviews were audio- and video-taped with prior consent by participants. The audio tapes were transcribed for data analysis. I personally transcribed seven interviews. A paid professional transcriber transcribed the remaining three interviews. In order to ensure the accuracy of the three transcripts produced by the hired transcriber, I compared them once again with my own audio recordings of the interviews. During the reviewing process, I noticed that the transcriber had left notes having to do with inaudible portions of the recordings, as well as places where some words were misspelled. I was able to correct the missing words using the audio recordings. Videotapes were used to back-up the audiotapes, and were referred to only when the audiotape was unclear. As it turns out, there were only two occasions when this became necessary, in order to ensure

the accuracy of one participants' speech. Participants were notified before the first interview that subsequent follow-up interviews might be required in order to ensure the accuracy of information.

Participants

Contextual data about each participant, such as age, race, ethnicity, nationality, education, income levels, and marital status, were collected using the demographic information form (Appendix L). Participant demographics are listed in Table 1.

Ten women from a very small population pool participated in the study. As developed by the Cultural Context Model, sponsorship is practiced nationally, in less than five settings. Since the identity of the participating agency, i.e. IFS, was revealed early in this manuscript, the likelihood that respondents in this study can be identified is very high. Therefore, a tension exists between reporting their demographic data in a public document and preserving confidentiality. In reconciling this conundrum, I have chosen to profile the sample as fully as possible without divulging information that might render any particular participant readily identifiable. In doing so, I acknowledge that some aspects of the demographic profile may leave the reader wanting more specificity and additional information.

Personal demographics. Participants' ages ranged from 26 to 66 with an average age of 46.3 (See Table 2). Eight participants (80%) were White; two participants were non-White (20%). Regarding marital status, three participants (30%) had never been married, two participants (20%) were currently married, and five participants (30%) were divorced. All ten participants (100%) had a minimum of a high school diploma; four participants (40%) graduated from college and six (60%) had master's or

postmaster's education. Eight participants (80%) worked in full-time employment and two participants (20%) worked part-time. When asked to identify their socioeconomic class, two participants (20%) reported being working class, seven participants (70%) as middle class, and one participant (10%) as upper class. With respect to the number of children under 18 years old living at home, six participants (60%) had none, one participant (10%) had one child, and three participants (30%) had two children under 18 years old living at home.

History with therapy. Five participants (50%) were referred to IFS through mental health providers, three participants (30%) through family court, and two participants (20%) through personal network. Regarding presenting problems, four participants (40%) stated issues related to family issues, four participants (40%) stated intimate partner violence, and two participants (20%) cited divorce.

Seven participants (70%) had previous counseling experiences. Six (60%) had received some form of formal mental health treatment, either as the only form of treatment or in combination with other forms of treatment. Modalities of treatments received included family therapy, marriage counseling, individual therapy, cognitive therapy, behavioral therapy, and group therapy. One participant (10%) had received alternative treatment, namely incense therapy, in addition to formal mental health treatment. Three participants (30%) had had no mental health treatment experience.

Each member of the sample had family members participate in their therapeutic processes at IFS. The duration of sponsorship experience at IFS ranged from two years to 19 years, with the average duration being 13.5 years. All of the participants were still active members of IFS process and continued to perform sponsorship roles.

When asked about their prior knowledge about IFS process, three participants described IFS as a place where sessions took part in a group setting, as opposed to traditionally individual therapy. Two participants had heard that the IFS's approach would involve a team concept where multiple therapists worked together with clients. They also had prior knowledge that the IFS process would deal with issues of power, control, and abuse in relationships, as well as the differences in power between women and men. This group of participants had been informed that they would go through educational sessions, called socio-ed sessions, to learn about power differentials in the society. As the reader will recall, socio-ed sessions use short media material such as TV programs and movie clips, with which some of the clients have a degree of familiarity. Clients were asked to interpret and discuss the material in relation to power differentials among gender, race, and other factors. One participant, who had been referred to IFS by her friend, had been told about the emphasis on accountability, as well as the presence of a team of therapists behind a mirror. Conversely, two participants reported no prior knowledge of the IFS approach prior to involvement.

Nine participants provided clear rationales for the individual decisions they made to continue therapy at IFS after the socio-ed phase. Four participants cited validation by the therapists, whereas three cited strong recommendations by trusted former therapists. Two participants continued because they knew they needed help, and because other people in the community shared stories similar to theirs.

Table 2

Sponsors' Demographic Information

Sample Characteristics	(N=10)	(%)
Personal Demographics		
Age		
20-45	4	40
> 46	6	60
		M = 46.3
Race		
White	8	80
Non-White	2	20
Marital status		
Never married	3	30
Married	2	20
Divorced	5	50
Years of education		
12-16	4	40
>16	6	60
		M = 17.5
Employment status		
Employed part-time	2	20
Employed full-time	8	80
Class (self-identified)		
Working class	2	20
Middle class	7	70
Upper class	1	10

Table 2 (cont.)

	Sample Characteristics	(N=10)	(%)
	# of children under 18 years old living at home		
	No children	6	60
	1 child	1	10
	2 children	3	30
History of Therapy			
	Presenting problems		
	Divorce	2	20
	Family Issues	4	40
	Intimate partner violence	4	40
	Prior mental health treatment experience		
	Formal Treatment	6	60
	Alternative Treatment	1	10
	No Treatment	3	30
	Family participation		
	Yes	10	10
	No	0	0
	Years at IFS		
	1- 15 years	7	70
	>16 years	3	30
			M = 13.5
	Number of years as sponsor		
	1-10 years	4	40
	> 11 years	6	60
			M = 10.9

Case summaries. After the each interview, I developed a case summary of each participant to enrich data sources (Miles & Huberman, 1994). The case summary profiled the participant, identifying some of her key demographic features (age, race, history of therapy before IFS, reason for coming to IFS, number of years at IFS, etc.), as well as summarizing her responses to interview questions and the interview globally. Description of each participant is given below (See Table 3).

Table 3

Case Summaries

Name	Description of participant
Patrice	Patrice is a 45 year old who has been at IFS for over 10 years. She has been a sponsor for less than 10 years. She came to IFS to deal with marital issues. In the process of dealing with marital issues, she also found ways to name and experience feelings that were threatening in the past. Prior to her experience at IFS, she had previous experience with formal therapy. For Patrice, sponsorship experience helped her learn to understand larger perspectives and their impact on her and her family system. She also learned to have more compassion and understanding of others, which she gained after becoming aware that people may behave in certain ways due to their upbringing. She has been impressed with the support she received from the community around her own family.
Ashley	Ashley is not yet 45 years old. She has been at IFS over 10 years and had been a sponsor for less than 10 years. She came to IFS to deal with marital issues. Prior to her experience at IFS, she had previous experience with formal therapy. She emphasized marking life events with others who were absent in her life before. The change process for her as a sponsor meant getting out of isolation and building connection with others in the community. Her identity as a sponsor was forged after she was strongly supported by the community during some very difficult parenting and legal battles. She felt that she started to give support that is more genuine afterwards. She used the word 'liberation' multiple times to stress the importance of supporting change in others in order to change herself. She believed her liberating change process was one on a continuum.
Jennifer	Jennifer is over 45 years old. She came to IFS to deal with intimate partner violence in the family. She has been at IFS more than 10 years and has been a sponsor for more than 10 years as well. Prior to IFS process, she did not have any formal therapy experience. She

	characterized the change processes of her own and of others she witnessed as transformative. She also said she had seen other people leaving when the real work had just begun but that she believed if people stayed and went through the process in the community they could experience transformative changes. She was articulate in describing her change process and was eager to share her experience. She talked about becoming aware of her privileges and letting others hold her accountable for her choices.
Sophia	Sophia came to IFS for family issues. She had not had any previous mental health treatment history. She has been at IFS over 10 years and has been a sponsor for over 10 years as well. As she dealt with family loyalty issues, she became involved with women in the community who supported her throughout her career advancement, building social networks, and restructuring her relationship with family members. The process of change for her was one of evolving from surviving to thriving in many areas in her life, personally and professionally. She has been involved with social activism. She believed that the IFS process instilled leadership among women and helped build self-confidence. Her hope was to continue her process at IFS not only for her and her family but also for the betterment of others.
Jessica	Jessica is over 45 years old. She came to IFS to address intimate partner violence. She had experience of formal therapy before coming to the IFS. She has been at IFS over 10 years and has been a sponsor for over 10 years, too. She believes that her sponsoring activities began in a limited capacity initially while she was still a relatively new client. She said she did not lose anything through the process but gained everything, mainly herself, new career, her business, new relationships with inside and outside of IFS community, etc. She said that she received a lot of support but sometimes it was not given in the way what she wanted. The community always held her accountable for her choices, which helped her to reflect on her actions and be more compassionate toward others. She emphasized that she learned to receive by providing support to others over time, and also that she gained more than what she gave to others.
Gwen	Gwen is in the 45 years old and older group. She said that before coming to IFS she had gone through many different formal therapy and alternative therapeutic treatment. She has been at IFS over 10 years and has been a sponsor for over 10 years. She said that she was able to gain clarity on the impact of family legacy on her emotional health. The community support has helped her sustain emotional stability and get out of victimization. She also emphasized the importance of having connections with women who have different backgrounds.
Lena	Lena is over 45 years old, has been at IFS for less than 10 years, and has been a sponsor for less than 10 years. She had received formal therapy prior to coming to IFS for family issues. She said that at IFS the therapy process involved a lot of accountability. Her critical consciousness had

	developed around her privilege and her location in the society. Lena talked about significance of marking life events with her family members through rituals and celebrations, which she had initiated a family tradition in her family.
Paige	Paige is over 45 years old. She has been at IFS over 10 years and has been a sponsor for less than 10 years. She has had experience with formal therapy prior to coming to IFS for intimate partner violence. She talked about a long process she had gone through to become independent with support of the community. She said that it took her many years before she identified herself as a sponsor. Since she had started the IFS therapy, she learned to prioritize herself and not sacrifice everything for others she looked after. She was proud of regaining emotional and physical health. She added that she continues to attend IFS as a sponsor to support newer women who might need to hear her story.
Madison	Madison is a not yet 45 years old. She has been at IFS longer than 10 years and has been a sponsor for over 10 years as well. She did not have any therapy experience prior to IFS. She came to IFS for family issues. She had witnessed many changes in herself and others over time. Because of support she had received from the community, she has been able to succeed professionally and enjoy her life. She said the interaction with the other sponsors helped her expedite her process. She would like to look out for opportunities to support others.
Jasmine	Jasmine is not yet 45 years old, and she has been a sponsor for over 10 years. She did not have experience with counseling prior to IFS. She was actively involved with social activism. She said development of critical consciousness enabled her to become close to people authentically and have more compassion toward others. She learned to consider people in their contexts and have better understanding of who they were. She has built self-confidence over time and was not afraid of asking for support from others. She was able to support her friends in difficult or abusive relationships.

Data analysis

Epoché. In order to disengage from my biases, I first localized them, primarily using free-flowing reflection. The biases I have identified were as follows: biases about the CCM, biases about female sponsors, and biases about process of participants' therapeutic change. This step of locating my own biases and being intentionally aware of them allowed me to be more conscious of questions to ask to participants in order to bring thick description of their experiences.

- Biases about CCM: I do not think CCM is the answer to solving all problems but I view it as a rather comprehensive approach in dealing with relationship issues. I also believe that CCM is effective in dealing with relationship issues because the model looks at issues in a context. I believe that other therapeutic models do help clients make changes. However, I think that they do not tend to be effective for helping participants to learn to consider the impact of their own power and privileges on people in their relationships. I also believe that my training, education, and experience as a family therapist have taught me that therapists in general do not have adequate training in looking at issues of power and privilege in relationships. Rather, I believe that therapists tend to neutralize or equalize impact of power and privilege, at the cost of people who are less privileged or more oppressed in relationships or social bearings. Even in intimate partner violence, therapists are not really trained to look at subtle forms of abuse or control in relationships unless the symptoms become outwardly obvious or extreme. I believe, however, that CCM encourages clinicians and clients to consider power relations and its influences in all relationships. I think this is necessary because power relations are embedded in all relationships. I have witnessed that some people find new consciousness on power relations to be helping them in dealing with relationships issues. However, for others, it seems that focus on power relations brought strong negative reactions, making them make choices to quit CCM therapy and stop looking at the power and privilege issues. It seems

people who are more powerful or privileged due to their skin color, gender, ability, and sexual orientation, etc, find it harder to cope with power and privilege issues.

- Biases about female sponsors: First, I had a pre-formed expectation that the participants would not be able to pinpoint the timeline of becoming sponsors. I had enough prior knowledge of CCM sponsors to know that the sponsorship process would tend to be a fluid and natural progression from receiving support to giving support within the like-minded community. I expected that many participants would not quite consider themselves as 'sponsors' of other people in the community but rather 'friends' with those people. I expected they would talk more about friendship and intimate connections. This was due to two pre-conceptions I had. The first was that since many participants had more than 10 years of sponsoring experience I thought that they would have a shared long history together in the community, and that any notion of 'formal sponsoring' may have dissipated over such long time horizons. The second preconception that led me to believe that participants would identify themselves as 'friends' rather than 'sponsors' was that female participants would tend to have relatively minimal self-confidence and self-awareness for the roles they played in social settings. In terms of sponsors' responses on their views of the relationships they had with others in the community, I expected they would answer that giving support to others was a part of their own process of looking at their issues in the relationship with others. I also expected they would say they did not expect to stop sponsoring and would

continue supporting their friends, given that more than half of the participants had more than 10 years of experience as sponsors. In answering the questions about gains and losses from CCM therapy, I expected participants to speak extensively about losses rather than gains. This was due to my belief that it is not easy to be critically consciousness and resist against mainstream influences. I expected they would say they sometimes longed for the old days when, being 'ignorant', they followed mainstream ideology and stayed in their respective comfort zones.

- Biases about change process: I expected they would say a great deal about their initial experiences of IFS process where they had to overcome resistance to sharing personal issues with complete strangers. I also expected participants to state that the IFS process would be ongoing for them even after they became sponsors and that they would continue to be engaged with the IFS process. They would sponsor long term because they would feel morally responsible to give back, and would be encouraged to feel that way by others in the community. They would also continue to be engaged because they would recognize the growth and changes they had achieved with the IFS process, and they would want to continue the path of growth and change in a healthy and positive way. I expected that participants would say there was always something to work on or to improve. I also expected participants to talk about their own accountability process to deal with their prejudices or biases around racism, sexism, classism, or homophobia, etc, as well as their experience of reparation, since I knew that in CCM reparations was

considered an important mechanism to be self-accountable and to begin to repair damaged relationships with others. I expected too that participants would talk about impact of their own changes on other members in the community, and especially on other women. I expected them to have been inspired by witnessing other members' changes, and to have been impressed (both positively and negatively) by witnessing the impact or consequences of the choices others have made. I thought the influence of positive encouragement from other women would inspire sponsors to build their self-confidence and courage to do more to help themselves and others.

Bracketing. As Creswell and Miller (2000) noted, it is critical for researchers to acknowledge and describe their beliefs and biases early in the research process to allow readers to understand their positions, and then to bracket or suspend those researcher biases as the study proceeds (Creswell & Miller, 2000). In order to perform phenomenological analysis, however, it is not sufficient to just disclose the self of the researcher. Rather, the researcher must attempt to willfully suspend her pre-existing assumptions and biases during the core phases of data analysis.

As I indicated earlier in this chapter, I used the technique of bracketing as a primary tool of my analysis. The reason for this choice was mainly related to my own location as the researcher of this study as illustrated in Chapter 3. I have been a supporter and practitioner of the CCM approach of social-justice-based therapy. Since I have strong beliefs in the effectiveness of the CCM approach, I realized that those beliefs might affect my study. In order to suspend my own beliefs and biases - and to uncover essential phenomena from the various experiences of the participants - I believed that the

use of bracketing allowed me to conduct a systemic analysis for this study.

Bracketing, as I employed it during data analysis, was an attitudinal approach I took to disengage and then re-engage the text with consciousness recognition of my own beliefs and biases. I maintained conscious effort to be cognizant of my own location and beliefs, and to be open to the risk of allowing prior beliefs to heavily influenced interpretation of the transcripts. Bracketing, for this study, also involved using a set of specific actions I carried out at different stages of the data analysis. The procedure started before the interviews, as I read the location of researcher written in Chapter 3 to remind myself of my own experience of CCM and biases toward it, and jotted down my assumptions about how the interviews would progress and what responses I expected from participants.

After the interviews, I wrote down reflections of the interviews. In addition, during the initial data analysis phase, I attempted to stay with participants' words very closely, paying attention any tendency to interpret or transcribe any words based on my prior knowledge and beliefs on CCM. As I was doing descriptive coding on the first two transcripts using MaxQDA, I made conscious efforts not to review and utilize what I had written down on the hard copy during the descriptive coding phase, to ensure I focused on capturing participants' descriptions of the lived experience of sponsorship. In order to maintain and use an 'immersed' state of consciousness that exclusively focuses on the present text while carrying out descriptive coding and initial meaning-unit extraction work, I also paused after every three to four pages to review the result of the initial coding and meaning-unit extraction work. This helped me to capture the newly occurring thoughts that surfaced during the time of the work, rather than going back to and relying

on pre-formed thoughts or feelings.

Bracketing also involved re-engaging the findings at a later stage of data analysis as I set out to synthesize higher-level topical codes. At this stage, I began to reapply my knowledge in family therapy and its languages, as well as my belief in the importance of social justice work in people's lives to synthesize the higher-level topical codes. By reapplying this knowledge, my intent was to produce topical codes that would be consistent and comprehensively representative of participants' phenomenological experiences.

Phenomenological analysis. For the current study, data analysis was preceded by preparing the transcripts of the interviews for analysis. Data clean-up involved re-reading the transcribed interviews while listening to the audio-taped versions of the interview. Any identifying information was altered or removed from transcripts to protect confidentiality. As noted earlier, each participant identified a pseudonym for use during the interview. These pseudonyms were retained for data analysis, as well as reporting in this manuscript. Transcripts were then analyzed using a modified version of phenomenological analysis outlined by Giorgi (1985). Giorgi suggested five steps for systematically reducing and analyzing data from the raw data to creating a description of the phenomenon under investigation. He identified the following steps:

1) Initial reading of the entire description or text
2) Re-reading and initial extraction of meaning units
3) Removing redundancies and clarification of meaning units
4) Linking related meaning units and obtaining essences of each of the meaning units

5) Synthesizing all surviving units to construct a consistent description of the phenomenon under investigation

Procedure. Data analysis consisted of eight steps. In my procedure, I have integrated both the use of MaxQDA - a computer-based analysis tool (VERBI Software, 2007) - and a specific implementation of the technique of phenomenological bracketing. In doing so, I applied multiple reiterations of analytical synthesis at different levels, thereby expanding step 4) and step 5) of Giorgi (1985) into two (steps #4 and #5) and three different steps (steps #6, #7, and #8), respectively, in my own procedure. My procedures also reflected the fact that I used two computer-based software tools - Microsoft Excel, and MaxQDA (VERBI Software, 2007) and also applied bracketing as an embedded component of analysis. The eight-step process proceeded as follows.

Step #1 I read each interview to obtain a sense of the whole. During this step, I created my first bracketing memo in order to practice readying myself for emergent ideas and concepts. In the memo, I reflected on my own biases as well as initial impressions and feelings that arose from the reading the interviews. I also made conscious efforts to prevent myself from interpreting from my own perspectives, but rather focused on familiarizing myself with the raw stories and specific expressions used in the text.

Step #2 I re-read the transcripts more slowly to identify recurrent or salient themes. During this step, I also conducted descriptive coding, which allowed me to discover and describe a series of meaning units from the participants' perspectives. Each speaker's (i.e., me and the interviewee) talk turns were designated as meaning units. If talk turns were lengthy, they were further

divided based on ideas or concepts. Meaning units were coded using participants' language expressions, such as phrasing, repetition, and description of meaningful actions and events in sponsorship experiences. The specific components of bracketing that I performed during this were as follows:

a. First, I tried to identify the meaning units based exclusively on participants' language rather than from any attempted personal interpretation of the text. For example, I fought the urge to interpret some of the meaning units extracted from a transparent reading of the transcripts. I had to be very conscious about staying close to the participants' words or expressions rather than relying on my own analysis or interpretation.

b. Second, I reflected on how the interviewee's narratives and emotions extracted from the text affected me and my ability to capture the meaning units. Some of the meaning units that deeply affected me during this step included words such as racism, (woman of) color, violence against women, social justice, and activism. I put them aside for further reflection in my research journal. The objective was to avoid over-weighing the meaning units that may have been biased due to my own views or experiences over those that did not affect me as much.

Step #3 Next, I created conceptual matrix (Miles & Huberman, 1994) using Microsoft Excel software to identify each participant's responses by

interview question. In this step, I also removed redundant meaning units.

Step #4 In this step, I imported the data in the conceptual matrix into MaxQDA qualitative data management software (VERBI Software, 2007). MaxQDA software displayed each participant's responses under interview questions. Using the displayed responses, I then read and annotated the data, and then grouped meaning units within and across interviews by relating some of them to others. As I reviewed text units, I created memos about questions, definitions of coding, links to other coding, or themes that were notable. This process of reading, memo taking, pruning, and grouping of the coding units within and across interviews progressed to the next step.

Step #5 In this step, I collapsed conceptually similar meaning units into broader conceptual categories (topical codes) systematically aided by MaxQDA. In this step, I also conducted the synthesizing part of bracketing, which consisted of efforts to bring back my skills and intimate knowledge of the CCM process to help the task of accurately and systematically grouping and categorizing the surviving coding units.

Step #6 I transformed the topical codes that I created in the previous step into a written document summarizing the most frequent responses to each interview question. I repeated the process of comparing these topical codes with the frequent responses to ensure the topical codes would accurately represent participants' responses with regard to their CCM-based sponsorship experiences. During this phase, new and deeper insights surfaced which helped chunking up (collapsing) topical codes to a higher

level of analytic units or themes.

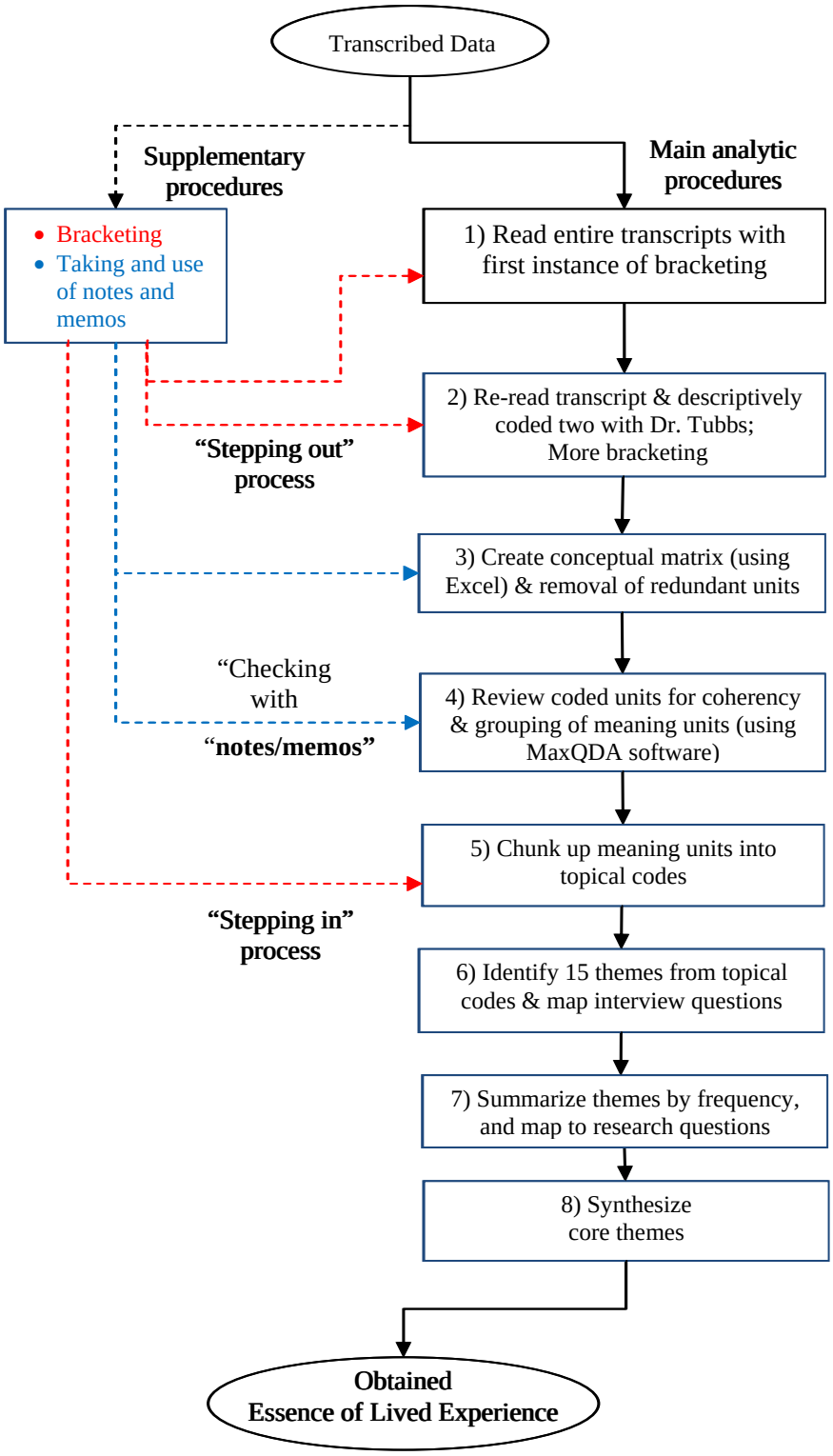
Step #7 *Responding to Research Question Based on Data*. In this step, I summarized the 15 themes based on how they seemed to respond to the interview questions (Step #6). Then, I proceeded to respond to the research question and its secondary questions, and identified the higher-level themes that answered the research questions. I wanted to ensure that the link guiding the study existed from participants' comments to my interpretation of the responses to the questions.

Step #8 *Identifying the Essence.* In this final step, I then transformed the 15 themes obtained in Step #6 (which still retained the specificity from the interview questions) into a even higher level codes (or level of interpretation) called four 'core themes'. The four core themes were synthesized in order to identify a central theme or "essence" of female sponsors lived experience of change.

Figure 1 provides a graphical summary of the eight-step analytical process I conducted. The codes and themes that emerged from this analytical process can be found in detail in Chapter 5: Findings.

Figure 1.

Data analysis process flow chart



Research memos. Throughout the course of the interviews, I created research memos, which were an important source of data in this study. Research memos in qualitative research are observational records that are detailed, non-judgmental, and concrete descriptions of what is observed (Marshall & Rossman, 2006). A memo could contain a sentence, a paragraph, or a few pages. I used the research memos not only in the data collection phase but also in the data analysis phase of the study as suggested by Marshall and Rossman (2006). They suggested keeping memos detailing the research process in order to provide analytic insights and clues to areas worthy of attention. Research memos also would help and point to places that would be more strategic for data collection or would assist in identification of questions for subsequent interviews. Some of the research memos were stored in a MaxQDA file and they were analyzed along with other data sources. I used them to capture personal and methodological information instructive to understanding sponsors' lived experiences (Miles & Huberman, 1994). I also used research memos as reminders to '*bracket*', or acknowledge and suspend my beliefs, and possible biases, and to refocus my inquiry to experiences emergent from the texts of participants. I shared and discussed these notes with my dissertation committee chair, Dr. Tubbs, who guided me to be aware of any "blind spots" throughout the course of the investigation and to ensure that I maintained a measure of reflexivity. The research memos became part of the material I used to ensure trustworthiness and rigor in the study.

Trustworthiness

Trustworthiness in qualitative research is equivalent to the concept of validity used in quantitative research (Patton, 2002). Lincoln and Guba (1985) proposed that trustworthiness of a study requires credibility, transferability, dependability, and confirmability, in order to reflect the qualitative paradigm accurately in validating research findings. Credibility or internal validity (this term is used by some phenomenologists) ensures objectivity through appropriate identification and description of the study's subject (Lincoln & Guba, 1985). Transferability determines the usefulness of research findings to others in similar situations with similar questions (Marshall & Rossman, 2006). Dependability evaluates how well research can be replicated (Marshall & Rossman, 2006). Confirmability is similar to the concept of objectivity, and seeks to discover if other findings confirm those of the study (Creswell, 2007).

Creswell and Miller (2000) proposed a number of specific validation strategies that researchers can utilize to enhance trustworthiness of their studies. They included triangulation, member checking, an audit trail, and peer debriefing. This study applied these strategies in order to ensure trustworthiness of findings.

Triangulation. Triangulation, a notion drawn from land surveying, makes use of the fact that a more accurate account can be provided when a point (or data) is described from different perspectives or angles (Malterud, 2001). The method also involves corroborating evidence from different sources to elucidate a theme or common perspective (Creswell, 2007). Leedy & Ormrod (2009) described four different types of triangulation: methodological, theoretical, investigator, and data triangulation. Methodological triangulation refers to the use of two or more data collection strategies,

whereas theoretical triangulation involves using multiple theoretical perspectives or frames of reference in considering data and findings. Investigator triangulation refers to the use of multiple sources of investigators, i.e., multiple interviewers, coders, or analysts, for data collection and analysis. Finally, data triangulation is concerned with the use of multiple data sources to verify findings.

In this study, I utilized several triangulation methodologies. First, I performed data triangulation by collecting data from a number of different sources, including interviews, drawings, case summaries, and research memos. Second, in order to effect theoretical triangulation, I considered a number of theoretical frameworks, including theories based on post colonialism, critical pedagogy, critical theory, intersectionality, various family therapy models, and the Cultural Context Model.

Third, I engaged investigator triangulation by involving Dr. Tubbs throughout the entire research process. For instance, after all the transcription was completed, Dr. Tubbs and I compared descriptive coding of the two initial interviews. We descriptively coded these transcripts in order to ensure that I was staying close to participants' language as well as being open to "seeing" aspects of the phenomenon that might not be readily evident. After the initial coding, I provided weekly updates regarding my progress on data analysis and sent updated versions of my MaxQDA project to her for review of my findings as I progressed through the steps of the analysis, except Step #1. After the 15 higher-level codes were created, Dr. Tubbs reviewed the process by which I used these codes to respond to both the interview and research questions. Several times, she asked me to go back to the data and codes for additional analyses. In addition, Dr. Tubbs, independent of my work, created a set of higher-level codes from the 15 codes I

identified. Her codes aligned closely with the four core themes I identified and influenced the eventual presentation of those themes.

Finally, I utilized data triangulation of themes by "verifying" them through member checking, research memos, case summaries, and the participants' drawings (See Appendix O for an example drawing). This step was done to examine thematic overlaps from various perspectives.

Member checking. After I completed the analysis, I interviewed two different informant groups to validate the findings from the research - a process called member checking, as suggested by Creswell (2007). The first member check occurred with participants who were willing to meet in person or receive an email about emergent themes from the study. Member checking consists of soliciting the research participants' views of the credibility of the findings and interpretations (Lincoln & Guba, 1985; Miles & Huberman, 1994). This process allowed me to ensure credibility and introduce rigor into their work. For this study, I shared themes found in the data analysis process with six participants in a second interview conducted in a group setting. The majority of participants endorsed the themes that had emerged from the data analysis process and did not wish to add anything else. One participant suggested that the dissertation emphasize the fact their connections with each other have deepened over time. She thought it was important for readers to understand the uniqueness of the IFS community and the level of intimacy and trust that develops among community members.

The second member check occurred with the IFS clinical staff. I met with them as a group to invite their input on the emergent themes from the study, especially the themes congruency with their envisioned expectations for the sponsorship process. With

this interview, I learned that the participants agreed with the emergent themes and did not have exceptions or objections to offer. I therefore determined that no additional data needed to be collected.

Additional sources of data triangulation. In addition to the triangulation strategies noted above, I utilized research memos, case summaries, and participants' drawings during data analysis in order to increase credibility of findings.

Research memos. I wrote research memos during various points of this study, including during the periods of pre-interview preparations, the interviews themselves, and the analysis phase of the study. While I was readying myself for the interviews, I wrote memos to remind myself of the questions I wanted to ask, and to help me formulate the interview processes. During the actual interviews, I wrote memos when new thoughts, impressions, or insights would come to me regarding the interview that was taking place, or others that were yet to occur. I referred to them throughout the remainder of data collection and into the analytical process (See Appendix P for an example). During the analytical phase of this study, I also wrote numerous research memos. Frankly, these memos helped keep me and my large dataset organized. The raw transcripts alone were over 400 pages long and there were more than 100 identified keywords and sub-themes initially created during the descriptive analysis. Even with the aid of computer tools such as MaxQDA, it was not easy to handle all of the data just with the text from the transcripts. Therefore, I used many short memos, primarily as visual aids to help me organize and re-organize the various patterns and themes in a recursive manner.

Case summaries. I also produced case summaries for all participants and used them for several purposes. First, I used them as a tool to familiarize myself with participants and their clinical therapeutic histories. Second, I referred to them in order to cross-check the consistency of the interview transcripts - particularly during the descriptive coding phase of the analysis. Finally, I used the case summaries to remind myself to 'step-in' to the cases with all of my prior knowledge and beliefs after the *bracketing* or *belief-suspending* phases of the analysis were over.

Participants' drawings. Each participant created a drawing as part of the interview. Some participants used them primarily as tools to remind themselves of their life histories, while others made the drawings to illustrate or clarify points when words failed to convey them effectively. Still others used vivid, colorful, and richly patterned drawings to help them emphasize points they were already clear about, but which took on new layers of meaning and importance through the aid of their lively drawings. I referred back to participants' drawings during data analysis in order to check the accuracy and applicability of their descriptions of their change processes. Some of them used straight lines to show their progression to sponsorship, but included several other lines to indicate changes on the individual and familial levels, and involvement in social activism. For example, Sophia included in her drawing a single line (representing a monotonic, undeveloped and unreflective lifestyle she had prior to IFS therapy) that then splits into many lines (representing her progress and evolution in many aspects – personal, professional, relational, etc – of her life). Using this drawing, I was able to support the finding I extracted from her interview transcript that the CCM therapy process resulted in 'transformative changes' in many aspects of her life (See Appendix O).

Audit trail. Trustworthiness in qualitative research is addressed by describing the data collection and analysis methods in enough detail to produce an "audit trail" (Lincoln & Guba, 1985) that allows replication of procedures and methods. In order to preserve an audit trail of this study, all the data were carefully preserved as prescribed by Drexel's IRB. The stored data included the following: written and printed documents, hard copies of the transcripts including the audio and video recordings of the interviews, an MS-Excel file containing the conceptual matrix, and MaxQDA files generated and used during the data analysis.

Peer debriefing. Peer review provides an external check of the research process and this reviewer may be a peer or objective individual (Creswell, 2007). Throughout the study, I was engaged in peer debriefing activities with Dr. Tubbs and fellow doctoral students who assisted me in asking questions about methods, meanings, and interpretations of findings.

Chapter 5: Findings

The purpose of this study was to understand the lived experience of sponsorship from the perspectives of female sponsors in CCM therapy and to elucidate the relationship between sponsorship and sponsors' therapeutic change processes. Toward this end, interviews with female sponsors were analyzed using a phenomenological analytical strategy. The findings described in this chapter focus on the prevalent themes that emerged from the data analysis process.

Critically-Informed Progressive Transformation

The core component, or essence, of participants' lived experiences of sponsorship and change in the CCM is *critically-informed progressive transformation*. Sponsorship moved forward (i.e., progressive) inevitably toward a specified, but not rigidly defined, end characterized by greater self-awareness and self-accountability and raised critical consciousness (i.e., critically-informed), greater relational genuineness, enhanced personal and community empowerment, and more intentionality toward building community and social justice. Critically-informed underlined the essential influence of the critical consciousness on the CCM sponsors' change process. Critical consciousness examines the self, others, and the larger society with critical, reflective perspectives. Sponsorship both facilitated and was shaped by the constantly expanding and deepening consciousness of the participants. Progressive transformation captured the process-wise, cognitive, relational, and experiential aspects of the participants' sponsorship experiences. Progressive captured *directionality* and the *temporal* aspects of participants' descriptions of the sponsorship and change experiences. It also captured a perception of the nature of

the change where the changes take place toward ultimate aims, which included liberation of the self and greater good and justice of the community and society. Transformation conveyed the outcome(s) of being involved in sponsorship within the CCM model. Even though there appeared to be no clear landmarks for transitions within the sponsorship process, sponsorship was almost synonymous with change and change was inevitable and global.

In the remainder of this chapter, I will identify the four broad themes, and their subthemes from which the core concept of critically-informed progressive transformation were culled. The four themes were: 1) continuous and embedded process, 2) critical consciousness, 3) connections in community, and 4) transformative changes. The reader should note that these themes, although indicative of data reduction on my part, are being voiced from the perspective of participants. In essence, each of the four aforementioned items could be reported with quotation marks because they are the words of participants (See Table 4), which illustrate the interpretive steps I followed from the latter parts of the descriptive coding process until identification of the phenomenological essence. These items thus provide the reader the language that I used that mirrors participants' language. For each theme and sub-theme, I will share supporting quotes based on my interviews with participants. The reader should keep in mind that participants' pseudonyms, rather than their true names, are provided.

Table 4

Clustering themes

Sub themes	Core themes	Essence
a. Process was fluid, ongoing, and embedded b. Process was marked by individual breakthroughs and critical moments c. Identity lagged behavior as a sponsor by one to three years	Continuous and embedded process	**Critically-informed Progressive Transformation**
a. Different level of understanding b. Ability to keep own life stories and issues in perspectives	Critical consciousness	
a. An evolving notion of resource sharing b. A sense of belonging in community with moral responsibility c. Changing the self by helping others d. Criticality of reaching out and across separating lines e. Connections enriching lives	Connections in community	
a. Multi-contextual change b. A process of growing, learning, and evolving c. Becoming accountable in the community d. Restructuring of relationships e. Liberation of the self f. Giving back and bringing social justice	Transformative changes	

Legend:
Fluid, evolving
Changes in me
Connection
Criticality

Continuous and embedded process. Many participants characterized sponsorship as a continuous process that was embedded in their larger therapeutic process. By continuous the participants emphasized the on-going, un-halted and long-term nature of their sponsorship experience, while by embedded they noted the integrated and almost indistinguishable aspect of the sponsorship experience in the larger process of therapeutic change. This theme included three key ideas or sub-themes about the sponsorship process and the change involved. First, the process was notably fluid, ongoing, and embedded. Second, the process has been marked by individual breakthroughs and critical moments. Third, identity as a sponsor took time to catch up with behavior as a sponsor.

Process was fluid, ongoing, and embedded. Eight participants reported that their sponsorship processes were continuous over a long-term basis, and were fluidly embedded in the larger therapeutic processes. In a way, the sponsorship process was indistinguishable from the overall, long-term, therapeutic change process for participants. None of the participants could identify any specific time or event that marked the beginning of their sponsorship status. Rather, they remembered that becoming a sponsor was a fluid process that was embedded in their own therapeutic processes. Sponsorship initially started as a request to assist or support someone in a specific situation and then began to grow in scope and context. To be sure, participants were aware of being asked to become a sponsor; but no formal point marked "becoming a sponsor."

Jasmine reflected on her transition to becoming a sponsor as one that was informal, based on behaviors already evident in her personal change work, and contextualized by in the supportiveness of various IFS group contexts.

> Becoming a sponsor isn't a formalized process. When the therapists, the team

> really at IFS… sort of sees that you are able to critically reflect on your own experiences and connect them to other people, they call upon you to be like a junior therapist person. So I think it has to do with a certain level of development and a certain level of engagement in the process. (Jasmine, Sponsor more than 10 years)

Similarly, Ashley reported that transition to sponsorship was a mostly indiscernible shift from her personal therapeutic change to being more available to help others. Her comments, as well as those of Gwen and Madison, highlight the fact that sponsorship's fluidity was steeped in the reciprocity of giving and receiving among various members of the IFS community. They experienced sponsorship as an ongoing process of giving and receiving support while continuing to make changes in their own lives. Describing this experience, Ashley (sponsor less than 10 years) said,

> So my process is… if you're calling people for support and you are making some changes that are safer for your family and maybe for yourself, all of a sudden, I felt like I had more of a ground to giving support to other women. Then that's the process of sponsorship when actually people, other clients feel secure to call you and actually help with another change process, not just call to complain or just call (laughs) to stay stuck in a situation that is not working. But to get some advice and use that advice and make some changes. The process is like… fluid… it's not linear. It's not like you get a badge and now you're a sponsor. It was very fluid.

Participants continued to make personal changes during the sponsorship process, shifting effortlessly from being mainly recipients of support to persons who could

provide support to others as well. For example, Gwen (sponsor more than 10 years), in the context of identifying one of her critical moments in her sponsorship process, shared,

> I remember that because I remember, I started to shift from receiving at IFS, also giving in the community and (the therapist) really encouraged us to reach out, to support, to give, to help the women to build a community and get out of the isolation…. So the process was very organic. It wasn't like this training program and you got like a certificate or something. It was very fluid. So it wasn't like when I became a sponsor, I stopped being sponsored by other people, so it… kind of… went both ways.

Madison (sponsor more than 10 years) also emphasized continued sharing in describing the sponsorship process.

> I think it came to a point where you do begin to realize certain patterns and certain things that are going on. You begin to hear what's going on with you. You begin to actually see what's happening… what you're doing in your patterns and in your habits. And once you begin to realize and make those changes, what I noticed was that it really helped to be able to share that with somebody else.

Sponsorship "training" was embedded in the therapeutic processes from the beginning and practiced along the way. When questioned how she was trained for and then became a sponsor, Jennifer (sponsor more than 10 years) stated, "The great thing about sponsorship here (referring to the drawing) is that even in the very beginning, there was a level of sponsorship there…."

Process was marked by individual breakthroughs and critical moments.

Although sponsorship was experienced generally as a continuous and fluid process, nine participants also remembered that the sponsorship process was marked by distinct turning points. For these participants, sponsorship took off when they experienced certain breakthroughs or critical moments. Breakthroughs occurred across a range of temporal and contextual markings, including: recognition of specific inequities brought about by discussion in socio-ed classes; times of opening up to community's support; recognition from community members or therapists for verbal or behavioral contributions; times of functioning officially as a sponsor; and sessions with family members. Critical consciousness-raising activities in socio-ed sessions and an acute realization of unacknowledged power and privilege created the type of powerful breakthrough reported by Lena (sponsor less than 10 years) and two other participants,

> The first time… that's when I started to develop critical consciousness from being in the groups, of women, and the men, and, seeing things differently, watching movie clips and realizing how someone like myself, middleclass, white woman is actually privileged. I can walk in to a bank, a grocery store, and just walk in, and, be treated, no different than anyone else, while, people of color or accent or who look different, you know….

Others remembered breakthrough moments as times when they began opening themselves up to accepting support or challenges from other sponsors in the community. For these participants, real change came about when they moved from isolation to connection in the community of accountability and started to give and receive support. This sentiment was shared by Jennifer and Jessica. Jennifer (sponsor more than 10 years)

emphasized her change to be able to receive, and not just give support.

> The more time I spent in the group, it was very hard for me to accept help. But I don't think my sponsorship really took off until I was able to accept… was more open to accepting support. Because I was always the one throughout my whole life giving support…so…what I learned in this sponsorship from the very early time is a much more balanced way of having relationship. You are giving support to others…. You are also getting support for yourself.

Jessica similarly pointed out her change in learning how to receive support from the community, but she also remarked on how she had applied what she had learned in relationships with others in a more balanced way outside of the IFS community. The breakthrough for Jessica, therefore, was that she was able to apply her newly learned ways to relate to others to broaden areas of her life. Jessica (sponsor more than 10 years), in this regard, said,

> I started to learn how to live and how to live with myself, and how to receive, and how to connect. So… all these dots are the community at IFS, trying to connect, but I still was not fully… myself… and I guess, also using who I have become, I will have the same standards for the other people in my life, so… although they are not part of the community, I created, reproduced some of that in the way I related to others.…

Some participants thought that their critical moments came while still in the beginning phase of their own change processes, when they began to receive support from other sponsors. For Ashley, it was through receiving support from her sponsors that she began to form ideas of what her own experience of sponsorship would be like, and began

to look forward to taking on the role in her community one day. For others, the reality that they had become sponsors began to sink in when they were actually functioning in that official capacity. Ashley's (sponsor less than 10 years) recollection of her initial sponsorship experience was typical:

> I just started thinking of all the kinds of support that I got there, and I really didn't consider me being a true sponsor until about 2002ish. And it was like we were in one of the community sessions and one of the team members, 'Ashley, could you sponsor in the next room?' Before that, sponsorship was more like the support that I got from people who have been through the process, you know, either there in the group or outside of the group. And then I was probably sponsoring people, not really considering myself like a sponsor. But I was definitely helping other women, we were constantly helping each other with parenting, relationship issues, work issues…

Five other participants reported similar experiences of becoming aware of being a sponsor in a more official capacity when the team asked them to sponsor newer clients or fellow community members. Participants also reported that they experienced critical moments when they received recognition from fellow community members, other sponsors, or the therapist team, for their roles and contributions as sponsors who would give support to other members of the community. External validation of their newly acquired roles as sponsors, therefore, was important. To this effect, Paige (sponsor less than 10 years) stated,

> … then continuing to come here and actually just getting stronger and feeling like I had something to offer and being recognized for that… like when even

> something as simple as the other women or one of the other counselors saying, 'That was good feedback that you gave so and so', 'I like what Paige said' that sort of thing….

Jessica's experience was similar, but she also remarked on how she was able to observe how the therapists would ask questions and facilitate the therapy sessions and use them as a frame for her own behavior as a sponsor.

> Well, it always framed my contribution as a sponsor. If I was asked certain things, when they called me in to sponsor somebody, and when the new person came in and I was just starting. The way they would ask me to share or to be part of the conversation gave me a frame to how my sponsoring was valuable or what was that I needed that was a contribution to the conversation to the other person. (Jessica, sponsor more than 10 years)

Finally, four participants identified therapy sessions with family members as the times that provided those life-changing moments. Family sessions were important to the participants not only because having an open conversation around family issues tended to have long and large impacts to participants' lives but also because participants were able to apply new insights, such as holding themselves accountable for past wrongs they had committed or confronting family members for their wrong-doings like physical or emotional abuses. Such therapeutic work conducted in a community-based environment enabled the participants to feel safe and supported, yet still ensured that they were held responsible for their past behaviors, as well as, current efforts to address past behaviors, both of their own and of the other family members. Patrice (sponsor less than 10 years), for example, stated that attending a family session with her siblings was a critical

experience for her because the community held her accountable for her past treatment of her siblings while they were growing up.

> Well… the most critical for me was when my family came in. That had the biggest impact on me, when my family came in, that's… my brother and sister told me all the things I'd done wrong to them, so… that was an eye opener.

Despite the variety of responses about critical moments, participants commonly noted that critical "moments" were temporally more similar to hours and days because they unfolded gradually.

Identity lagged behavior as a sponsor by one to three years. Another notable subtheme in participants' temporal descriptions of change was participants' tendency to behave as sponsors from early stages in their therapeutic process, yet their identities as sponsors took time to catch up to the behavior. This notion was clearly stated by six participants. In general, most participants started sponsoring in limited capacities by the end of the first year - relying on the safety of the group setting where other, more experienced sponsors and therapists were present to provide guidance and coaching. However, it took about three years for them to feel confident in giving feedback to fellow community members, especially newer clients, and to be more independent in providing support in and outside of the therapy sessions. Sophia, for example, said that most women in the community were likely to be considered sponsors after the first three years of their therapy. Jessica (sponsor more than 10 years) spoke to her shorter timeline but also the uncertainty that accompanied it.

> When I started to connect with others, I'll say it took me like a year. I mean, I guess it was so dramatic that there were pieces of me that I was able to sponsor

somebody in what I have gone through. So, that part I was sponsoring in the way of sharing my story and what I got out of my own experiences. Then I guess took me like a year to be more like a sponsor.

Critical consciousness. The second core theme that emerged from the analysis was that sponsorship, as embedded in participants' change processes, helped develop a different kind of consciousness than they previously had prior to the CCM therapy. Participants called this new awareness "critical consciousness" and recognized it as the cognitive, epistemological essence of their change process in two ways. First, it fostered a different level of understanding about self, self in relationships and broader social structures. Second, critical consciousness enhanced their ability to keep their own issues and life stories in perspective, thereby depersonalizing adversities, avoid self-victimizing, and gain strength to make changes and move forward.

Different level of understanding. Six participants reported that they gained a different level, in both depth and breadth, of understanding which gave them heightened clarity and understanding of self, others, and systems from the sponsorship process. Sponsors not only have developed critical consciousness but also have worked on their family of origin issues as part of therapeutic process, which helped them understand their behavioral patterns in relationships with others. Jasmine said sponsoring others had deepened her understanding about herself, which resulted in developing closer relationships with others. Participants also cited increased understanding of the self and its role in the family of origin as a benefit of CCM therapy.

I witnessed time and time again how that critical lens that I've learned to use as a sponsor has allowed me to see things very differently. (Jasmine, sponsor more

than 10 years)

> The most important learning is that I understood how I incorporated some of the abuse that went on in my family, passed it onto my brother and sister. I wasn't verbally or physically abusive… but I wasn't the kindest older sister. So, I understand my role. I think the biggest thing I learned is my role in the family structure and how I may have hurt others. (Patrice, sponsor less than 10 years)

Sponsoring also provided opportunities to broaden understanding of one's own issues as an instantiation of larger, common issues faced by many other people, especially women. Such expansion of cognitive scope led to concrete behavioral learning as a sponsor, too, by allowing participants to better understand the issues faced by other individuals and to support, with more clarity and effectiveness, those who presented with difficult issues. Asked about her experience as a sponsor, Gwen said,

> My experience has been that you gain a different level of understanding and perspective on… not only supporting someone else, but your own story. I think you grow in a different kind of way. You're a little detached from your own stuff, and you could support someone else. So what they're going through maybe you've been through before, and you get a meta-position on yourself and your own process. And you gain support and strength by sponsoring, and bringing somebody along, like you've been brought along by other people. I mean the powerful thing is that as a sponsor, it's not just sponsoring someone who only has the issues you have. It's sponsoring over all kinds of things, so it's been empowering to continue to deepen your understanding of the commonality of women's issues across all lines.

Two participants used terms such as meta-perspectives or meta-positions, to describe the new and broader understandings of all personal, relational, and societal issues. Participants meant, by these words, a cognitive capability to think critically, and consider issues and contexts that are related to the issue at hand but may not seem so upon superficial understanding. Meta-perspectives also suggested the ability to consider issues and context at multiple levels and layers (e.g. individual, relational, gender-wise, class-wise, community-wise, cultural, political, geopolitical, etc), and integrate this gamut of nested issues and contexts in a holistic way, such that self and "embedded self" are not lost. Meta-perspectives affected their personal and communal views. Participants noticed that they and others in the community used newly gained meta-perspectives to free themselves from victimization and to de-personalize adverse situations. Participants also noted that acquiring meta-perspectives was one of the major gains of CCM therapy. Patrice and Jennifer alluded to their meta-perspective, respectively, in the contexts of it helping de-personalize issues at hand (in Patrice's case) and in the context of gains of CCM therapy (in the case of Jennifer).

> One thing is… I don't take things so personally. I see a lot of things as a reaction to people's environment or the way they were treated. I have a broader understanding of how people act. So that gives me comfort, it gives me more patience with my family. I understand why they behave the way they do.… (Patrice, sponsor less than 10 years)
>
> Just peace of mind because the critical consciousness… I would have never been able to negotiate it because I work with many people of color, mostly women and without having this critical consciousness, I can see how I could have made total

> disaster of this job and it is really worth hang on to… It's really… has many good aspects to it …. (Jennifer, sponsor more than 10 years)

Some participants also emphasized a new awareness of power and privilege issues. Using such new awareness, participants could gain a clearer and multi-faceted understanding of personal, relational, and social issues that had affected their relationships with others in and outside of IFS community. For instance, one participant, Jennifer, said that as a result of becoming aware of power and privilege issues, she was able to develop relationships that were 'in tune with others." Specifically, she was referring to those who - because of their race, gender, sexual orientation, age, ability, culture, and class - might have less power and privilege than she does. Gaining a meta-perspective on her power and privilege changed the way Jennifer looked at the world and her relationships with others. As a result, she was able to relate to them in more respectful and broader ways. By situating herself in relation to others, and thereby expanding her understanding on her own issues, she gained new visions on her own possibilities in life. Jennifer (sponsor more than 10 years) noted significant change in her attitude in this quote,

> I… separately from myself, people that have less power than I do because of sexual orientation, race, age, or handicapped, and how I can be more... just in tuned… and more, integrated... into the world in a respectful and wholesome way. And that was something that I had never really thought about before because I was always just trying to get along with everybody. (Laugh) It didn't occur to me that that I could look at the world that way in a much broader way. So it's

> really completely changed the way that I looked at the world and my relationships, my place where I belong in the world, and what's the possibility for my life, too.

Participants also noted that interacting with others helped them gain new consciousness on issues that affect people in general, and also heal from their pasts using the new awareness. Gwen, in particular, spoke about how the sponsorship experience helped her heal from victimization and see the connection between her personal issue and larger, political issues. Here she speaks about an example from her sponsorship experience that enabled her to see the collective struggles of women everywhere:

> It's helped me take me out of myself a lot, helped me take me out just that I am the only one with these kinds of problems and it takes me out of the victimization of things to seeing the larger stories of women. And how women work in the work world, in relationships, as parents, in a patriarchy and so… it takes you… out of like… it's only you… like it's a very individual problem to more of a political perspective on things. That's one thing that I haven't mentioned yet that sponsoring… I think…has helped me become much more political in a way and seeing a lot of intersections of racism, classism, sexism, homophobia. It's helped me become much more aware of the political forces that play on people. (Gwen, sponsor more than 10 years)

Ability to keep own life stories and issues in perspectives. Seven participants also noted that they gained new understanding on personal issues through broader connections to and interactions with fellow community members, and that such understanding helped them to recall their pasts with greater clarity and keep their life stories and issues in perspectives. Examples of the interactions that helped participants to

gain new understanding included being constantly challenged to examine one's own choices in relationships and to be authentic and accountable to the choices that they had made, and to receive constant reminders of what participants wanted or did not want in their lives. Participants also thought that interaction with other community members helped them remember their history and come up with options that were healthier for self and others. Such interactions also helped participants give them new insights into distinguishing which attitudes and behaviors would be healthy versus unhealthy. To these effects, Jasmine and Paige each said,

> Every time I have a conversation with someone, no matter at what point they are, whether they are beginning as clients or have become sponsors, it just reminds me of my own story and so you know… and I just see all of these parallels in everyone's stories. And I try to keep perspective for myself as well as for them to hold that space. This is manageable, that this can be done. Like, we can come up with a plan together on how to deal with these things and go from there and really look to our own patterns of how we've coped with it before in similar situations and look for healthier options that are more successful and have more longevity. (Jasmine, sponsor more than 10 years)
>
> It's a constant reminder of what I want and what I don't want, you know, 'cause it would be really hard like… to be here, talking about healthy relationships, and watching people in unhealthy relationships trying to change, or get out of those relationships.… I have certain expectations… and those expectations remain constant. (Paige, sponsor less than 10 years)

Perspective was also important in terms of remembering that the old interactional habits

of the past did not have to determine the interactional habits and problem-solving strategies of the present. Interactions with the therapists, other sponsors, or clients at IFS helped them to put current situations and participants' life stories in perspective. Participants noted that interaction with other sponsors helped them do things or feel differently about challenges they had encountered in the past. For example, Ashley (sponsor less than 10 years) said,

> When I get stuck on something, if I'm feeling a lot of pain, or I'm feeling isolated… There is some crazy thing going on in my head, reaching out to sponsors right now is a very quick…I've got to put things in perspective, put things in their cultural context… It's a very quick … not a solution but I just know I can rely on, even if I have 5 minutes, I just need to step outside of work or wherever I am, I'm just that phone call, I know, is going to make me either do something different or feel different way… so I can do something different.

Connections in community. The third core theme that emerged from the analysis was that sponsorship and change processes of participants depended on and revolved around developing and nurturing connections in a community. Participants, as they deepened their connections with others in this community, found that they intentionally worked toward using the community as their primary support system, in both giving support and receiving support. A number of key secondary themes were found along the lines of the core theme. The five themes were: 1) an evolving notion of resource sharing, 2) a growing sense of belonging and moral responsibility within the community, 3) recognizing the importance of helping others to help self, 4) experiencing the need to reach out across racial and other separating lines within the community, and

5) recognizing that connections in the community have enriched the lives of the participants.

An evolving notion of resource sharing. One major sub-theme was that connections in the community progressed over time concomitantly with the evolution of resource sharing by the participants with other members of the community. First, participants were able to share increasingly more emotional resources with others and take better advantage of the expertise of multiple sponsors. This often led participants to develop friendships with some sponsors and become allies to others - especially the women of color in the community. Participants also shared relational resources with others in the community by participating in communal activities occurring outside of therapeutic settings, such as group social and community activities. They also shared their resources with people outside of the community as well in terms of presenting on newfound knowledge around critical consciousness or social justice. These types of resource sharing helped participants avoid isolation. Five participants noted that the evolving scope of resource sharing coincided with evolution of the sponsorship process itself. Madison spoke clearly to this issue when she noted,

> I think the way it has evolved… we do this constantly through our phone conversations, through e-mail exchanges. The way the group has now developed, we have continuous supports, so in a way, we are constantly sponsoring each other through these other mediums as well. We are in each other's life supporting each other. So it is still yet another form of sponsorship. (Madison, Sponsor more than 10 years)

A sense of belonging in community with moral responsibility. Resource sharing seemed to be a natural outflow of participants' discovered sense of moral responsibility to the people in the therapeutic community. Establishing meaningful connections with community members represented another way acknowledging a sense of moral responsibility. Describing the nature of their change process as a 'transformative' one, several participants shared that people in the community provided feedback and coached them to deal with issues in different ways, which helped them make changes in multiple dimensions. By giving and receiving support, participants were also able to break away from isolation and develop a sense of belonging in a community where they could encourage others to benefit from connection. Five participants also reported development of a sense of responsibility for helping others, as well as feelings of honor associated with being intimately involved in other people's lives. In terms of helping others, participants believed that to share their personal histories, even ones that are painful (e.g. domestic violence) or shameful (e.g. sexual abuse) to share, with other members of the community, was being morally responsible, since with such openness they could be part of the force that creates prevention and remediation of similar pains or abuses subjugating others in the community. Thus, this type of willingness to share was part of contributing as a sponsor. Jennifer and Paige make this case.

> There is lots of dimension to it. But I also developed… I think always had a kind innate sense of community in my life. I always thought it's important for my children to be connected to a broad community and for myself too, not to be isolated. I think that was just something innate… But through this process, the way I look at things is that I just see the danger of isolation and that's how I live

> my life in a community minded way…. (Jennifer, sponsor more than 10 years)
>
> I make myself available to talk to other women if they ever need it, so I'm proud of it and I feel like a little bit of a responsibility since I did that and can do this that I should do it in this world if I can. (Paige, sponsor less than 10 years)

Developing a sense of belonging and of moral responsibility were natural steps on participants' paths to self-helping changes – the focus of the next sub-theme.

Changing the self by helping others. Helping self by helping others was a sub-theme similar to a sense of moral responsibility around belonging, but it was expressed more in the language of benefits and pragmatism rather than the language of moral obligations. Seven participants agreed that the sponsorship experience helped them look at their own issues with clarity and gave them opportunities to work on them. The parallel process of sponsoring others while working on one's own issues also helped participants to see commonalities between theirs and others' struggles. Endorsing the idea that sponsorship provided them with opportunities to help others, which in turn aided self-help, Jessica summarized this idea.

> When I am the sponsor doing that, what it does also, it just helps me process my own… things, too. So it's just like I'm helping somebody else and also am helping me. And then, by working on their processing, it's moving my own process. And most of the time, it's more what I get than what I give. Like most of the time, after I have the conversation, and by sharing and by the questions that I get and I feel like I give something but I think that in my own process, I'm getting more than what I'm giving. (Jessica, sponsor more than 10 years)

Madison voiced a similar sentiment when she compared sponsorship to the instructive power of teaching. Being required to teach others forces the teacher to learn well that which she teaches.

> My experience with sponsorship… I think the best analogy is almost like when you're teaching, you learn so much more because you are talking about things. So it sort of like… when I would be with Angela, she would tell me something, and I would be like, 'Oh my goodness!' When hearing it from somebody else, I can see the thing that I tend to do, and how frustrating, and how wrong, and how destructive it is. So I would feel that not only was I like trying to help somebody else but in listening to it, I was also helping myself. And seeing something else that would have been much harder for me to realize, if I was just taking it in from somebody. So actually, thinking it out and talking to somebody helped me with my own process. (Madison, sponsor over 10 years)

Sophia gave perhaps the most succinct description of the parallelism in helping others and helping the self when she said, "everybody's problems are your problems." She thought that helping others gave her both an opportunity to move out of both isolation and victimization and thus helping herself, but also to support others while making genuine connections with fellow community members.

> There's going to be something that parallels, whatever, whoever you have contact with as a sponsor. It will parallel something you have to deal with, it helps you so much to grapple… to not disassociate yourself (from) other people's problems because you think, 'Oh, you'll never, you know, how does it benefit me?' But

staying connected to other people's problems, they are your problems, too. Everybody's problems are your problems, too.

Sophia's poignant comment punctuated not only the reciprocity of resource sharing and support, but also the isomorphism of issues occurring at both the sponsored and sponsorship levels. Accounts such as these indicated that helping others allowed sponsors to relate to struggles of others and reflect more objectively and authentically on their own situations. By observing and identifying with others while trying to help them as sponsors, participants were able to develop empathy for and connections with fellow members in the community. Five participants reported that issues became clearer to them when they observe similar issues in others and they also experienced less resistance in making necessary changes.

Criticality of reaching out and across separating lines. Participating sponsors also reported experiencing breakthroughs when they reached out and across separating lines, such as racial and class lines, to support fellow community members in their times of critical needs. Gwen, for example, elaborated on a defining moment that occurred when she reached out to support a fellow community member from a different socioeconomic and family background than her own. The event was critical for her because she was confronted with someone experiencing her privileged and powerful – ways in which she had not thought about nor experienced herself. Similarly, another participant, Jennifer, shared that her critical moment came when she reached out to a woman of color in the community who was going through a difficult situation. In making steps toward crossing structural boundaries, Jennifer recalls the tension between her responsibility as a sponsor and the new territory that she was exploring as a white woman

seeking to use privilege in a different way. Gwen and Jennifer provide exemplar comments.

> I think that the defining moment for me was becoming friends with Margaret and sponsoring her and supporting her, especially around that time when she was writing letters to the police to be protected for herself. And I think that was a really important thing for me to break down my own classism as well, and to be open to someone else's experience…. So I remember that being very important and powerful for me. I remember Margaret said to me once 'I didn't really even know you and I thought you were this… white, a highly educated… sort of stuck up woman. (Laugh) You have nothing in common with me… it was very generous of you to open your heart and support me.' And that I think deepened our friendship from that moment on. I do remember that specifically.... (Gwen, sponsor more than 10 years).
>
> … And I accompanied her as an ally? A White ally? For many different things, I spent time with her and I went with her to support her in her process where she was supporting her children, strategizing and also reporting… And she had (a) very critical situation so that was a big thing for me because it was my role as a White woman and ally to a woman of color and really in a huge crisis… so that was a big turning point for me. (Jennifer, sponsor more than 10 years)

It is interesting to note that Jennifer used the word *ally* while going through her experience of reaching out and supporting a woman of color. By applying newly acquired critical consciousness on her own white privileges, she leveled her own position in relation to the other woman and acted as a supporting partner rather than as a person

who acts from a superior position. This also showed the influence of the post-colonial approach of CCM. The significance of 'reaching out and across' was that it helped participants break away from a societal norm that dissuades people from different racial and/or class backgrounds from crossing dividing lines and making social connections. The community provided opportunities for people from unequal backgrounds to meet and to interact as sponsors and the sponsored in a multi-cultural and multi-racial group.

Five participants ascribed their ability to reach out and across to critical consciousness and the community-based accountability they received from developing connections in the CCM therapeutic community. Using these processes as self-regulating mechanisms, participants were able to reach out to others from different backgrounds, and give and receive support in ways that were authentic, pragmatic, and fair. A white sponsor, for example, could become an ally and advocate of a less privileged woman of color, using her privileged means and social positions. In return, the sponsored woman of color would give her white sponsor the rare gift of growing in humility while becoming an agent of social change. Likewise, a sponsor of color could give support to a white sponsored person not only by helping her with her own personal issues but also by holding her accountable for her white privilege. In return, sponsoring a white woman would give the sponsor of color a chance to come into her own sense of power and to use it for the social good – in other words, to bring about change that is not abusive or privileged. The gist of this theme was that the community and the sponsoring relationships within it allowed people in different social locations to become authentically vulnerable with each other while giving and receiving support.

Connections enriching lives. The final sub-theme under connections in community was that the connections in the community have enriched the participants' lives immensely. This sub-theme became apparent from an analysis of the gains and losses that participants had experienced within their sponsorship experiences. Eight participants cited examples of being enriched through new friendships and relationships, achieving more colorful or richer life experiences, and being able to exchange authentic challenges to hold each other accountable and thereby exchanging genuine supports. In this context, Ashley (sponsor less than 10 years) said,

> So… the gains are… I can be connected on a different level… on levels that I never thought I could before… I mean… really a lifeline like a new family. My family is in (State in west coast) and they act the way they do, but here I'm in this therapeutic community. We become friends outside of the process, so it's like I really gained a lot of friendships. And people with all kinds of different backgrounds, skills, interests, just like my life went from black and white to color….

Ashley used a metaphor, 'my life went from black and white to color,' which represents the experiences of many sponsors who developed deeper connections – some even used the term friendships – within the safety of the community over time. With their interactions supported by a process of community-based accountability, participants representing traditionally marginalized groups felt safe processing their issues and seeking support from people who had more power and privileges in the community. They were able to challenge others and hold them accountable, while at the same time building trust and developing connections. This dynamic was also true with issues of

power and privilege, because participants were able to build authentic connections with others while maintaining respect and integrity. These relationships were very different from what society offered, i.e., superficial relationships with 'friends' from various backgrounds who did not question the impacts of unbalanced power and privilege on the authenticity of their relationships. Connections between sponsors based on public accountability evolved, and relationships developed with fellow members enriched their lives.

Transformative changes. In foregoing sections of this chapter, I have described three core themes of the sponsorship experience. They were continuous and ongoing change process, critical consciousness, and connections in community. If continuity and embedded nature of the change process captured the process-wise aspect of the experience, and critical consciousness and connections in community broadly represented the cognitive and behavioral aspects of sponsorship experience, then one could ask what would be a component of the change process that may capture the consequential and concluding aspect of the change process. This section describes the fourth, and last, core theme of the analysis: transformative changes.

In studies on change, researchers are careful to avoid exaggerating their findings by using words such as 'transformative'. They fear that unfiltered use of such words indicate a pre-existing bias toward exaggerating the therapeutic impacts of the particular therapy modality being investigated. Therefore, explanation of the choice of the term 'transformative' in my analytical finding may be warranted. Now, one would expect cognitive shifts or behavioral transitions to be outcomes of any self-description of a person's change process. However, the incredulity and awe with which participants

described their change processes in the sponsorship experience warranted the sense of profound, qualitative metamorphoses that the participants' choice of the word 'transformative' implied. Clearly, participants wanted their descriptions to convey a sense of extraordinary change, some of which they themselves had never anticipated to achieve or witness.

The reader is also advised here that I have identified a relatively large number (six) of related subthemes under the umbrella of the current core theme of transformative changes. The first subtheme, in fact, related directly to the large scope and contextual breadth of the testimonials and the conceptual categories identified from the testimonials. It also represented the very diverse and multi-faceted nature of the changes that participants experienced throughout their sponsorship experience. Thus, the first subtheme of 'transformative changes' was multi-contextual change. Besides this first subtheme, I extracted five additional sub-themes, each of which represented an analytical axis in describing the broad contexts and levels of changes that participants expressed of having experienced. These remaining subthemes were 1) process of growing, learning, and evolving; 2) becoming accountable in the community; 3) restructuring of relationships; 4) liberation of the self; and 5) sharing changes by giving back and bringing social justice.

Multi-contextual change. The gist of this subtheme was that participants experienced their change processes as being multi-contextual, with multiple layers, aspects, and contexts accompanying the experience of the changes. This characterization applied to both individual accounts of experience as well as the cumulative accounts from the entire ten-participant sample group. First, the participants had varied answers

regarding where and how in their therapeutic journeys the characterization of 'transformative changes' applied. For example, two participants thought the sponsorship experience was transformative in terms of the impact on the overall change processes, while three participants viewed their CCM therapeutic process as a whole was transformative. Participants' answers also varied in terms of the textual contexts where they applied the characterization of transformative changes. Six participants applied this characterization in terms of 'the language that best describes experience of the CCM therapy', while others applied the characterization with respect to 'impact of sponsorship', 'relationships with others', and 'gains and losses'. There was variety of answers on whose changes were characterized as transformative, too. On this, five participants noticed such changes primarily in their own processes, while three participants felt that their change processes mirrored the transformative changes they had witnessed in others.

There was also variety in the areas or aspects of the participants' lives where respondents have experienced transformative changes. Respondents offered diverse examples in many facets of their lives, spanning personal, professional, relational, and societal dimensions. In referring to transformative changes in personal lives, participants cited examples of profound changes in more education (two participants) and learning of newer skills such as better parenting skills (three participant), growth in cognitive and/or empathic capabilities (six participant), and professional advancements (three participants). One participant said that she was able to come out to her family and friends with her sexual orientation, while another participant, Madison, stated that she was thriving in different areas in life.

Due to the breadth and variety of the topics on which participants associated

transformative changes and impacts, ‘transformative changes’ became a lexical umbrella for a number of relatively loosely connected ideas or subthemes. The various and multi-faceted subthemes, therefore, warrant their own, detailed elaborations, which are provided in the subsequent subsections.

A process of growing, learning, and evolving. The second major sub-theme that emerged about transformative changes was that the participants’ change processes led to profound growth, learning, and evolution. In particular, participants felt that they grew and learned immensely by helping others, and experienced great gratification, from doing so. The rewards included feelings of goodness, happiness, joy, confidence, being valued, being empowered, and being enriched. From sponsoring experience, participants had been exposed to various issues presented by other fellow community members individually and in the culture circles, they had learned to explore different options collaboratively. Sophia, in this regard, explained her process as follows:

> It gives you a chance to grow and learn, too, about how to give, how to help a person, and help them so that they hear it and they could do something with it, but it’s hard, too, at times.

Participants also felt that learning new skills had a transformative effect on their change process. Sophia, for example, said,

> Being in the women’s, the culture circle was so helpful to me like… I remember it was like going to a spa every time I go there because I can say to myself now that was really odd… like I was really odd, socially odd back then but… everybody is so accepting and they help you with social skills and stuff….

Another participant, Jennifer (sponsor more than 10 years), described her change process as one of growth and moving forward as a result of interacting with the other community members.

> It always helps my process grow and move forward…. I mean you might imagine yourself just being constantly surprised and enlightened. I just feel very open to the way other people look at life and how they take life… the other sponsors are just such courageous, amazing women that I just feel so honored to be a part of them. And they have incredible wisdom, so I think it just helps me to think in a more expanded way. I find myself constantly processing…. I think that's just what happens….

Five participants offered their opinions of the broad scope of growth that they witnessed during their processes at IFS. One of these participants, Gwen (sponsor more than 10 years), said,

> I… feel that I have changed in terms of my emotional health, I've gone on to have two children on my own and found the strength and resilience to do that, which I never would have done if I did not have the support of the process of the community. I've seen every single person go back to school… change their lives. Some people started in different places. Many women were victims of domestic violence but have gone on to completely liberated lives. Gaining power individually, financially, and emotionally….Every single person I've know has literally transformed in a way I've never seen in any therapy process.

For others, the scope of transformation was more bounded, but no less profound. Perhaps unsurprisingly, the most cited area of transformation for participants was in the

area of personal relationships. As evident in Jennifer's (sponsor more than 10 years) comment, shifts in relationships marked the most transformed aspect of their changed lives, She said,

> I think it's completely transformative. Because I really had never been in a therapeutic process before this and I couldn't even really think in terms of any sense of autonomy basically. I was always thinking in terms of how events or everything would affect other people. I was in very controlling relationships. I have never had time to think about myself, what I wanted or needed. I was worried about everyone else's needs. So for me, it's been complete, really complete transformation. I have a much clear sense of myself, who I am in the world, how to relate to others, how to negotiate relationships not only on personal level with family and close friends but also, in society… in general, in my work place. And basically this process… it just helps me make sense of the world because I don't feel intimidated by any system. It's also helped me learn how to depersonalize and detach. So it's just completely transformed my whole personal process.

Changes occurred on professional levels, too. Five respondents cited career advancements and obtaining higher education. Sophia mentioned specific progress in her career after obtaining an advance degree while going through the change process. She said,

> I got my (advanced degree)… and again I would've never gotten my (advanced degree), none of this stuff would've happened, had I not been at IFS. And I see the privilege, I mean, it's… basically almost doubled my salary, from before I got

my (advanced degree), and it's unbelievable the access that I have…

Participants also emphasized growth in their empathic abilities, and cited examples such as becoming more compassionate, patient, and nurturing toward self and others. Such growth in empathy helped participants to accept people as they were and move forward with them. Madison and Jasmine shared,

> I'm able to pull back and be a little more compassionate and just give it more time and be more patient. (Madison, sponsor more than 10 years)
>
> I think a lot of the other women in this process… a different type of compassion when we're engaging with our co-workers or when we're engaging with our bosses. When we're engaging with people in the streets, their stories might be like the stories of the woman that we know and so I think it's given all of us a different lens to sort of see this world. And understand that there's more to someone just being rude or irate that we can have a lot of compassion for them…. (Jasmine, sponsor more than 10 years)

Participants also reported that sponsorship had a transformative impact by helping them become better supporters of people in general. For these participants, what they had learned from the sponsorship experience enabled them to see people from different angles and relate to them more authentically. Two examples follow.

> There is a positive side to that because I'm able to see things in people's lives and be able to support people even at work, my colleague… struggling with her boss and I was giving her just some support like I know somebody would give me.... (Gwen, sponsor more than 10 years)
>
> It affects in many ways, one is that I'm always looking at it in that angle from…

> ‘Okay! Well, what’s going on here?’ In an analytical way, which is as an expert, but then also, with the help of other people, I’m also able to see that to be more compassionate to think on a different level. (Madison, sponsor more than 10 years)

The transformative effect of the sponsorship process also helped participants grow their abilities to face challenges *outside* of therapy, developing their inner strengths to defend themselves from oppressive environments while also building self-confidence. In this regard, Patrice (sponsor less than 10 years), for example, said,

> I think I have wisdom in dealing with people outside of IFS. I also understand more about patriarchy and male control and that gives me some insights in dealing with my part-time jobs, or in the past, if something happened, I sometimes just didn't like it, but now I can put my finger on exactly what it was. So it gives me understanding… and I don't want to say that I just accept it. I know what it is… I can verbalize all the things that come to you from the outside.

Further, for some participants, the changes meant learning to live their lives truly connected to other people. Ashley (sponsor less than 10 years), for example, said,

> I guess for me, it was just sort of get over myself… not sharing or not making the call to get help, or not giving back, sort of living in a little bubble… like I was in suburbia. That was like a killing, like literally just eroding me, physically, spiritually, and emotionally. I’m so sort of get over that, just open up, and really live life with people.

Finally, in the context of explaining her personal growth as a lasting change from CCM therapy process, one participant, Jessica (sponsor more than 10 years), also noted that

humbleness was the word that captured the essence of her experience. She said, "Humbleness, to be humble. Sponsorship is not about telling them how to, but about being with the person and sharing and processing together. That I think it's the most important experience, for me."

As I have described in detail in the above, six participants identified their sponsorship process as one of growing, learning, and evolving. Participants also commonly reported that as they strengthened their connections in the community, not only did they receive support for struggles in life, but they also learned from observing other people struggling with their own issues. New insights on latent issues also emerged when participants observed and listened to others' stories in the community, which helped them deal with and make necessary changes before hidden issues became bigger and more serious.

Becoming accountable in the community. Self-accountability, promoted by sponsorship, was the third sub-theme that emerged. In fact, participants learned not only to hold themselves accountable for their personal integrity, but also to help others in the community with their own accountability issues. Accountability was thus extended outside of personal domains and processed within the community where constructive feedback and support could be given and accepted. The group-wise accountability-holding process was viewed critical to ensure integrity on all sides, and to help the community to collectively maintain memories of people's choices and actions, and their consequences and impacts to others for better remembrance of the contexts.

> Really encouraging people and myself to not victimize about their circumstances and instead really see opportunities for change towards what they perceive to be is

> better than what they have now. And so I think staying out of that victimization is what allows the change to occur. And so the accountability piece is really huge and when I say the accountability piece, I mean the piece that something doesn't just happen to you, but you have a hand in it in some way and if you don't have a hand in it some way, that's okay too. But what circumstances led that event to happen and then from there, what choices can you make? So it's a way of inserting powerful experience to something that would otherwise feel very disempowering, very hopeless, and very doom and gloom. So I think that staying out of that victimization also means that you are the designer of your own life and you get to make choices for your own self. (Jasmine, sponsor more than 10 years)

The accountability process was thus experienced as an inherent, embedded component of the CCM change process. It was accepted that personal empowerment comes with genuine accountability on a social/public scale. This was a point of departure for social-justice based therapy compared to traditional therapy context where accountability is usually defined and applied in a much more limited context of both scale (limited to personal or couples relationships) and extent (limited to 'making apologies', rather than following up with practically meaningful reparations). On the other hand, the CCM sponsors participating in this study reported that their sponsorship processes involved giving and receiving challenges, and following up on them with collective memory and reparations within the community.

Restructuring of relationships. The fourth sub-theme of transformative change focused on restructuring relationships in profound ways. For the first time, participants were able to set limits with people in their couple, familial, and other social relationships.

For instance, three participants reported that they learned to not have family cutoffs and maintain relationships based on self-respect. Participants learned to set limits by applying newly acquired insights into action or by witnessing examples of other people's experiences. Different options of setting limits were explored in the community and participants exchanged ideas on how to maintain relationships that were difficult to manage in the past without support from the community.

Restructured relationships also meant new friendships and communities. In the process of re-organizing friendships and support networks, participants learned to mark life events with others through rituals or celebrations. Two participants specifically mentioned the importance of learning to mark life events with others in a community level, which they mentioned as ways of transforming negative life events to positives ones. They marked typical celebrated events, like birthdays; however, other events became significant for them to acknowledge publicly too. For example, Lena and Ashley shared,

> I see people working on their relationships…and knowing how to enter a situation that 10 years ago, they would have avoided it or it would have been ended up a fight, a family fight, and now people go in… they get through it… they maintain that connection. (Lena, sponsor less than 10 years)
>
> I have seen relationships, marriages take a break, a separation, and then gotten back together with a new set of ground rules that was more equal or equitable, more intimate, and closer. (Ashley, sponsor less than 10 years)

Sometimes restructuring relationships took the shape of rituals or celebration that had not existed previously. For example, Lena said,

> These little things that make us change. I've never had traditions and holidays. I've never really acknowledge them. Now when it's my child's birthday, we will sit around the table. I had everyone give the story of my son. I didn't realize how important traditions are, how important rituals are, how they just fill you up. I think passing that along to my children, and to my sisters, it sounds like a little change but it's really a big change.

To some participants, the changes they made to existing relationships or existing ways of relating to other people were felt as losses, and came with some pain. Sometimes making transformative change also meant that new limits had to be set, behavioral patterns had to be altered, old relationships had to be ended, and damaging family legacies had to be left behind.

> So the losses.... I would say those relationships that weren't working for me anyway. I've dated several people, and of course lost them for good reason. But I lost the way that I used to be, which is actually like a…a piece of clothing that didn't work anymore. So it's a good… it's a good kind of loss. (Ashley, sponsor less than 10 years)

Jasmine, while acknowledging the loss of losing connections with people she once were close to, also looked at the positive aspect of such losses, and said,

> But I think you grow beyond people, so if people aren't growing in the same way, it's okay not be connected with them so I think it has given me that perspective, like, it's okay to move on with friendships.

Experiences such as Jasmine's are examples of change in which clients are not only relieved of their symptoms, but make changes in the systems in which they are involved.

Participants reported that restructuring of relationships occurred as they obtained critical consciousness of the consequences of un-restructured relationships, and sought and received support of the community. Turning towards their communities provided participants with emotional sanctuaries, sustaining them through the difficult process of restructuring their relationships.

Liberation of the self. Six participants reported that they experienced the sponsorship and change processes as those of self-liberation. They further noted that self-liberating actions they took were possible because of the help they received from the community. Participants who took specific steps to liberate themselves from oppression or abuse further noted that taking such steps were the critical moments in their change processes. One participant, Paige (sponsor less than 10 years), for example, was able to walk out on an abusive marriage with support from the community. She said,

> I mean I have to go back to the beginning with getting out of the abusive marriage. I mean that was first… that was first. Sustaining that because getting out wasn't a one night deal. It was… it was a process.

Another participant, Jasmine (sponsor more than 10 years), reported that one of her critical moment of self-liberation occurred when she wrote a letter to her father.

> I think the first time I wrote a letter to my father was a huge one, huge, huge, huge! Because it got me out of this place of victimization. It really put me into a place where I was actively engaging those thoughts and processes and in a way that a lot of other participants needed to do as well for themselves. And so I feel like that really put me in this launch position to be feeling confident about my choices, feeling good about the way that I see my life story that it is accurate.

Participants also associated the liberating aspect of their change with the sense of empowerment and fulfillment, which to them was beyond just a sense of healing. Jennifer (sponsor more than 10 years), for example, said,

> I am not interested in fluff or dramatics…but really being present in life and I went from a place where I was just barely surviving to a place where I feel I am really thriving in the full sense of the word. I am happy (Laugh). I have personal happiness and it's a sense of fulfillment, the healing but also fulfillment, it's just very empowering, very, very profound, very empowering.

Similarly, musing on an enlivened, liberated state of being as a result of CCM therapy, Jessica shared,

> When I started with IFS, I was like listening to my head, listening to myself that a lot of things happened. But basically what my life is now, my life is me. I want to live, I want to have, and I want to create, and succeed, I want to love, and I want to be around. I like myself, that's the biggest thing. I didn't like who I was. Now, I like myself. I'm proud of me. And I'm happy to be with others. I feel like I contribute to others. I have others contribute to me. So it's really like, very organic.

Some participants felt that their first steps toward liberation were taken when they began to confront challenges in public spheres and as part of their practice of social justice. Attending anti-war demonstrations and picketing in front of the office of a medical doctor who allegedly had practiced unethical treatment of women were some of the specific examples cited. One of the participants who participated in activism, Sophia said,

> The other critical point in my development was when I was told I was an activist, I was like, 'I'm an activist?' So, that was an interesting thing. And then another critical part was actually instead of reading about things, learning from my mistakes personally, and actually going out, and doing something, and taking a risk to do something like anti-war demonstration. And I never in a million years would've thought I would do something like that. And then actually doing it, to go through the process of doing it, and taking action. And then, when we went down to a number of times and we actually would do public displays, when you took your politics publicly, showed, did something, not just anti-war activism, but like any time I did something publicly, we went down to the state, and presented to the state on trial, trying to activate them to really protect children and it was like, 'Wow!' Every single time, every single time I did that, actually engaged a public entity with our critical consciousness, that has been mind blowing to see how we interface., stuff like that has always brought me to another level of my sponsorship and critical consciousness.

Participants also noted that one's own liberation would only be complete when one helped to liberate others. Ashley (sponsor less than 10 years), in this context, said,

> And one other thing that my life… my empowerment or my liberation is really connected to liberating others… You can't just do the other and like… not take care of yourself and just help somebody else, and you can't... like… not in this world. So there is no separation in that… so, that is really important.

Giving back and bringing social justice. Giving to others and promoting social justice constituted the final sub-theme of transformative changes. Overwhelmingly, nine participants reported that their sponsoring experiences had inspired them with a sense of moral obligation to give back. Participants also thought that an essential meaning of the sponsorship and the larger CCM change process was that the participants would make efforts to promote social justice into their communities. After completing therapeutic work around personal issues, participants were ready to take steps to change larger systems.

Referring to the moral dimension of giving back, Patrice and Jennifer, respectively, said, "For me, it's a sense of giving back. That's very nice feeling of giving back. Then the other thing too is it is a learning experience. It is a learning experience. You can learn from everybody." (Patrice, sponsor less than 10 years)

> I think that we have a moral obligation… a mission… moral obligation to share what we know. We need to pass it on, or what the heck is the use? And I think that I really feel like it makes a difference. It helps to ease some suffering and promotes some healing. (Jennifer, sponsor more than 10 years)

Referring to the process-wise shift from focusing on therapeutic work around personal issues to expanding contribution to give back, Sophia (sponsor more than 10 years), stated,

> It has big meaning in my life that you have come to a certain level of critical consciousness that you can give back to others. I think it means that you're committed to this new morality of like fairness and equity. You're trying to work towards that and trying to bring it to others and that's I think, that's what it means

> to me. Being a sponsor is really… you're trying to use your critical consciousness, to take actions and help others, become more aware of power analysis, and to bring about fairness, equity in society.

Additional Findings

In addition to above mentioned major findings, two additional themes emerged from the data analysis including: 1) perceptions of therapy within the CCM; 2) impact on family members.

Perceptions of CCM therapy. Two important perceptions of the CCM became salient in the analysis of the data. First, participants underscored the differences between the CCM therapy and their previous experiences with therapy. Second, participants punctuated that which worked for participants in CCM therapy. Two major characteristics distinguished CCM-based therapy from prior mental health treatments: 1) the giving and receiving of support among the group members of the IFS therapeutic community, and 2) an accountability process built into the therapeutic process. With respect to the support provided by the IFS therapeutic community, Sophia noted,

> I'm always helped to go forward instead of backwards. This whole notion of 'I'm not there just speaking to a… a therapist by myself, and like I just go home and then, you know, I have no connection to anything else….

Another difference noted was the accountability process embedded into the therapy process. Lena (sponsor less than 10 years), in this context, said, "I got the help… I needed but for the most part… it's the accountability. They don't really take no for an answer. It's a big difference…very big difference…." Lena's experience had been one where she received support but at the same time was challenged by fellow community

members regarding her choices.

I also asked participants to tell me about the aspects of CCM that worked for them. Analysis of the responses revealed three main findings: 1) connecting to people in the community, 2) gaining meta-perspectives, and 3) witnessing men challenging other men. On the first finding, connecting to people in the community, this finding's key seemed to be participants' initial struggle with, and progressive appreciation of, diversity within the community. Participants reported making connections at different levels of intensity and connecting to people from different backgrounds, as well as connecting in novel contexts, such as group-wide celebrations and ritual-informed gatherings. These findings indicated that participants found it challenging yet rewarding, and educational to experience new types of connections with people from disparate backgrounds. Identifying connections in community to be the factor that worked for her from CCM therapy, Lena said,

> What parts of the IFS therapy? I like seeing new people come in and watching them change. I like watching people evolve and I also like finding out about myself by listening to other stories and… from the other stories. It's a very close knitted community… everybody knows me, and they care, and I can't get away with anything, and I am challenged…

Ashley (sponsor less than 10 years), on the other hand, emphasized a different aspect of the community, by singling out the group-wide celebrations and rituals when asked what worked for her. She said,

> Celebrating…marking things that are really important. Like a…when I lost a really hard… court battle with my ex, I… I had a pizza party to celebrate, and I had lost so much but I had gained a lot too. So I had a pizza party with everybody

> and that felt good. Like celebrations, things you should really mark that I never used to do.

During the member checking, the staff at IFS also stressed the importance of clients' marking life events through celebrations and rituals among community members. They believe this practice of communal marking and celebrations of life altering events helped build lasting coalitions around liberation (Personal communication, February 21, 2010). During the interview, sponsors reported that learning about marking life events through rituals and celebrations brought deeper connections with people inside and outside of the community.

The second aspect of the CCM process that worked was gaining broad and systemic perspectives on the self, relationships, and larger societal systems. As I explained earlier in the description of the second core theme (critical consciousness), sponsoring experiences allowed participants to perceive issues with clarity, objectivity, and broadened perspectives. Patrice's and Paige's comment capture the essence of this perspective.

> Yes! In a sense that it puts in… into a broader context. You don't… feel that everything is on you. You feel that there is a system out there, family systems. And there is a certain amount of comfort knowing that, why things happen.… I think understanding… the issues coming from a dysfunctional, alcoholic family and how that impacts your choices and what it does to the family systems.... (Patrice, sponsor less than 10 years)
>
> There's so many things, so, this isn't necessarily in order of importance but one big thing is seeing other women who have been in the same situation as me and

> realizing that it is the domestic violence, control, and abuse… our situation… marriage…. (Paige, sponsor less than 10 years)

Paige was able to discuss her situation with other women, and gain some objectivity on her marriage, which she was not able to achieve in marriage counseling prior to attending IFS treatment.

The third finding on what worked for the participants was the ability to witness people with greater power and privilege, particularly men, being challenged, and held accountable by the community. By observing these kinds of reactions in a supportive community setting, participants were able to identify these issues in their own lives and relationships. More importantly, they were able to start making necessary changes in their views and behaviors. Paige (sponsor less than 10 years), for example, said,

> Another thing that was powerful in the beginning for me was seeing… hearing other men challenge him on the way that he was acting. That never happened, like other men in my family never did that. This was powerful for me….

Paige shared that seeing men publicly challenge her ex-husband about domestic violence issues helped her think about her marriage and start taking steps to protect herself.

Impact on family members. When participants were answered questions on who noticed their changes and who were affected the most by the changes, they shared that the family members were those who noticed the changes the most and also those who were the most affected by the changes.

Family members noticed the changes the most. Family members - parents, partners, children, or siblings - were mentioned the most often when participants were asked who had noticed the changes in their attitudes and behavior. People outside the

immediate family, but when participants' immediate spheres of influence, were the second most frequently mentioned "audiences" to their change, i.e., relatives, co-workers, or friends outside of IFS community. Participants often heard remarks mostly from close family members; but occasionally they heard comments that indicated others had noticed a difference in the way participants were acting.

> Certainly, my family, the people I work with definitely noticed! The people that old friends that I had from years ago that I reconnect with. They've told me…they just experience me in a different way. So I think… everybody can notice. (Jennifer, sponsor more than 10 years)

Family members were the people who were affected by change the most too. As might be expected, family members were the people who were affected most profoundly by participants' change processes, followed by sponsors and clients. People who were close to participants, like partners and children, were considered most affected by participants' change processes among the family members. Moreover, two participants could not help but notice that they themselves had changed the most. Ashley (sponsor less than 10 years) said,

> Me, my (children)…, and that… my friend… my other sponsors, too….

Likewise referring to the impact on her family members, Jessica (sponsor more than 10 years) shared,

> My brother. My brother had the most transformation from my shares. One of my aunt… I'm saying like outside that has been my brother because of the work that I've done at IFS with my family and my parents. And then I think a lot of people at IFS has received a lot from my sponsorship and not only directly, the way I'll

share what I say and the way I… kind of blow wind under the wings. I think that's… very powerful.

Summary of the Chapter – Critically-informed Progressive Transformation

This chapter provided a synthesis of the findings on the experiences of the participants as a group. Through phenomenological analysis explained in Chapter 4: Methods, I developed the following four core themes, which best describe the essence of sponsorship experience.

1. Continuous and embedded process
2. Critical consciousness
3. Connections in community
4. Transformative changes

Looking within and between these core themes, I developed the final finding of this chapter. *Critically-informed progressive transformation* was the essence of the lived experience of the CCM female sponsors.

Chapter 6: Discussion and Implications

This study examined the sponsorship experiences reported by female sponsors within a relatively new family therapy model, the Cultural Context Model (CCM). The study utilized a phenomenological methodology to invite and analyze female sponsors' accounts of experiences of therapeutic change in CCM therapy. In order to reach its objective, this study analyzed participants' accounts through progressive levels of interpretation in order to identify the essence of the sponsorship and change processes.

As described in detail in Chapter 5, the findings from my study suggest that the essence of participants' lived experiences of sponsorship and change in the CCM is *critically-informed progressive transformation*. This essence was supported by four core themes: 1) continuous and embedded process, 2) critical consciousness, 3) connections in community, and 4) transformative changes. Each of the core themes was supported by several subthemes.

This final chapter will first present and map connections between the core findings and the research questions of this study. Then, I will discuss my findings, focusing on comparison with the findings from previous research in the transtheoretical model (Prochaska, 1999), second-order change model in systemic family therapy (Nichols, 2008; Becvar & Becvar, 2008), community psychology (Nelson & Prilleltensky, 2005), and CCM (Hernandez, et al, 2005; Almeida, et al, 2008). Next, I will discuss the significance and implications of the study, for use in the CCM and in the field of couples and family therapy. That will be followed by a discussion of the study's limitations and suggestions for further research. Finally, I present a brief conclusion.

As indicated in Chapter 1, the primary research question of this study was: *What is the lived experience of female sponsors engaged in the therapeutic change process promoted by CCM?* The following secondary questions were considered and integrated into the interview questions and the analysis framework:

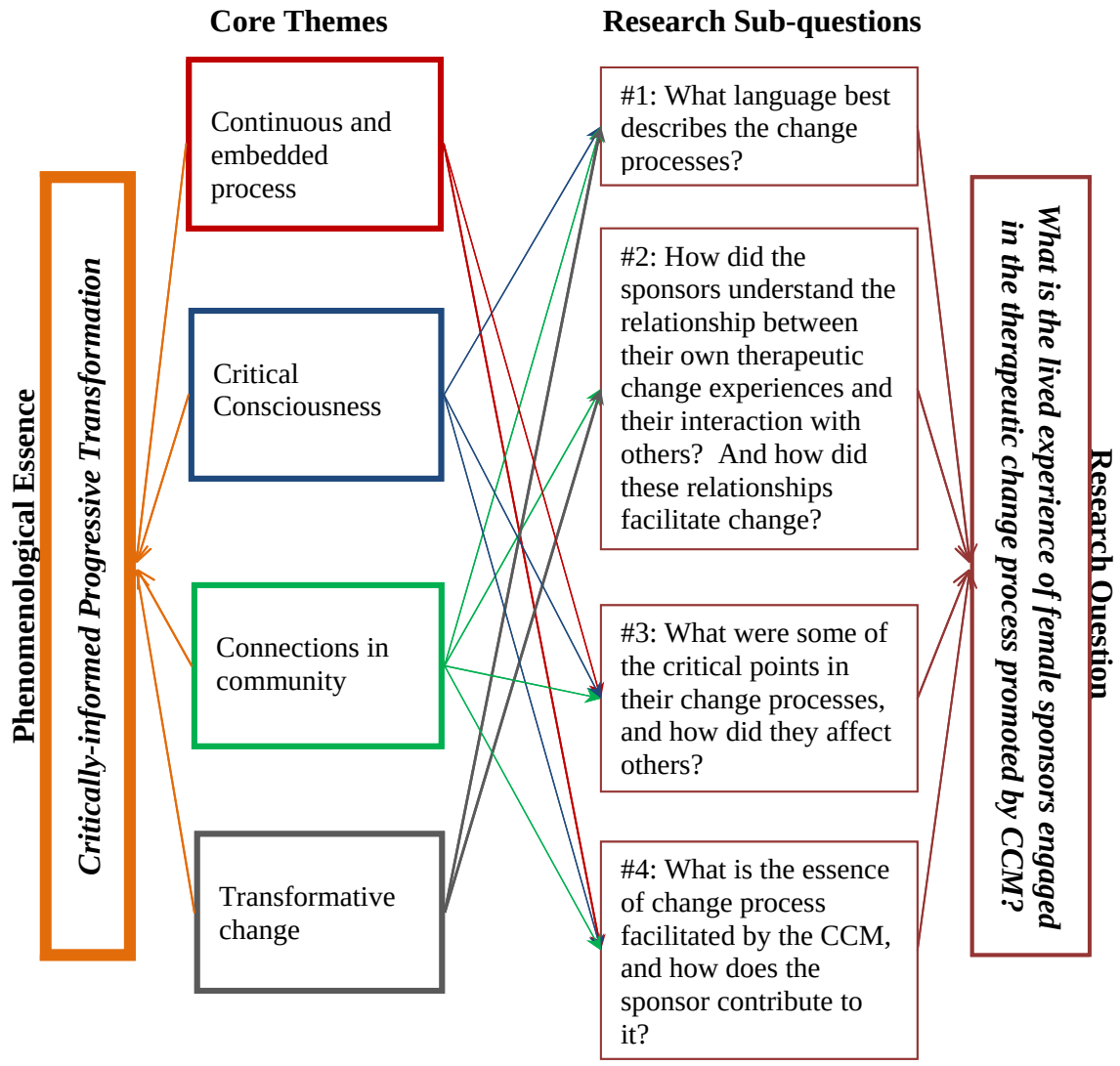
1) What language best describes the change processes?
2) How did the sponsors understand the relationship between their own therapeutic change experiences and their interaction with therapists, other sponsors, and clients? And how did these relationships facilitate change?
3) What were some of the critical points in their change processes, and how did they affect others?
4) What is the essence of the change process facilitated by the CCM, and how does the sponsor contribute to it?

Critically-informed progressive transformation emerged as the core aspect, or essence, of sponsorship for participants. The essence was supported by four core themes of analysis: 1) continuous and embedded process, 2) critical consciousness, 3) connections in community, and 4) transformative changes.

Core themes were not only essential in creating the essence of the sponsorship experience, but they were also critical to answering the research questions in a multi-faceted, integrated manner. That is, the ultimate research question on the essence of the lived experience for female sponsors was answerable only by integrating all of the core themes and their constituent sub-themes in a holistic manner. Figure 2 serves as a graphical map of the core themes' functions in creating the essence, as well as, answering the study's research questions.

Figure 2:

Mapping between research questions and findings



In the following sections, I provide a brief discussion of the essence of the sponsorship experience, first describing the essence, and then contrasting it with what the literature on phenomenological research suggests for findings on investigated essences. I discuss the findings in greater detail, organizing the discussion section according to the

four core themes described above. For each core theme, I first present a discussion of each core theme and how it corresponds to one or more of the research questions. Then I present an analysis of the core theme in comparison to findings from the literature.

The Essence – Critically-Informed Progressive Transformation

The essence of participants' lived experiences of sponsorship and change in the CCM is *critically-informed progressive transformation*. "Critically-informed" underlined participants' development and use of critical consciousness during their sponsorship experience. Critical consciousness examined the self, others, and the larger societies with critical, reflective perspectives. "Critically-informed" captured two aspects of critical consciousness. First, it identified participants' critical cognitive abilities improved continuously with directionality. Secondly, "critically-informed" also signaled that developing critical consciousness shaped and enabled further and deeper changes in participants.

The term "progressive" captured multiple dimensions of meaning and experience, specifically the process-wise (directional, temporal) aspects of the participants' sponsorship experiences. The *process* of sponsorship moved *forward*. One notable finding, as I described in Chapter 5, is that participants experienced sponsorship as a process whose overall direction was forward, but not linear. That is, it reflected a great deal of recursion and dialectical movement. The movement was circuitous, not always predictable, and in many cases slowed or even regressed; but in the end, each of the slowing and apparently regressing motions resulted in greater understanding and empowerment via the help of the community. Ultimately, therefore, the movement was inevitably toward a specified, but not rigidly-defined end characterized by not only greater self-awareness and accountability, raised consciousness, and personal empowerment, but also greater relational genuineness, liberation

and empowerment of others, and intentionality toward building community and social justice. Progressive thus also captured a sense of concerns that are larger than individual or personal, i.e., the community.

"Transformation" underlined the transcendental and consequential aspects, i.e., the outcome(s), of the CCM therapy. It signified states of beings, and processes toward such states, where changes were indisputably metamorphic. It also captured the sense of awe and incredulity that participants felt upon systematically remembering and re-interpreting their processes with the aid of the interviews.

van Manen (1997) asserts that the aim of phenomenological data analysis is to "transform lived experience into a textual expression of its essence – in such a way that the effect of the text is at once a reflexive re-living and a reflective appropriation of something meaningful" (p.36). According to Moustakas (1994), the findings of phenomenological research should be simple and straightforward. This is to ensure that readers who may have experienced the same phenomenon may be able to analyze their own reality with the findings. I believe that this study's finding on the essence meets this criterion well. It would be hard, I would argue, for anyone to characterize critically-informed, progressive transformation as ambiguous or confusing.

The essence of the phenomenon of interest, i.e., *critically informed, progressive transformation* also seems to meet another requirement of phenomenological investigation, which is to give a rich invocation to the lived experience of the study subjects (van Manen, 1997). First, the words *critically-informed* and *progressive*, although more descriptive than evocative, are still very solidly based on, and capture participants' vocal descriptions of their lived experiences. Moreover, the term *transformation* arguably leaves a degree of mythic, expectant nuance, one that hints that,

in the future, an essence that is richer and more evocative than the current one may be found on this topic. That is, the current study and its findings are just a beginning, and there is more to discover from female CCM sponsors' experiences. In fact, I am hopeful that future research will shed fuller and richer lights on the essence of CCM female sponsorship experience.

In the following, I will discuss the components of the essence, which are the four core themes. In these discussions, I will first describe the core themes themselves and how they were constructed, and then give detailed contrast of the core themes focusing on the existing findings on the change processes from the literature.

Core Themes

Continuous, embedded processes. Those who participated in this study strongly believed that their sponsorship experiences were those of a continuous and on-going nature. Further, they also noted that the sponsorship processes were inextricably linked to their larger therapeutic processes. Participants used key terms that conveyed flow and movement. There were few if any discernible markers for distinct phases.

Findings on the continuous nature of participants' change processes were consistent with those of Prochaska (1999), who reported that behavioral changes tended to unfold over time (See Table 5). For example, Prochaska and Norcross (1984) claimed that change processes generally consisted of a number of change processes. Some of these change process codes, such as consciousness raising, reevaluation of environment and self, self-liberation, and helping relationships were in agreement with the change processes that participants had noted of their own. They showed a deeper understanding of the ongoing process of change as they moved closer and closer to free themselves from

oppression and abuse, and also help others in their own freedom-seeking struggles through the formation of community connections and mutually helping relationships.

There were also points of departure between the current study's findings and some of the results reported in the literature. For example, Prochaska (1999) considered that change processes were generally sequential and consisted of distinct stages, i.e., *precontemplation, contemplation, preparation, action, maintenance,* and *termination* (Appendix A). Findings from this study, however, suggested that participants experienced gradually evolving processes with few markers for distinct stages. This difference can be understood in several different ways. First, this study's finding represents a potential point of departure from Prochaska's work because it emphasizes change from the perspective of the change-experiencer, i.e., the sponsors rather the perspective of the scientist. Second, and similar to the first reason, this finding punctuates the difference between articulating a descriptive theory of change (focused on life in a naturalistic environment) and a theory of change focused on measurement. Finally, Prochaska and DiClemente (1982, 1983) probably entered into their work looking for a change-over-time progression that was step-based, and in their work, the change steps were stages. Such an orientation would be informed by a deductive paradigm. This study, on the other hand, was informed by a qualitative research paradigm and followed participants' lead in terms of how the change-over-time progression was experienced and language as a gradual progression with notable landmarks (i.e., critical moments), but not bridges to cross (i.e., stages).

The notion of gradual, fluid, and continuous change as experienced by most participants of this study also contrasted with some of the more traditional findings on the

subject. For example, systemic family therapists believe that resolving problems requires a meaningful, most often abrupt, and monumental, change in the system or the process of change itself (Palazzoli, Cecchin, Prata, & Boscolo, 1979). Such systemic changes are thought to be possible at a relatively later stage of therapeutic work. Findings from the current study, however, suggests that significant changes and even 'breakthroughs ' were observed or experienced quite early on in the sponsorship and therapeutic processes before second-order change happened in the client's system. In fact, several participants noted critical moments even before they officially became sponsors, which happened when they supported fellow members in the community.

Another interesting point of departure had to do with the *termination* stage, which was identified by Prochaska (1999) as the last stage of change processes where there would be no temptation to relapse to old behavior and people would exhibit 100 % self-efficacy. Participants mentioned that they may have reached "maintenance" modes in their therapy processes, but none thought that she had reached any kind of termination stage. Thus, it appeared as if participants did not believe that such a termination phase would be attainable. Rather, they believed that in order to maintain changes that they have attained, they needed to commit to continuous and long-term connections to a like-minded community. Their collective attitude was that relapse could happen any time, to anyone, unless they stayed strongly connected and remained accountable for their actions within a like-minded community. This perspective may be informed by the fact that therapy provided a venue for both problem resolution, as well as, a context for personal group and social support; therefore, notion of termination was "not applicable" to the latter function of the therapeutic community.

Participants' beliefs about the need for a long-term commitment to a like-minded community provided an interesting contrast to prevailing notions about therapy in our society, i.e., that it is most often conducted and evaluated on a relatively short-term basis. The participants of this study had on average more than ten years of sponsorship experience, and were apparently leading lives that were satisfying and meaningful. Still, they were very mindful of the latent danger of complacency and the need for continuous engagement in the like-minded community. Analysis on transtheoretical model (Prochaska & Norcross, 1994) in fact confirmed that the maintenance stage of client's change would only last between six months and up to five years unless clients developed plans to take active roles in averting relapse. This finding indicates clients prefer some form of active preventative measures in order to avoid relapses, thus corroborating Prochaska and Norcross' work. The specific preventative measure taken by this study's participants was keeping continuous connection to a like-minded community and avoiding complacency as a result.

The choice to stay connected to a therapeutic community rather than find connections with a community outside the therapeutic context raises interesting questions. Are sponsors too afraid to leave the safety and inevitable growth found in this context? Is long-term connection with a therapeutic community healthy? Are participants in the CCM encouraged to leave the therapeutic context; or is "health" sufficiently vague that it cannot be possibly achieved? I can only speculate about their responses; however, I believe that if alternate venues or institutions in the fabric of society (faith communities, self-help groups, social clubs, or special interest groups) offered a context similar to those practicing the CCM, then sponsors/CCM-oriented therapeutic practices would see more

transitioning from “in therapy” to “out of therapy”/termination status for participants and sponsors. My insider knowledge of CCM would indicate that CCM-oriented agencies would welcome broader dissemination of its practices rather than fight to keep clients. However, the power of CCM’s focus on accountability, empowerment, and critical consciousness to address power, privilege, and oppression cannot be overstated. The intense loyalty of clients and sponsors to a diverse community that espouses and practices CCM’s ideas is an impressive testament to the power of its ideas and practices. To be clear, not all clients remained involved with IFS after their work; and some clients, although not disengaged, “checked in” regularly and periodically to touch base with support and accountability.

While largely emphasizing the continuous, embedded, and fluid nature of their sponsorship and therapeutic processes, participants also reported on their critical moments and breakthroughs. Some cited the times they obtained greater clarity by reaching across comfort zones to members of the community who differed from them, shifting from receiving to giving support while earning recognition from the community for their contributions as sponsors. Other participants made changes that resulted in the liberation of self and others, whether others were family members or members of the IFS community. Although participants remembered – and often relished - these breakthrough moments, most agreed that their sponsoring experience and therapeutic processes had a continuously evolving nature and there were few clearly distinguishable stages.

Participants also shared observations about the fluid nature of their involvement with community. They reported that, depending on the particular issues they were dealing with, they would attend sessions based on how much help they felt they needed.

Therefore, as predicted by Almeida (Almeida et al., 2008), participants who were in maintenance phases would usually attended less frequently, participating in the community on as-needed basis. This differed from other types of support groups where people would meet and interact under contract while they attended the group sessions, but would then disengage and completely disconnect after their participation in the group therapy ended.

Table 5

Findings vs. Existing Research: Continuous, Embedded Process

	Agreement	Departures
Transtheoretical Model	a. Behavioral changes unfold over time b. Some of the change process codes: 1. Consciousness raising 2. Evaluation for self and environment 3. Self-liberation 4. Helping relationships c. Maintenance stage of change would only last short term unless clients take active steps to avert relapse	a. Change process was NOT sequential, but more fluid and gradually evolving b. Participants did not consider that they were in, or would reach, "termination" stage: 1. Most thought they would have continuous engagement with supportive community to avoid 'relapse'
Systemic Family Therapy	a. Significant system-changing changes take place over time	f. Significant changes noted at relatively Early phases of sponsorship experience
CCM	a. Participants who were in maintenance phases would usually attend less frequently and participate in the community on as-needed basis	

Critical consciousness. Critical consciousness was alternately described as a broadening and clarifying. This theme presented me an opportunity to compare this theme with some of the findings from the literature on the subject (See Table 6). For example, extending a classical notion of oppression and critical consciousness credited to Freire (1970), Watts, et al. (1999) considers oppression to be the principal target of critical consciousness. In his model, Watts (1999) identifies five stages of the sociopolitical development of consciousness. In the first 'acritical' stage, a person is oblivious to social inequality. In the second 'adaptive' stage, the person recognizes inequity but does not confront it. In the third 'precritical' and the fourth 'critical' stages, the person becomes increasingly aware of oppression and the historical, cultural, and political processes that maintain inequity. Finally, in the last stage of 'liberation,' the person has a strong desire to improve social conditions and eliminate oppression, and becomes an active agent in the transformation of his or her environment (Watts, et el., 1999). Citing lack of empirical evidence in earlier works such as Freire (1970) and Perneman (1977), Watts concedes that the so-called 'stages' of critical consciousness may need to be re-considered as 'statuses', reflecting the possibility that there may be no common starting or end point in the process (Watts, et al., 1999).

Existing work on change processes such as the transtheoretical model (Prochaska and DiClemente, 1982) or the systemic family therapy (Watzlawick et al., 1974, Wilkinson & O'Connor, 1982, Bishop, 1984, Nichols & Schwartz, 1998) have not specifically considered critical consciousness as a component of change process. The transtheoretical model entertains concepts such as *contemplation* and *consciousness-raising* (Prochaska and Norcross, 1994) that may seem congruent to the concept of

critical consciousness in CCM. However, this model does not consider the 'critical' part of critical thinking, which is to say that it does not, for example, question oppressive systems and their rules within the broader contexts of culture and society. Rather, concepts such as *contemplation* and *consciousness-raising* tend to be limited in scope to cognitive changes in individual, personal, or familial relationships. Likewise, a systemic family therapist's description of the change process based on the concepts of first-order and second-order changes does not address critical consciousness as a component of change process nor as an essential part of therapeutic change. For example, Watzlawick (1974) notes that the second-order change focuses primarily on the *effects* of the problems, not on the critical analysis or understanding of the causes.

Existing work on CCM, on the other hand, considers development of critical consciousness to be evidence of therapeutic change. For example, Hernandez, et el. (2005) cite awareness of personal dynamics in social and political context as an essential component of the change process – one that alters the fundamental aspects of family systems. Further, the initial process of raising critical consciousness is centered on issues of oppression, including - but not limited to - institutional racism, male dominance, homophobia, capitalism, and class discrimination (Hernandez, et el., 2005). Use of multiple socio-educational materials to address the intersections of power, privilege, and oppression in personal and public life is therefore emphasized in the historical and sociopolitical context of specific cultures (Almeida, et al., 2008). CCM practitioners also stress the importance of group-based discussions (Almeida, et al., 2008). Such discussions draw attention to the notion that although one may be oppressed in one context, that same individual may be the oppressor in another, or intersectionality

(Crenshaw, 1995; Hernandez, et al., 2005). Most significantly, critical consciousness, along with work on accountability and connections in community, was considered an essential pre-requisite for any liberation or social change actions (Almeida, et al., 2008).

The findings of this study and the literature on the CCM agreed in that they both identified 'development of critical consciousness' as an essential, relatively early component of the change process. Participants' emphasis on the multi-dimensionality and intersectionality of their developing critical consciousness, for example, was in line with similar findings from the literature (Almeida, et al., 2008; Hernandez, et el., 2005; Hernandez et al. 2007). One aspect of the finding that could be contrasted with the predictions from the literature was the progression of critical consciousness toward social activism. To the participants of this study, activism seemed a natural progression in the change process. Through the process of change, many participants also became aware of systematic oppression in societies and subsequently took actions to engage in change activities and encouraged others to do the same. These findings were consistent with literature on CCM where developing critical consciousness was a predictable indicator of those people who would get involved with social action on a collective basis (Almeida, et al., 2008).

In the findings, participants noted deepened clarity surrounding personal and relationship issues, as well as better understanding of such important social contexts as power, privilege, and oppression – especially as they relate to the intersectionality of race, gender, and sexual orientation. However, participants did not seem as troubled about issues of economic inequality and classism in society. Considering that economic discrimination, inequality, and resulting social disempowerment is experienced by many

women, it was noteworthy that the current study's participants did not make similar observations.

Table 6

Findings vs. Existing Research: Critical Consciousness

	Agreement	Departures
Transtheoretical Model	a. Some similarity with concepts such as consciousness-raising and contemplation	a. Transtheoretical model does not depict critical consciousness utilized in social justice approach
Systemic Family Therapy	a. N/A	b. Second-order change focuses primarily on the effects of the problems, not on the critical analysis or understanding of the causes
CCM	a. Critical consciousness considered evidence of therapeutic change, and prerequisite of liberation and social activism b. Importance of multi-dimensionality, intersectionality, and awareness of oppression	

Connections in community. The third core theme was building connections in the therapeutic community while giving and receiving support from its members. As one would expect, this idea was languaged in ways that emphasized community, reaching out, enrichment, and reciprocity. Participants believed developing and nurturing connections in a community was vital to the success of their sponsorship and change processes.

Existing literature on systemic family therapy has put little emphasis on the importance of therapeutic communities. This gap may have more to do with the fact that

therapy modalities explored by these earlier models revolved around individual therapy sessions. Nevertheless, if one expanded the scope of the 'therapeutic community' to include larger communities, there was some resonance between earlier models and the current study's findings (See Table 7). For example, one of the sub-processes in the transtheoretical model called *helping relationships* has a large overlap with the notion of 'supportive community' found in the current study's theme. Likewise, family members are considered important observers and facilitators in systemic family therapy, and often viewed as critical supporters of those going through the change process as well.

It has to be pointed out again, however, that the notion of 'supportive community' in earlier literature does not fully encompass the findings of this study, since the former lack the notion of 'therapeutic' community (Goolishian, H., & Anderson, H. 1981; Greenblatt, et al., 1982; Speck & Attneave, 1971). Likewise, although restorative justice literature offers a conceptual framework of public accountability (Clear, 2005) to bring justice to victims of violence, evidence of actual work in restorative processes are scarce (Strang & Braithwaite, 2002). Connections based on public accountability, critical consciousness, and social-justice objectives, had not been envisioned in these earlier models of change processes.

On the contrary, research on social-justice based models of therapy reveals a strong emphasis on the role that therapeutic community plays in providing support to clients going through change processes. Aldarondo (2007) notes that family therapists with social justice orientations are engaged in the work of building community and creating social change. Likewise, community psychologists use the narratives of community members extensively, especially as they relate to telling the stories of those

who have been disadvantaged and yet managed to survive – largely by writing about their experiences (Nelson & Prilleltensky, 2005). Community psychologists also deny the traditional role of the helper as the authoritative expert, promoting instead the idea of therapists as mediators and resource-collaborators, who bring their knowledge and social activism to their community work (Nelson & Prilleltensky, 2005). Furthermore, since community psychology emphasizes connecting clients with others in mutually supportive and power-sharing relationships, the aim is to help the community regain power and solidarity through collective resistance and social action (Moane, 2003).

Therapists in CCM take the notion and importance of community to a new level, even making therapeutic community *the* defining characteristic of the CCM (Hernandez et al., 2005). Individuals and their families are supported in the context of the community, rather than solely by individualized therapy. According to CCM, one of the roles of therapy is to provide connections to a community whose function is to promote liberation through critical consciousness, empowerment, and accountability (Hernandez, Almeida, & Del-Vecchio, 2005). In addition, as clients gain knowledge and support from this community, they are encouraged to work within, and contribute to, as collective to challenge systems of power, privilege, and oppression that are viewed as the foundation of many presenting problems (Almeida, et al., 2007). The community then holds the individual accountable for her actions, and the consequences thereof, in the more public setting of the therapeutic community. Individuals are expected to grow as they change their behaviors, and this transformation is not only in regard to the clients' primary relationships but also in terms of their relationships with – and their contributions to – the larger community.

The findings of this study regarding the therapeutic community and connections within it have strong resonance with some of the characterization of 'community' made by community psychologists. For example, sub-themes found in this study such as the importance of 'sharing of resources', 'parallel process of helping others while receiving help', and 'power of community with critical consciousness' agreed well, respectively, with concepts in community psychology such as 'sharing of expertise', 'mutual support', and 'regaining of power as an objective of community'. One departing point between this study's findings and those in community psychology literature was that, in this study, participants did not characterize the roles of CCM therapists as non-professional, lay member of the community. Rather, they were viewed with respect as interpreters and commentators of contexts, as well as the providers of behavioral guidance. Sponsors had clear understanding of boundaries between therapists and themselves. They seemed to regard therapists as authority figures rather than peers in their change processes.

Findings in this study also agreed quite strongly with existing CCM literature's emphasis on connections formed in the therapeutic community (Almeida, et al, 2007). The significance of these connections in effecting the change process was evident in the participants' testimonials. Upon closer examination, however, there appeared to be some subtle differences between the experiences expressed by the participants versus the findings made in the literature. The CCM literature tended to emphasize the community's facility in developing clients' critical consciousness and interest in social activism, thereby emphasizing the 'social' dimension of the therapeutic change (Almeida, et al, 2008). While the current study's findings also strongly indicated a newfound passion for justice and social change, participants in this study were equally – or perhaps

even more – influenced by personal and intimate dimensions of their connections to the community. For some participants, it was the first time in their lives that they had experienced such a strong sense of belonging, and they saw the CCM community as a new family – supporting and preparing them for a fresh start in the world. Rather than contradicting the existing research, the findings from the current study seem to indicate that there may be richer and more intimate dimensions of the CCM therapy as 'lived by the clients/sponsors' than was thought before by CCM theorists. This aspect may need to be more fully explored in future investigations.

Table 7

Findings vs. Existing Research: Connections in Community

	Agreement	Departures
Transtheoretical Model	a. Same notion of 'helping relationships' b. Families considered critical source of support	a. Connections in community based on public accountability, critical consciousness, and social-justice objectives, have not been conceptualized in these models of change processes
Systemic Family Therapy	a. N/A	
CCM	a. Social justice model focuses on building community and social change b. Shares similarity with community psychology (e.g. resource sharing, helping others while getting help) c. CCM takes therapeutic community as the defining characteristic of itself (Hernandez, et al., 2005)	a. Participants viewed CCM therapists as experts and professionals, rather than peers, as in community psychology models b. Participants emphasized intimate personal connections to the community, more than just social justice action oriented connections

Transformative changes. The fourth and final core theme created from the lived experience of the sponsors was that the changes they have experienced over the years have been 'transformative.' Participants in this study were unequivocal about expressing their views that they have experienced real and impactful changes in their lives. They used the word 'transformative' to characterize the processes. Further, analysis of the participants' answers also identified a number of sub-themes associated with this core theme. Within these sub-themes, participants defined their change processes as 'growing, learning, and evolving', 'becoming accountable in the community', 'restructuring of relationships', 'taking steps for liberation', and 'giving back and bringing social justice'.

The transtheoretical model of change process (Prochaska and DiClemente, 1982, Prochaska and Norcross, 1994) observes that lasting therapeutic changes must include a combination of a number of sub-processes - some of which agree very well with the findings of this study (See Table 8). For example, there is a sub-process called *self-liberation* in which a client acts upon the belief that she can change and re-commits herself to doing so. This goes along well with this study's identified sub-theme of 'taking steps for liberation.' Another sub-process called *helping relationships* - which combines caring, openness, trust, acceptance, and support for changing - agrees at least in parts with identified sub-themes such as 'learning, growing, and evolving', 'becoming accountable,' and 'giving back and bringing social justice'.

The literature on the CCM presented many more specific points of agreement with the findings of the current study, especially regarding the core theme of 'transformative' changes. Hernandez et al. (2005), for example, considers empowerment a postcolonial and liberating stance in that it expands the boundaries of nuclear-family

therapeutic conversations to community conversations, and then links them to social action. The emphasis on collective empowerment and social action are found to be well in line with the current study's findings on the topic of 'transformative changes'. In addition, Almeida, et al. (2008) observes that the *culture circles*, which is the term for the therapeutic community in CCM, gives and receives support in an environment of collective accountability. Again, this point is well supported by some of the findings of this study, such as the identified sub-theme on 'becoming accountable'. Further, research on CCM observes that sponsors partner with clients in culture circles with the aim of mentoring a life of accountability and empowerment, breaking down the secrecy surrounding oppression, expanding conversation about family life to include the community, and healing the isolation that results from the relational choices made by people with power and privilege (Almeida & Durkin, 1999; Almeida & Lockard, 2005). These points were also supported by the current findings in this study, where participants (who are sponsors) emphasized keywords and sub-themes such as 'help others hold accountable', 'help and nurture others to grow', and 'change (others') lives'.

There was one subtle yet discernible difference between the findings of the study and those of the CCM literature, which was the difference in the nuance or tone of the expressions. The language used by the participants to describe their change processes was full of genuine wonder and excitement. In contrast, the language used in the literature was decidedly more objective and drier. While cooler tones might be expected in academic work, one may be allowed to conjecture that the current literature may not have fully grasped the immanent expressivity of the CCM clients' lived experiences, freely uttering their own unfiltered voices.

Another noteworthy finding was that, in describing the transformative nature of their therapeutic processes, participants were overwhelmingly positive about their experiences. In fact, in response to a direct question about the gains and losses of the change process, very few losses were identified or acknowledged. One notable exception was the loss of old relationships and ways of dealing with people, which was mentioned by a few participants. However, participants qualified even these losses as net-positive ones, citing that the old relationships were destructive or draining. Participants were able to escape or restructure abusive or non-functioning relationships through their sponsorship and change processes. Since the existing CCM literature has not treated questions about the gains and losses of clients due to their change processes, it was not possible to draw comparisons with this study. However, it would make an interesting topic for further exploration.

Table 8

Findings vs. Existing Research: Transformative Changes

	Agreement	Departures
Transtheoretical Model	a. Findings agreed with some sub-processes predicted by Transtheoretical Model: 1. Helping relationships 2. Self-liberation	a. Transtheoretical model does not predict client's perception of the therapeutic change process being characterized as 'transformative'
CCM	a. Many specific points of agreement: 1. Collective empowerment 2. Social action 3. Collective accountability 4. Help others to grow 5. Exchange of support within community (e.g. Culture Circles)	a. Subtle differences in tones: 1. Language used by the participants to describe their change processes are full of wonder and excitement 2. In contrast, the language used in the CCM literature more objective and drier 3. May signify qualitative 'gap' in existing CCM research

Core Themes and Research Questions

Question #1 - "What language best describes change process?"

Research question #1 was best answered by the data from three core themes. For example, participants languaged their evolving *critical consciousness* as "gaining meta-perspectives." Participants' language about *connections in community* varied on the idea that living life in a community increases one's sense of belonging and acceptance while breaking down isolation. Finally, in reference to the *transformative* nature of *change,* participants used words such as 'incredible' to describe the changes they had experienced or witnessed in their sponsorship processes.

Question #2 – "How did the sponsors understand the relationship between their own therapeutic change experiences and their interaction with others?" "And how did these relationships facilitate change?"

Research question #2 was answered by data from the *connections in community* and *transformation* themes. For instance, participants discussed *connections in community* in terms of enriched lives, sharing of resources, reciprocity based on various forms of experience and expertise in the community, and actively supporting others in the community. Therapeutic change and interactions with others meant *transformation* in the form of profound learning, growth, and constant evolution of self. Participants noted that the meaning of sponsorship in their lives was to rely on themselves and others for support and liberation, and to work together to bring social justice.

Question #3 – "What were some of the critical points in their change processes, and how did they affect others?"

Participants reported that critical points were marked by three types of occurrences. First, accepting as part of their community and reaching out to sponsor people from drastically racial or economic backgrounds from their own, constituted one type of critical occurrence. They recognized that these actions truly signaled a monumental cognitive shift. Second, occurrences in which raised critical consciousness deepened and clarified awareness of societal oppression and injustice (and location within this frame), and invited liberation, were also cited as critical moments. These moments reinforced the notion of transformative change because their new knowledge warranted new actions. Finally, a sense of important change occurred when participants

experienced gratitude and appreciation for new connections formed in the community – a recognition that the CCM community uniquely offered them a form of community not available in any other venue or institution in their lives.

Critical points equated to change points, and change points in participants' lives also fostered important, typically positive, changes in the lives of those close to them. Although some relationships were lost, for the most, relationships were recalibrated and strengthened; even those that had been "broken" for extended periods of time.

Question #4 – "What is the essence of change process facilitated by the CCM, and how does the sponsor contribute it?"

Critically-informed progressive transformation was the essence of the change process experienced by female sponsors in the CCM. A critically-informed community provided the context for this dynamic transformation to occur and sustain progress. Participants reported that change facilitated by the CCM occurred within a community founded on critical consciousness and focused on understanding the role of self in one's family of origin and its impact on relationships. They stressed the importance of being connected with people who have critical consciousness, and also mentioned that they have learned to live life connected with people. For them, the CCM experience underscored the fact that one's own sense of being liberated was strengthened and validated by helping to liberate others.

Implications of the Study

Implications for the Cultural Context Model. This study of female sponsors' lived experiences in relationship to their therapeutic changes provides an in-depth description and analysis of sponsorship as a phenomenon. It is important for three

primary reasons: (1) the study constitutes a starting point from which to understand the experience of sponsorship through the words and perspectives of female sponsors in CCM therapy, (2) it describes how sponsors interact with therapists, other sponsors, and other non-sponsor clients in the context of sponsorship, and (3) it provides new insights that might improve CCM intervention strategies, alter, or refine its existing assumptions or applied methods, and facilitate the change process more effectively.

Implications for the family therapy field. This study sought to understand the essence of female sponsors' experiences and therapeutic change processes in CCM. I believe that it can have an impact on the field of family therapy in several different ways. First, findings from this study can be used to advance the development of a research base about the CCM and similar approaches – specifically social justice-based, systemically- and relationally-oriented approaches. Therapeutic processes within these approaches could improve by incorporating the insights of the significant stakeholders (e.g. sponsors). On a larger scale, this study helps answer the call for a "more context-specific microtheory of change" (Moon, et al., 1990) by describing the change experiences of a particular group of clients and identifying the phenomenological essences of their experiences.

Second, this study enriches the research base of therapeutic approaches that advocate inclusion of multiple perspectives from both clients and therapists (Lebow, 1981; Moon et al., 1990; Pinsof, 1988). Participants' experiences of therapy (e.g. their thoughts and feelings about their roles as clients and sponsors) are legitimate and valuable, possibly to the same extent as observable behaviors (Pinsof, 1988).

Third, the research findings from this study add to a research base that illustrates the basic advantage of a family therapy approach that implements a community-based, indigenous model in the structure and format of therapy as well as incorporates a social justice perspective (Aldarondo, 2007). This study also illustrates the advantages of a family therapy approach that includes multiple perspectives in therapeutic interventions. The findings also advance the notion that there is no single objective reality, but rather multiple realities that contain unique perceptions and views of treatment (Gurman, Kniskern, & Pinsof, 1986). In addition, this study illustrates the advantages of a family therapy approach that not only implements use of in-therapy mentors or sponsors to facilitate progress and anchor change, but also encourages clients' social justice growth in therapy with a view to facilitating clients' growth in regard to social justice outside of therapy.

In reaching its stated goal of understanding the essence of female sponsors' experiences and therapeutic change processes in CCM, this study also achieved the following objectives:

- Contributed to the knowledge base on the topic of female sponsors and their change-related experiences,
- Described how and why female sponsors continue therapy and their involvement in sponsorship,
- Explored what brings the sponsors to continue to participate and contribute voluntarily as members of a community that functions both inside and outside of therapy sessions,

- Facilitated family therapists' learning about new and deeper ways to understand and address issues that sponsors may face beyond the presenting issues that they bring into therapy sessions,
- Investigated how the process of change in the CCM can be better facilitated to move clients forward in their therapy, and what can be done to maintain the changes they have made.

Implications for theories of change. Findings from this study suggested that participants experienced gradually evolving processes with few markers for distinct stages. This finding suggested some departure from the results of meta-study based on transtheoretical model (Prochaska, 1999). First, this study's finding suggested a potential point of departure from Prochaska's work because the former emphasizes change from the perspective of the subjects who experience the changes, i.e., the sponsors, rather than from the viewpoint of the scientist. Second, this finding implies differences in change-process description between articulations of experienced change (focused on lived experience in a naturalistic environment) such as this study's, and a theory of change focused on measurement. Finally, this study's findings on fluid change process may imply a possibility that existing work on change processes may have been entered with pre-formed objectives to looking for step-wise, temporally linear description of change process, as may be informed by the deductive paradigm based on quantifiable measurements. This study, on the other hand, used qualitative research paradigm and followed participants' leads, which were often circuitous, non-linear, and recursive, in characterizing temporal aspects of their change processes.

Another implication on change process due to this study's findings is that a

client's internal, individual change process and her progress in social roles and communal responsibilities may need to be considered in an integrated viewpoint for a full understanding of both, since the findings from this study suggests that these two processes are inextricably intertwined. This study finds that the process of developing and then acting on social roles and responsibilities was a continuously co-situated, i.e., 'embedded,' co-process of the whole change process of the participants. Thus, this study may imply that future change-process theories would need to take into account the social, communal aspects of their subjects' lives as importantly as their inner, private life aspects.

Another implication, which is due to the finding that participants experienced sponsorship as a process that is ultimately transformative, is related to the 'directionality' of the change process. To the subjects in this study, their change processes were clearly 'directional', in the sense that the overall change process was definitely toward a positive, affirmative metamorphoses of lives. Individual changes processes in this study had much recursion and reflection, and was full of setbacks and regressions. Therefore, it implied that change process theories may need to reconsider any remaining notion of linear, step-wise predictability of change processes. On the other hand, however, ultimately each of the slowing and apparently regressing motions was found to all point to greater understanding and empowerment through the help of the community. Therefore, the movement of change processes were almost teleologic in this study, in that they were inevitably moving toward unspecified, but clearly perceived destinations characterized by greater self-accountability, raised consciousness, relational genuineness, personal as well as communal liberation and empowerment, and intentionality toward building community and social justice. Participants succinctly characterized the states of such changes as

'transformation'. Thus this study's findings also imply that theories of change process will be further analyzed based on the presence (or absence), extent, and characteristics, of evidence and notion of the endwise directionality or vision of the change process.

Limitations

Several limitations must be acknowledged about the study. First, although I attempted to bring together diverse voices from participants with different backgrounds at IFS, the majority of participants represented a fairly homogeneous group: White, heterosexual, middle class, educated, and professional women. Obviously, this group does not represent diverse voices from people with different backgrounds or who benefit from the CCM. This limitation does not allude to generalizability, but rather, transferability, i.e., limiting the applicability of this study's findings to other studies focused on similar processes. This study's findings reflect the unique characteristics of its context and population, i.e., majority women who had time and financial means to afford long-term mental health services. Second, since this study is about the lived experience of sponsorship from the perspectives of females, it necessarily does not include male perspectives, which prevents a cross-gender analysis and comparison of results. Third, limited empirical research on the CCM constrains attempts at confirmability of the study's findings. Fourth, because of time, sampling strategy and the small population from which participants were drawn, this study did not include negative case examples, or female sponsors who may have dropped contact with IFS. One potential participant declined participation based on confidentiality concerns. Therefore, the absence of her voice, or voices like hers, suggests that additional aspects of the female sponsorship experience have yet to be incorporated into the identified essence.

Strengths

First, this study provided clients' perspectives on healing within a systemically oriented, community-focused family therapy model, the CCM, and gave voice to the distinct experience of women who participate in a therapeutic community educated within a social justice model. In doing so, it uncovered not only points of agreements with the findings from existing research work on the therapeutic change processes but also a number of important points of departures that contrasted with the existing work's predictions.

Secondly, this study examined CCM sponsors' own voices for the first time in empirical research, thereby enriching and adding a new dimension to the research on the CCM, which hitherto has been limited to work that focused on findings from the perspectives of therapists and researchers.

Lastly, this study provided a template for beginning to describe "change" in CCM therapy. By critically comparing their own findings with those of this work, such as the themes and sub-themes, as well as the mappings between the research questions and the themes/sub-themes, future researchers of CCM may benefit and gain new insights into the model and its change processes.

Suggestions for future research

The limitations of this study provide a source for suggesting future research. First, future research could be expanded to include other – and more diverse – voices, including those with different backgrounds in terms of race, sexual orientation, class, education, and length of sponsorship experience. Second, further research with men will broaden the range of sponsorship experiences available for analysis. When female participants

were asked if they thought the change process would be similar for males, most of the women agreed that it would be harder for men. However, some participants in this study thought the sponsorship process for men would be similar, while others thought it would be different. Exploring similarities, differences, and unknown possibilities would enhance understanding of this unique sponsorship experience; therefore, it would be worth exploring the perspectives of male sponsors in the future.

Third, further study can also be taken to explore therapeutic efficacy of the CCM. Since this study is one of few research literatures on CCM, it did not attempt to explore this question. Although the participants' answers and lived experiences were overwhelmingly positive toward the CCM, the effectiveness of the model cannot really be measured, given the participant-selection criteria. Fourth, additional research into CCM sponsorship should employ a negative case sampling strategy into their designs in order to allow for a broader range of experiences to further inform the CCM's evolution. Findings from this study may be further used to advance the development of a research base about the CCM and similar approaches – specifically social justice-based, systemically- and relationally-oriented approaches.

Summary and Conclusion

This qualitative investigation sought to identify the essence of sponsorship as experienced by a particular group of therapeutic clients within a relatively new family therapy model, the Cultural Context Model (CCM). The primary research question for the study was: *What is the lived experience of female sponsors engaged in the therapeutic change process promoted by the CCM?* From this central question, several secondary questions were emerged: *What language best describes the change processes? What are*

the sponsors' understandings of the relationship between their own therapeutic change experiences and their role of interacting with therapists, other sponsors, and clients? And, *How did these relationships facilitate change? What were some of the critical points in their change processes, and how did they affect others? What is the essence of change facilitated by the CCM, and how do the sponsors contribute to it?*

The study utilized a phenomenological methodology to collect and analyze female sponsors' accounts of their lived experience in relationship to their own therapeutic change process in CCM therapy. Participants were recruited from Institute for Family Services (IFS) based on the primary inclusion criteria for the study, i.e., recognition as a sponsor by IFS, and being a female. Criteria for sponsors were reviewed in Chapter 2 and are also listed in Appendix I. Chapter 4 detailed procedures for participant selection, contacting, soliciting for interviews and participation in the study, conducting of interviews, methods of care of participants' confidentiality and wellbeing, use and care of data including interview results, and analyses.

Following the data collection phase, a phenomenological data analysis was conducted. The data analysis procedure represented a modified version of Giorgi's (1985) analytical method. Critically-informed, progressive transformation formed the core of participants' experiences of sponsorship and change within the CCM. Four core themes emerged from the analysis: 1) Sponsorship was a continuous process embedded in the therapy process, 2) Critical consciousness the participants gained through their sponsorship process was essential in their change processes, 3) Sponsorship was about building and gaining connections in the community; and 4) The changes that sponsors have experienced were transformative.

This study is important for three primary reasons: (1) it constitutes a starting point from which to understand the experience of sponsorship from the words and perspectives of female sponsors in CCM therapy, (2) it describes the ways sponsors interact with multiple members of the therapeutic community (therapists, other sponsors, and other non-sponsor clients in the context of their sponsorship) and how these interactions impact sponsors' therapeutic change process, and (3) it provides new insights that might improve the intervention strategies of the CCM , alter, or refine its existing assumptions or applied methods, and facilitate the change process more effectively.

REFERENCES

Aldarondo, E. (2007). *Advancing social justice through clinical practice.* Mahwah, NJ: Lawrence Erlbaum.

Almeida, R. V. (1994). *Expansions of feminist theory through diversity* (Ed.). New York: Harrington Park Press.

Almeida, R. V. (1998). The Dislocation of women's experience in family therapy. In R. V. Almeida (Ed.), *Transformation of gender and race: Family and developmental perspectives (*pp. 1-22). New York: Haworth Press.

Almeida, R. V. (2004). Creating collectives of liberation. In Silverstein, L.B. & Goodrick, T.J. (Eds.), *Feminist family therapy* (pp. 293-306). Washington D.C.: American Psychological Association.

Almeida, R. V. (1993). Unexamined assumptions and service delivery systems: Feminist theory and racial exclusions. *Journal of Feminist Family Therapy, 5*(1), 3-23.

Almeida, R.V., & Bograd, M. (1991). Sponsorship: Men holding men accountable for domestic violence. *Journal of Feminist Family Therapy, 2,* 234-256.

Almeida, R. V., Dolan-Del Vecchio, K, & Font, R. (1998). Finding the words: Instruments for a therapy of liberation, In Almeida, R. V. (Ed*.), Transformations of gender and race: Family and developmental perspectives*, (pp. 85-97). Haworth Press.

Almeida, R. V., Dolan-Del Vecchio, K., & Parker, L. (2007). Foundation concepts for social justice-based therapy: Critical consciousness, accountability, and empowerment, In E. Aldarondo (Ed.), *Advancing social justice through clinical practice* (pp. 175-206). Mahwah, NJ: Lawrence Erlbaum.

Almeida, R. V., Dolan-Del Vecchio, K., & Parker, L. (2008). *Transformative family therapy: Just families in a just society*. Boston: Allyn & Bacon.

Almeida, R. V., & Durkin, R. (1999). The cultural context model: therapy for couples with domestic violence. *Journal of Marital and Family Therapy, 25*(3), 313-324.

Almeida, R.V. & Lockard, J. (2005). The Cultural context model: A new paradigm for accountability, empowerment, and the development of critical consciousness against domestic violence, In Sokoloff, N. J., & Pratt, C. (Ed.), *Domestic violence at the margins: Readings on race, class, gender, and culture* (pp. 301-320). New Brunswick, NJ: Rutgers University Press.

Almeida, V. R., Woods, R., Messineo, T. (1998). Child development: Intersectionality of race, gender, class, and culture, In Almeida, V. R. (Ed*), Transformations of gender and race: Family and developmental perspectives* (pp. 23-47). Haworth Press.

Almeida, R.V., Woods, R., Messineo, T. & Font, R. (1998). The Cultural context model: An overview, In McGoldrick, M. (Ed), *Re-Visioning family therapy: Race, culture, and gender in clinical practice* (pp. 404-432). NY: Guildford Press.

Almeida, R.V., Woods, R., Messineo, T., Font, R. and Heer, C. (1994). Violence in the lives of the racially and sexually different: A public and private dilemma, In Almeida, R.V. (Ed), *Expansions of feminist family theory through diversity* (pp. 99-126). Harrington Park Press.

Alva, J. K. (1994). The postcolonization of the (Latin) American experience, a reconsideration of "colonialism," "postcolonialism," and "meztizaje." In G. Prakash. (Ed.), *After colonialism, imperial histories and postcolonial displacements* (pp. 241-275). Princeton, NJ: Princeton University Press.

Andersen, T. (1987). The reflecting team: Dialogue and meta-dialogue in clinical work. *Family Process, 26*(4), 415-428.

Atkinson, D. R., Morten, G., & Sue, D. W. (1979). *Counseling American minorities: A cross-cultural perspective.* Wm. C. Brown Company.

Bartky, S. L. (1990). *Femininity and domination: Studies in the phenomenology of domination.* New York: Routledge.

Becvar, D. S. & Becvar, R. J. (2008). *Family Therapy: A systemic integration* (7th ed.). Boston: Allyn and Bacon.

Beech, B. M., & Goodman, M. (2004). *Race & research: Perspectives on minority participation in health studies.* American Health Association.

Berg, B. (1998). *Qualitative research methods for the social sciences* (2nd ed.). Boston: Allyn & Bacon.

Berg-Cross, L. (2000). *Basic concepts in family therapy: An introductory text* (2nd ed.). NY: Haworth Press.

Berger, P. L., & Luckmann, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge.* Garden City, NY: Anchor Books.

Bishop, S. M. (1984). Perspectives on individual-family-social network interrelations. *International Journal of Family Therapy, 6*(2), 124-135.

Bohart, A. (2007). An alternative view of concrete operating procedures from the perspective of the client as active self-healer. *Journal of Psychotherapy Integration, 17(1),* 125-137.

Bograd, M. (1992). Values in conflict: Challenges to family therapists' thinking. *Journal of Marital and Family Therapy, 18*(3), 245-256.

Bulhan, H. A. (1985). *Franz Fanon and the psychology of oppression.* New York: Plenum Press.

Caldwell, P. E., & Cutter, H. S. G. (1998). Alcoholics' Anonymous affiliation during early recovery, *Journal of Substance Abuse Treatment, 15*(1), 221-28.

Charmaz, K. (2005). Grounded theory in the 21st century: Applications for advancing social justice studies. In N. K. Denzin, & Y. S. Lincoln (Eds.). *The Sage handbook of qualitative research (3rd ed.)* (pp. 507-535). Thousand Oaks, CA: Sage.

Chenail, R. J. (2005). Future directions for qualitative methods. In D. H. Sprenkle & F. P. Piercy (Ed.). *Research methods in family therapy (2nd ed.)* (pp. 191-208). New York, NY: Guildford Press.

Chenail, R., Somers, C., & Benjamin, J. D. (2009). A recursive frame qualitative analysis of MFT progress note tipping points, *Contemporary Family Therapy: An International Journal, 31*(2), 87-99.

Christensen, L. L., Russell, C. S., Miller, R. B., & Peterson, C. M. (1998). The process of change in couples therapy: A qualitative investigation. *Journal of Marital and Family Therapy, 24*(2), 177-188.

Condelli, W.S., De Leon, G. (1993). Fixed and dynamic predictors of client retention in therapeutic communities. *Journal of Substance Abuse Treatment, 10,* 11-16.

Corey, M. S. & Corey, G. (1992). *Groups process and practice* (4th ed.). Brooks/Cole publishing.

Couture, S. J. (2007). Multiparty talk in family therapy: Complexity breeds opportunity. *Journal of Systemic Therapies, 26* (1), 63-82.

Crape, B., Latkin, C., Laris, A., & Knowlton, A. (2002). The effects of sponsorship in 12-step treatment of injection drug users. *Drug and Alcohol Dependence, 65,* 291-301.

Crenshaw, K. (1997). Intersectionality and identity politics: learning from violence against women of color. In M. Lyndon Shanley, & U. Narayan. (Eds.), *Reconstructing political theory: Feminist perspectives* (pp. 111-132). University Park, PA: Pennsylvania State University Press.

Crenshaw-Williams, K. (1995). Mapping the margins: Intersectionality, identity politics and violence against women of color. In K. Crenshaw Williams, N. Gotanda, G. Peller, & K. Thomas, *Critical race theory: The key writing that formed the movement (*pp. 357-383). New York: New Press.

Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, California: Sage.

Cresswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. Theory into Practice. 39, 124-130.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process.* Thousand Oaks, CA: Sage.

Dahlberg, K. (2006). The essence of essences – the search for meaning structures in phenomenological analysis of life world phenomena. *International Journal of Qualitative Studies on Health and Well-being, 1,* 11-19.

Daly, K. J. (2007). *Qualitative methods for human development and family studies*. Thousand Oaks, CA: Sage Publications.

Denzin, N. K. & Lincoln, Y. S. (2000). Introduction: The discipline and practice of qualitative research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.) (pp. 1-29). Thousand Oaks, CA: Sage.

Denzin, N., & Lincoln, Y. (2005). *The Sage handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.

Dolan-Del Vecchio, K. & Lockard, J. (2004). Resistance to colonialism as the heart of family therapy practice, *Journal of Feminist Family Therapy, 16*(2), 43-66.

Duffy, M., & Chenail, R. J. (2004). Qualitative Strategies in Couple and Family Assessment. In Sperry, L. (Ed) *Assessment of couples and families: Contemporary and cutting-edge strategies.* (pp. 33-63). New York, NY: Brunner-Routledge.

Duffy, M., & Chenail, R. J. (2008). Values in qualitative and quantitative research. *Counseling and Values, 53*(1), pp. 22-38.

Fanon, F. (1963). *The wretched of the Earth*. Constance Farrington, NY: Grove Weidenfeld.

Font, R., Dolan-Del Vecchio, K., & Almeida, R. V. (1998). Finding words: Instruments for a therapy of liberation. In Almeida, V. R. (Ed*), Transformations of gender and race: Family and developmental perspectives* (pp. 85-97). Haworth Press.

Foucault, M. (1975). *The birth of the clinic: An archeology of medical perception*. New York: Random House.

Fox-Genovese, E. (1991). *Feminism without illusions*. Chapel Hill: The University of North Carolina Press.

Fox, D. & Prilleltensky, I. (1997). *Critical psychology: An Introduction*. Thousand Oaks, CA: Sage.

Freire, P. (1972). *Pedagogy of the oppressed.* New York: Continuum.

Frisbie, R. (1986). The use of microcomputer programs to improve the reliability and validity of content analysis in evaluation. Annual Meeting of the American Educational Research Association, San Francisco. http://web.ics.purdue.edu/~rfrisbie/Professional/Dissertation/EvaluationandContentAnalysisAERApaper.pdf

Gadamer, H. G. (1989). *Truth and method*. (J. Weinsheimer and D. G. Marshall. Trans.). New York: Continuum. (Original work published 1960).

Galanter, M (1993). Network therapy for addiction: A model for office practice. *American Journal of Psychiatry, 150,* 28-36.

Galanter, M. (1999). *Network therapy for alcohol and drug abuse:* Expanded Edition. New York: Guilford Press.

Gallegos, N. (2005). Client perspectives on what contributes to symptom relief in psychotherapy: A qualitative outcome study. *Journal of Humanistic Psychology, 45*(3), 355-382.

Gearing, R. E. (2004). Bracketing in research: A typology. *Qualitative Health Research, 14*(10), 1429-1452.

Giorgi, A. (1985). Sketch of a psychological phenomenological method. In Giorgi, A. (Ed.), *Phenomenology and Psychological Research* (pp. 8-22). Pittsburgh, PA: Duquesne University Press.

Giorgi, A., & Giorgi**,** B**.** (2003). Phenomenology**.** In J. A. Smith (Ed.). *Qualitative psychology*: *A practical guide to research methods (pp. 25–50).* Thousand Oaks, CA: Sage.

Glick, I. D., Berman, E. M., Clarkin, J. F., & Rait, D. S. (2000). *Marital and family therapy* (4th ed.). Washington DC: American Psychiatric Press.

Goodrich, T. J., Rampage, C., Ellman, B., & Halstead, K. (1988). *Feminist family therapy: A case book.* W.W. Norton Company.

Goolishian, H., & Anderson, H. (1981). Including non-blood related persons in treatment: Who is the family to be treated? In A. Gurman (ed.), *Questions and answers in family therapy.* New York: Brunner/Mazel.

Grassi, E. (1990). *Vico and Humanism: Essays on Vico, Heidegger, and Rhetoric.* New York: Peter Lang.

Green, R. (1998). Traditional norms of masculinity. In Almeida, V. R. (Ed*), Transformations of gender and race: Family and developmental perspectives* (pp. 81-83). Haworth Press.

Greenblatt, M., Becerra, R. M., & Serafetinides, E. A. (1982). Social networks and mental health: An overview. *The American Journal of Psychiatry, 139*(8), 977-984.

Grinnell, R. M., Unrau, Y. A. & Williams, M. (2007). Introduction. In R. M. Grinnell, & Y. A. Unrau (Eds). Social work research and evaluation: Quantitative and qualitative approaches (8th ed.) (pp. 3-28). Oxford University Press.

Guerin Jr., P. J. (1976). Family therapy: The first twenty-five years. In P. J. Guerin. Jr. (Ed), *Family therapy: Theory and practice.* Gardner Press.

Gurman, A. S., Kniskern, D. P., & Pinsof, W. M. (1986). Research on the process and outcome of marital and family therapy. In S. Garfield & A. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed.) (pp. 595-631). New York: Family Process.

Haley, J. (1971). *Changing families: A family therapy reader (Ed.).* Grune & Stratton, Inc.

Hare-Mustin, R. (1978). A feminist approach to family therapy. *Family Process, 17,* 184-194

Hare-Mustin, R. T. & Marecek, J. (1997). Abnormal and clinical psychology: The politics of madness. In D. Fox & I. Prilleltensky (Eds), *Critical psychology: An introduction*. (pp. 104-120). Thousand Oaks, CA: Sage.

Heatherington, L., Friedlander, M., & Greenberg, L. (2005). Change process research in Couple and Family Therapy: Methodological challenges and opportunities. *Journal of Family Psychology, 19*(1), 18-27.

Heidegger, M. (1962). *Being and time.* (J. Macquarrie & E. Robinson, Trans.). New York: Harper & Row. (Original work published 1927).

Helmeke, K. B., & Sprenkle, D. H. (2000). Clients' perceptions of pivotal moments in couples therapy: A qualitative study of change in therapy. *Journal of Marital and Family Therapy, 26*(4), 469-483.

Hernández, P. (2003). The cultural context model in supervision: An illustration. *Journal of Feminist Family Therapy, 15*(4), 1-18.

Hernández, P., Bunyi, B., & Townson, R. (2007). Interweaving ethnicity and gender in consultation: A case study. *Family Psychotherapy, 18*(1), 57-75.

Hernandez, P., Richard, J. & Giambruno, P. (in press). Psychotherapy process research: transformative family therapy with a lesbian couple. *Journal of Feminist Family Therapy*.

Hernández, P., Almeida, R., & Del-Vecchio, K. (2005). Critical consciousness, accountability, and empowerment: Key processes for helping families heal. *Family Process, 44* (1), 105-130.

Hernandez, P., Siegel, A., & Almeida, R. (2009). How does the Cultural Context Model facilitate therapeutic change? *Journal of Marital and Family Therapy, 35*(1), 97-110.

Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist, 25*(4), 517-572.

Hume, N., O'Connor, W. A., & Lowery, C. R. (1977). Family, adjustment, and the psychosocial ecosystem. *Psychiatric Annals, 7*(7), 36-49.

Husserl (1964). *The idea of phenomenology* (W. P. Alston & G. Nakkvikian, Trans.). The Hague: Martinus Nijhoff. (Original work published 1950).

Husserl, E. (1973). *Logical investigations* (J. N. Findlay, Trans.). London: Routledge. (Original work published 1913).

Hut, P. (1999). Theory and experiment in philosophy. *Journal of Consciousness Studies,* (2-3**),** 241-244

Hyde, R. B. (1994). "Listening authentically: A Heideggerian perspective on interpersonal communication." In K. Carter and M. Presnell (Ed.), *Interpretive approaches to interpersonal communication*. State University of New York Press.

Kuhn, T. S. (1962). *The Structure of Scientific Revolutions.* Chicago: University of Chicago Press.

Kuehl, B. P., Newfield, N. A., & Joanning, H. (1990). A client-based description of family therapy. *Journal of Family Psychology. 3*(3), 310-321.

Lamb, H. R., & Zusman, J. (1979). Primary prevention in perspective. *American Journal of Psychiatry, 136,* 12-17.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3*, 102-120.

Lebow, J. (1981). Issues in the assessment of outcome in family therapy. *Family Process, 20,* 167-188.

Lee, E. (1997). *Working with Asian Americans: A guide for clinicians.* NY: Guildford Press.

Leedy, P. D., & Ormrod, J. E. (2009). *Practical research: Planning and design*. (9th.Ed.). Prentice Hall.

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry.* Beverly Hills: Sage.

Locke, D. C. (1992). *Increasing multicultural understanding: A comprehensive model.* Newbury Park, CA: Sage.

Loomba, A. (2002). *Colonialism-post colonialism*, London: Routledge.

Makkerell, R. (1992). *Dilthey, philosopher of the human studies*, Princeton University press.

Malterud, K. (2001). The art and science of clinical knowledge: evidence beyond measures and numbers. *The Lancet, 358(4),* 397-400.

Mannino, F.V., & Shore, M. (1982). The wider contexts of family interventions, *Family Therapy Networker, 6,* 13-15.

Markowitz, L. (1997). Culture healers, UTNE Reader, 56-64.

Marshall, C., & Rossman, G. B. (2006). *Designing qualitative research* (4th ed.). Thousand Oaks, CA: Sage.

Maxwell, J. A. (2004). *Qualitative research design: An interactive approach* (2nd ed.). Thousand Oaks, CA: Sage.

Mayers Avis, J. (1992). Where are all the family therapists? Abuse and violence within families and family therapy's response. *Journal of Marital and Family Therapy, 18(3),* 225-232.

McGoldrick, M., Giordano, J. & Pearce, J. K. (1996). *Ethnicity & family therapy.* (2nd ed.). NY: Guilford Press.

McNamee, S. & Gergen, K. J. (1992). *Therapy as social construction* (Ed.) (pp. 1-6). Newbury Park: Sage.

Merleau-Ponty, M. (1962). Phenomenology of perception. (C. Smith. Trans.) London: Routledge & Kegan Paul. (Original work published 1945).

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd Ed.). Thousand Oaks, CA: Sage.

Mitchell, J. C. (1974). Social networks. *Annual Review of Anthropology*, *3*, 279–299.

Moane, G. (2003). Bridging the personal and the political: Practices for a liberation psychology. *American Journal of Community Psychology, 31,* 91-101.

Moane, G. (1999). *Gender and colonialism: A psychological analysis of oppression and liberation.* London: Macmillan.

Molina, I. (2004). Intersubjectivity and intersectionality for a subversive antiracist feminist. *Sociologisk Forskning, 3,* 19.

Moon, S. M., Dillon, D. R., & Sprenkle, D. H. (1990). Family therapy and qualitative research. *Journal of Marital and Family Therapy, 16(4),* 357-373.

Moos, R. H. & Fuhr, R. (1982). The clinical use of social-ecological concepts: The case of an adolescent girl. *American Journal of Orthopsychiatry, 52(1),* 111-122.

Morgenstern, J., Frey, R., McCrady, B., Labouvie, E., & Neighbors, C. (1996). Mediators of change in traditional chemical dependency treatment. *Journal of Studies on Alcohol.* 57, 53–64.

Morse, J. M. (1994). Designing funded qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 220-235). Thousand Oaks, CA: Sage.

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage.

Mueller, D. P. (1980). Social networks: A promising direction for research on the relationship of the social environment to psychiatric disorder. *Social Science and Medicine, 14,* 147-161.

Nelson, G., & Prilleltensky, I. (2005). *Community psychology: In pursuit of liberation and well-being.* New York: Palgrave MacMillan.

Nichols, M. P. (2008). *Family therapy: Concepts and methods* (8th ed.). Boston: Allyn and Bacon.

Nicholas, M. P., & Schwartz, R. C. (1998). *Family therapy: Concepts and methods (4th ed.).* Boston: Allyn and Bacon.

O'Connor, W. A. (1977). Ecosystems theory and clinical mental health. *Psychiatric Annals, 7(7),* 63-77.

Palazzoli, M. S., Checchin, G., Prata, C., & Boscolo, L. (1979). *Paradox and Counterparadox.* New York: Aronson.

Parker, I. (1999). Critical psychology: Critical links. *Annual Review of Critical Psychology, 1,* 3-20.

Parker, L. (2003). A Social justice model for clinical social work practice. *Affilia, 8*(3), 272-288.

Pattison, M. E. (1981). Introduction: The social network paradigm, *Contemporary Family Therapy, 3*(4), 241-245.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Perneman, J. E. (1977). Consciousness through education. On-line dissertation summary. http://www.ped.gu.se/biorn/diss.sum/perneman1/html

Pinsof, W. M. (1988). Strategies for the study of family therapy process. In L. C. Wynne (Eds.), *The state of the art in family therapy research: Controversies and recommendations.* New York: Family Process.

Prilleltensky, I., Dokecki, P., Frieden, G., & Wang, V. O. (2007). Counseling for wellness and justice: Foundations and ethical dilemmas. In E. Aldarondo. (2007). *Advancing social justice through clinical practice* (pp. 19-42). Mahwah, NJ: Lawrence Erlbaum.

Prilleltensky, I., & Nelson, G. (2002). *Doing psychology critically: Making a difference in diverse settings.* New York: Palgrave MacMillan.

Prilleltensky, I., & Nelson, G. (1997). Community psychology: Reclaiming social justice. In D. Fox & I. Prilleltensky (Eds.), *Critical psychology: An introduction* (pp. 166-184). Thousand Oaks, CA: Sage.

Prochaska, J. O. (1999). How do people change, and how can we change to help many more people? In M. A. Hubble, B. L. Duncan, & S. D. Miller (Ed.). *The heart & soul of change: What works in therapy* (pp. 227-255). Washington, DC: American Psychological Association.

Prochaska, J. O. (1979). *Systems of psychotherapy: A transtheoretical analysis*, Chicago, Dorsey.

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: theory, research and practice,* 19, 276-288.

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology,* 51, 390-395.

Prochaska, J. O., & Norcross, J. C. (1994). *Systems of Psychotherapy: A Transtheoretical Analysis (pp. 453-492) (3rd ed.).* Wadsworth, Inc.

Rappaport, J. (1977). *Community psychology: Values, research, and action.* New York: Holt, Rinehart & Winston.

Rappaport, J. (2000). Community narratives: Tales of terror and joy. *American Journal of Community Psychology, 28*, 1-24.

Rojano, R. (2007). The practice of community family therapy. In E. Aldarondo, *Advancing social justice through clinical practice* (pp. 245-263). Mahwah, NJ: Lawrence Erlbaum.

Rogers, B. J. (2003). An exploration into the client at the heart of therapy: A qualitative perspective. *Person-Centered & Experiential Psychotherapies, 2,* 19-30.

Rosewater, L. B. & Walker, L. E. A. (1985). *Handbook of Feminist Therapy: Women's Issues in Psychotherapy* (Ed.). Springer Publishing Company.

Said, E.W. (1978). *Orientalism.* Vintage publisher.

Sandelowski, M. (1995). Focus on qualitative methods: Sample size in qualitative research. *Research in Nursing & Health, 18,* 179-183.

Schaffer, L., Wynne, L. C., Day, J., Ryckoff, I. M., & Halperin, A. (1971). On the nature and sources of the psychiatrist's experience with the family of the schizophrenic (pp. 45-64). In J. Haley, *Changing Families: A family therapy reader* (Ed.). Grune & Stratton, Inc.

Sells, S. P., Smith, T. E., & Moon, S. (1996). An ethnographic study of client and therapist perceptions of therapy effectiveness in a university-based training clinic. *Journal of Marital and Family Therapy. 22,* 321-342.

Sexton, T. L., Ridley, C. R., & Kleiner, A. J. (2004). Beyond common factors: Multilevel process models of therapeutic change in marriage and family therapy. *Journal of Marital and Family Therapy, 30,* 131-149.

Silverman, D. (2005). *Doing qualitative research.* (2nd ed.). Thousand Oak, CA: Sage.

Silverstein, L. B., & Goodrich, T. J. (2003). *Feminist Family Therapy: Empowerment in social context* (Eds.). Washington DC: American Psychological Association.

Simms, K. (2003). *Paul Ricoeur.* New York, NY: Taylor and Francis Group.

Singer, M. (2005). A twice-told tale: A phenomenological inquiry into clients' perspectives of therapy. *Journal of Marital and Family Therapy, 31*(3), 269-281.

Sloan, T. (2000). *Critical psychology: Voices for change.* London: Macmillan.

Smith, J.A. & Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to methods* (pp. 51-80). London: Sage.

Smith, L.T. (1999). *Decolonizing methodologies: Research and indigenous peoples.* Zed Books.

Speck, R. V. & Attneave, C. L. (1971). Social Network Intervention. In J. Haley (Ed), *Changing Families: A family therapy reader.* Grune & Stratton, Inc.

Speck, R. V. & Rueveni, U. (1969). Network therapy – A developing concept. *Family Process, 8,* 182-191.

Spivak, G.C. (1988). Can the subaltern speak? In C. Nelson & L. Grossberg (Eds.), *Marxism and the interpretation of culture* (pp. 1-15). Urbana, IL: University of Illinois.

Sprenkle, D. H. & Piercy, F. P. (2005). *Research methods in family therapy* (2nd ed.). New York, NY; Guilford Press.

Strang, H., & Braithwaite, J. (2005). Restorative justice and family violence (Ed.). Cambridge University Press.

Taylor, D. M., & Moghaddam, F. M. (1994). *Theories of intergroup relations: International social psychological perspective* (2nd ed). New York: Praeger

Tolsdorf, C. C. (1976). Social networks, support and coping: An exploratory study. *Family Process, 15,* 407-417.

van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy.* Albany: State University of New York Press

Vargas, L. A., & Koss-Chioino, J. D. (1992). *Working with culture: Psychotherapeutic interventions with ethnic minority children and adolescents* (Eds). San Francisco, CA: Jossey-Bass publishers.

VERBI Software, (2007). http://www.maxqda.com

Vick, R. D., Smith, L. M., & Herrera, C. I. R. (1998). The healing circle: An alternative path to alcoholism recovery. *Counseling & Values, 42 (2),* 133-141.

Vidich, A. J. & Lyman, S. M. (2000). Qualitative methods: Their history in sociology and anthropology. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.) (pp. 37-84). Thousand Oaks, CA: Sage.

Waldegrave, C. (2005). "Just Therapy" with families on low incomes. *Child Welfare, 84(2),* 265-276.

Waldegrave, C. (1990). Just Therapy. *Dulwich Centre Newsletter, 1,* 5-47.

Walkerdine, V. (1996). 'Working-class women: Psychological and social aspects of survival'. In S. Wilkinson (ed.), *Feminist Social Psychologies* (145-163). Philadelphia: Open University Press.

Wark, L. (1994). Therapeutic change in couples' therapy: Critical change incidents perceived by therapists and clients. *Contemporary Family Therapy, 16,* 39-52.

Watts, R., Abdul-Adil, J., Griffith, D. M., & Wilson, D. (1996). Practical strategies for sociopolitical development in young, African-American Men. National Convention of the Association of Black Psychologists, Chicago, IL.

Watts, R., Griffith, D. M., & Abdul-Adil, J.(1999). Sociopolitical development as an antidote for oppression: Theory and action. *American Journal of Community Psychology, 27(2),* 255-271.

Watzlawick, P., Weakland, J. H., & Fisch, R. (1974). *Change: Principles of Problem Formation and Problem Resolution.* New York, NY: W.W. Norton & Company.

Wellman, B. (1981). Applying network analysis to the study of social support. In B, Gottlieb (Ed.), *Social networks and social support.* Beverly Hills: Sage.

Wilkinson, C. B., & O'Connor, W. A. (1982). Human ecology and mental illness. *American Journal of Psychiatry, 139(8),* 985-990.

Williams, K (1993). Beyond racism and misogyny: black feminism and 2 live crew. In M.J. Matsuda., C.R. Lawrence., R. Delgado, & K. Williams (Eds.), *Words that wound* (pp.111-132). San Francisco, CA: Westview Press.

White, J. M., & Klein, D. M. (2002). *Family theories: Understanding families* (2nd ed.). Thousand Oaks, CA: Sage.

WinZip Computing (2010). http://www.winzip.com/index.htm

Wolcott, H. F. (2001). *Writing up qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Wylie, M. S. (1996). It's a community affair, *Family Therapy Networker,* 59-66.

Yalom, I. (2005). *The theory and practice of group psychotherapy* (5th ed.). Basic Books.

Young, I. M. (1990). *Justice and the politics of difference.* Princeton, NJ: Princeton University Press.

APPENDIX A: TRANSTHEORETICAL MODEL

Stages of Change					
Precontemplation	**Contemplation**	**Preparation**	**Action**	**Maintenance**	**Termination**
Consciousness Raising Dramatic relief Environmental reevaluation	Self-reevaluation	Self-liberation	Contingency management Helping relationships Counterconditioning Stimulus Control		

(Prochaska, 1999)

APPENDIX B: HISTORICAL OVERVIEW OF THE CCM

The CCM originally developed by Almeida and her colleagues at the Institute for Family Services (IFS), New Jersey, is a family therapy model which centers on issues critical to diversity and social context in families (Almeida, 1998; Almeida, 2004; Almeida & Durkin, 1999; Almeida & Lockard, 2005; Almeida, Dolan-Del Vecchio, & Font, 1998; Almeida, et al., 2008; Almeida, Woods, & Messineo, 1998; Almeida, Woods, Messineo, Font, & Heer, 1994). As a trained family therapist from the Ackerman Institute for the Family in the early 1980's, Almeida began the first program for batterers in New Jersey in 1984. During the training at Ackerman, the concept of the *reflecting team* and having dialogue with families as a team (Andersen, 1987) motivated her to establish the principal of working alongside other therapists in the presence of clients. Other influences came from two feminist family therapists, Judith Meyers Avis (1992) and Michelle Bograd (1992), who are among the first family therapists to address the issues of gender and its powerful dynamic in relationships and families, including family violence (Almeida, personal communication, November 27, 2007). These factors together contributed to the emergence of the CCM and how it fosters working as a team to deal with power and privilege in the center of all clinical issues.

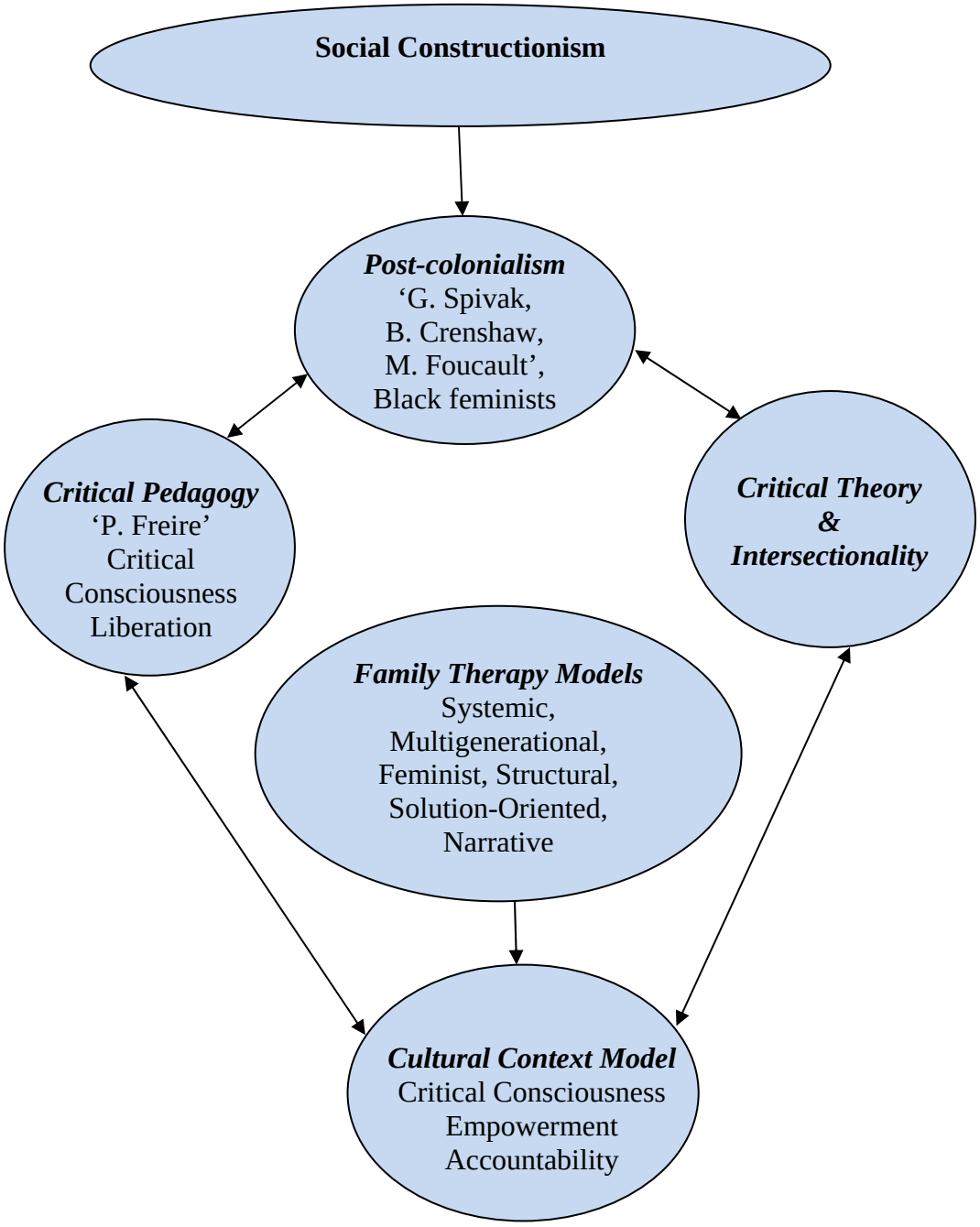
As there was no sophistication in understanding why men abuse women in early 1980s, Almeida experienced a lack of success in addressing domestic violence in standard martial therapy and had concerns about her own safety in dealing with violence-prone, intimidating men as a therapist. As a result, she recruited two police officers and other men out of civic organizations, the Lions and Rotary Club, to have a dialogue about

what men thought about violence toward their partners and then bring that dialogue into therapeutic work with other men and women (Markowitz, 1997; Wylie, 1996). This setup not only made Almeida and the partners of the batterers feel safe but also provided her male clients with role models of non-violent men. In addition, she noted that when the private context of relationship was intruded by the public context of others, violence was stopped (Almeida, personal communication, November 27, 2007).

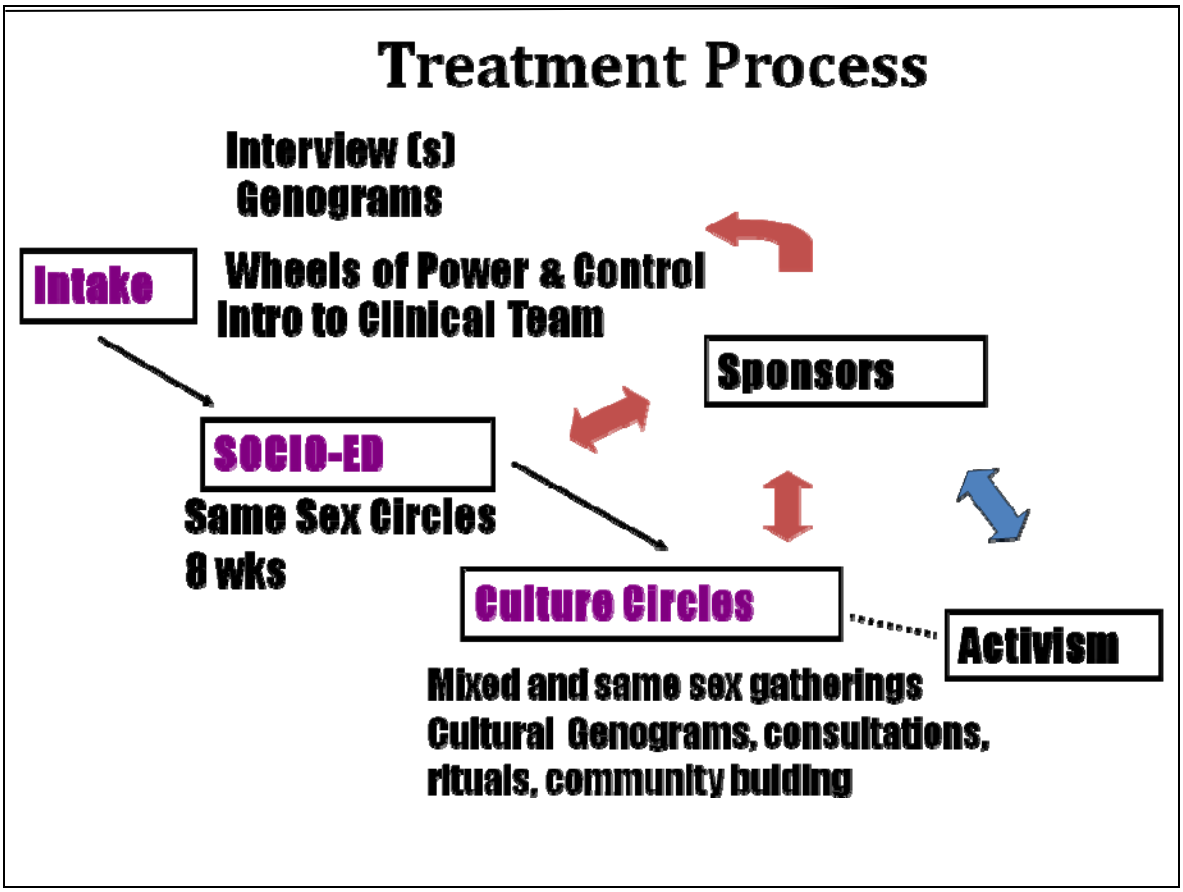
By 1987, Almeida began a more formal sponsorship program, utilizing her own clients, who volunteered to become sponsors themselves, both from a sense of gratitude and their own desire to continue relationships with others in the community (Wylie, 1996). As the sponsorship program has evolved over time, the power of using mixed groups of clients and sponsors became noticeable. Today, sponsors are used in every therapeutic group at IFS – women's, men's, children's, and teens' – and these groups include wide range of clients with various presenting problems ranging from domestic violence to social anxiety. The CCM has also been adopted by other counseling and therapy groups and therapists. In addition to IFS, the CCM was adopted since the early 2000s by the Affinity Counseling Group in North Brunswick, New Jersey, and by a number of therapists (Almeida, et al., 2008).

APPENDIX C: THEORETICAL UNDERPINNINGS OF THE CCM

(Modified from P. Hernandez, 2007)



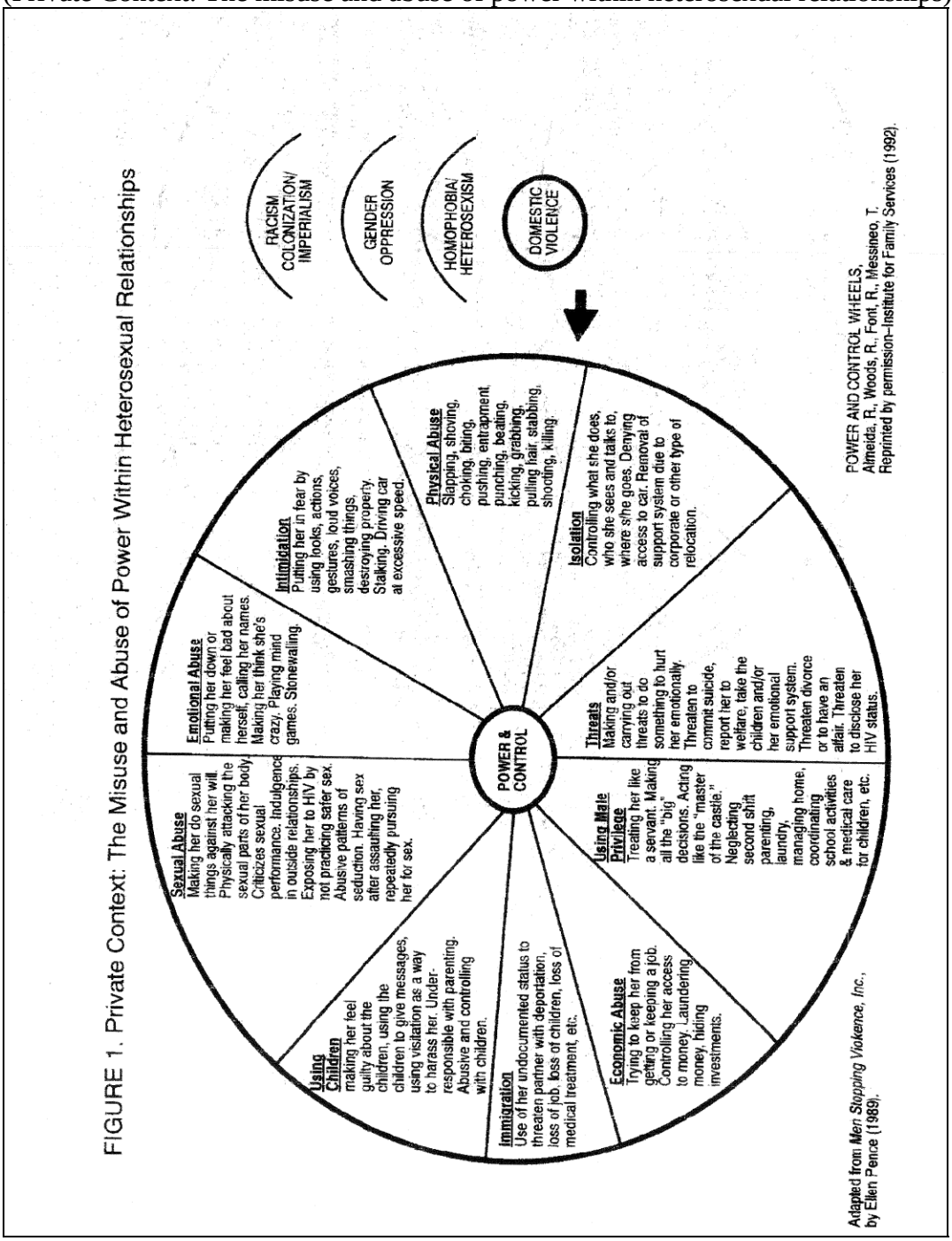
APPENDIX D: TREATMENT PROCESS OF THE CCM



(P. Hernandez, 2007)

APPENDIX E: POWER & CONTROL WHEEL

(Private Context: The misuse and abuse of power within heterosexual relationships)



APPENDIX F: TRADITIONAL NORMS OF THE FEMALE ROLE

1. *Seeking stereotyped feminine looks and behavior*. Thin, buxom, youthful; like a Barbie doll. Behaving in traditional female roles – around the house, choosing to be a nurse, because a woman can't be a Dr.
2. *Expressing emotion* except anger, adapting the caretaker role and dependency.
3. *Seeking social status* and self-esteem vicariously through husband.
4. *Seeking codependency* and hiding independence, competence, and competitiveness. Seeking to be smaller and smaller until you disappear.
5. *Passivity*, martyrdom and over-talkativeness. Overly emotional.
6. *Intense emotionality* and accommodating in the face of adversity.
7. *Super mom, superwomen syndrome*. Acceptance of a one-down position, lack of boundaries between home and work.
8. *Acceptance of sexuality* that is defined through male attitudes. Even with 20-30 years of the feminist movement, women's roles are still primarily defined by men. The stereotypes still invade your mind. We do not have at many places to go to define ourselves as sexual beings. It is all male defined.
9. A woman would be accused of betraying her man if she seeks closeness with a woman. If your man finds out you have confided in a woman you are a betrayer. Women get into rigid heterosexuality and devalue lesbians. A woman may devalue a man who shows feminine tendencies. Our own internalized homophobia gets us to devalue the softer side of men.

(Permission obtained through Institute for Family Services)

APPENDIX G: TRADITIONAL NORMS OF MASCULINITY

1. *Suppression of emotional vulnerability*; emotional distance; avoidance of painful feelings in self and others (fear, grief, hurt, sadness); emphasis on logic, rationality, and emotional restraint.
2. *Avoiding feminine behavior and activities* traditionally associated with women's role (such as housework, childcare, gender nonconforming leisure activities, and occupations).
3. *Primary of work role*; seeking power, admiration, and social status through achievement; self-esteem primarily based on work performance; willingness to sacrifice personal well-being and relationships in order to succeed at work and earn money.
4. *Independence*; avoidance and denial of dependency on others; withdrawal and isolation rather than seeking help, nurturance, or guidance from others.
5. *Aggression* used as a means to control others and as a means of conflict resolution.
6. *Toughness, stoicism*, projecting an air of confidence in the face of adversity, danger, or physical pain.
7. *Striving for dominance* and hierarchical authority in relationships; patriarchal control and leadership in family.
8. *Provider/protector* for others in family.
9. *Treating sexual partners as objects*; emphasis on rigid normative standards of beauty; using partner as a "trophy"; non-mutual approaches to sexuality; emphasis on sexual prowess and performance.

10. *Homophobia* (irrational fear/anger at gay men and lesbians; avoidance of emotional closeness and affection with other males). (Green, 1998)

APPENDIX H: EXPANDED NORMS OF MASCULINITY

1. *Expanded emotionality:* the willingness to express the full range of emotions, including exuberance, joy, love, wonder and awe at things beautiful, fear, sadness, remorse, disappointment, and all the rest.
2. *Embracing femininity:* valuing qualities and activities traditionally considered feminine (household and childcare tasks; cooking, creating art, dancing, and composing poetry; human service occupations).
3. *Balancing work and family life:* seeking pride through contributing both within the world of work and within an active participant in family life.
4. *Embracing relatedness over individualism:* valuing interdependence with all other human beings and with the rest of the natural world.
5. *Valuing collaboration:* using consensus building as a primary means for conflict resolution.
6. *Maintaining flexibility:* when faced with adversity, demonstrating respect for the opinions of others alongside assertiveness regarding one's own ideas, emotional availability, and emotional vulnerability.
7. *Valuing shared power of relatedness:* striving to create equal partnerships with adults and relationships with children that engender feelings of being loved and respected while also providing appropriate limits and structure.
8. *Relational attitude toward sexuality:* participation that affords each partner safety, dignity, and pleasure. Respect for others.

9. *Overcoming heterosexism/homophobia:* valuing difference by creating nurturing relationships with gay men, lesbians, bisexuals, and heterosexuals, and by borrowing expanded forms of participation in the following dimensions of relationships: non-threatening behavior; mutual respect; trust and support; honesty and accountability; responsible parenting; household responsibilities; economic partnership; negotiation and fairness in resolving conflicts (Font, Dolan-Del Vecchio, and Almeida, 1998)

.

APPENDIX I: CRITERIA FOR IFS SPONSORS

In order to be chosen as a sponsor, former IFS clients have to meet the following criteria. They will have:

(a) Attended two-hour group sessions weekly for a minimum period of nine months (thirty-six sessions)

(b) Consistently kept appointments and been punctual for sessions

(c) Actively participated in group discussions openly and honestly by contributing positively to other members, men and women, in the community

(d) Shared information about own family

(e) Acknowledged past use, misuse, and/or abuse of power and privilege

(f) Taken responsibility for categories of power and control: physical abuse, sexual abuse, economic abuse, intimidation, isolation, triangulation of children, treats, using male privilege, and/or immigration status

(g) Maintained safe home for self and family members

(h) Maintained sobriety and attended AA/NA, if needed

(i) Demonstrated a willingness to resolve conflicts in a nonviolent manner

(j) Written either a letter of accountability or empowerment in the context of her prior treatment process

(k) Reached out to sponsor(s) and maintained contacts consistently via phone, email, or in person

(l) Engaged in therapeutic and outside community activities

(m) Offered feedback to other members through interactions inside and/or outside of the therapeutic settings

(n) Completed sponsorship training

(o) been a sponsor for at least a year

APPENDIX J: RECRUITMENT EMIL

Dear Sponsor,

My name is Eunjung Ryu, a doctoral student at the Couple and Family Therapy Department in Drexel University. I have received your email address from the Director of Institute for Family Services (IFS), Rhea Almedia, regarding your interest in participating in a research study on female sponsors' experiences of the Cultural Context Model.

I'd like to take this opportunity to express my gratitude to you for your willingness to commit time and effort to sharing your accounts of your sponsorship experiences. Your testimony of the sponsorship experience will give deeper knowledge and understanding of the therapeutic change process of the sponsors of the Cultural Context Model therapy.

If you are still interested, I'd like to ask you to review the consent form attached to this email and review it. If you decide to participate in the study, you may return the consent form to me when we meet for the interview or I will bring a copy for you to sign, whichever works easier for you. Since this is a voluntary participation, you can cancel or withdraw from the study anytime you wish.

The interview which will take about 2 hours can take place either at IFS or a location of your preference that is agreeable to me too, whichever works better for you.

If you have any questions about the project, please feel free to contact me via email, name@drexel.edu, or phone, (xxx) xxx-xxxx.

Whether you are interested in participating in the research or not, please respond to this email letting me know your decision. If you are not interested, there will be no negative impact in terms of your relationship with IFS or its staff.

If you are interested, I will follow-up with details about preparing to participate in the study. We will discuss the location of your preference, and possible dates and times for the interview.

Thank you very much again for your participation and I am looking forward to hearing from you.

Sincerely,
Eunjung Ryu, LMFT, LCSW

APPENDIX K: APPROVED IRB APPLICATION

Drexel University
Consent to Take Part
In a Research Study

1. **SUBJECT NAME:** _____

2. **TITLE OF RESEARCH:** Sponsoring Change in Self and Others: Female Sponsors in the Cultural Context Model

3. **INVESTIGATOR'S NAME:** Carolyn Tubbs, Ph.D. (Investigator), Eunjung Ryu, LCSW, LMFT (Co-investigator)

4. **RESEARCH ENTITY:** Drexel University

5. **CONSENTING FOR THE RESEARCH STUDY:** This is a long and an important document. This is a long and an important document. If you sign it, you will be authorizing Drexel University and its researchers to perform research studies on you. You should take your time and carefully read it. You can also take a copy of this consent form to discuss it with your family member, attorney or anyone else you would like before you sign it. Do not sign it unless you are comfortable in participating in this study.

6. **PURPOSE OF RESEARCH:** You are being asked to participate in a research study which attempts to describe female sponsors' experiences of sponsorship facilitated by the Cultural Context Model (CCM) from their own perspectives. This research study is looking at how changes happen among female sponsors by sponsoring others in the therapeutic community. This research project is being conducted as partial fulfillment of the requirements of a doctoral degree in the Couple and Family Therapy

   The findings of this study will be used to learn more about the experiences of female sponsors at the Institute of Family Services (IFS), which follows the CCM approach of family therapy. Particularly, this study aims to capture the female sponsors' own accounts of their experience of being or having been a female sponsor at IFS, and understand how that experience has related to their own therapeutic change process.

   You are being asked to participate in this research study because you are or have been a female sponsor at the IFS. Non-sponsors at the IFS are excluded in this study as this research is to learn about experiences of female sponsorship. Including yourself, between six and ten current or former female sponsors at the IFS will be asked to participate in this study.

   You may choose not to be part of this study or may withdraw from it when you wish with no negative consequences.

7. **PROCEDURES AND DURATION:** You understand that the following things will be done:

- Your participation involves one face-to-face interview of a two (2)-hour length. You may be asked to participate in one additional follow-up interview of the same length of 2 hours.
- If we need to meet for a second time, it is to consult with you to ensure that what I will have found by analyzing the data from the first interview will have been the accurate description of your experiences of sponsorship. The purpose of the second meeting thus is to modify any discrepancies that might happen during analysis of the data from the first interview and also to reflect your description of experiences in a more accurate way.
- In addition, the second interview will be conducted in the form of a group meeting, where all of the sponsors who have participated in the research study will join.

If you are a current sponsor at the Institute of Family Services (IFS) in Somerset, New Jersey, the interview(s) for you will be held at the IFS. However, if you consent to do so, the interview can be held at a location of your preference that is also agreeable to the investigator.

- During the interviews, you will be asked questions about your background, your experience as a non-sponsor client of the IFS, your experience as a sponsor of the IFS, and your own perceptions of the process of any therapeutic change you think you may have experienced as a result of being or having been a sponsor at the IFS.
- After each interview you will be provided with debriefing. Debriefing refers to having a brief conversation regarding your experience in the interview and allowing you to ask the investigator any questions about the experience and this research.
- Your interview(s) will be audio taped and videotaped. The study will use the transcript of the audio tapes of the interview as the primary source of information and videotapes as a backup data source in case of inaudibility from the audio tapes of the interview. These data will be stored in lock-protected files in a secured room accessible only to the investigator and co-investigator. Also, the co-investigator will make a single copy of data as a backup in a protected file in a different location accessible only to the co-investigator. All data pertaining, both the original data and its backup copy, will be destroyed 7 years after the completion of the interview.

Please indicate your permission to videotape the interview by initialing your name.

Initial _____

Subject Initials_____

8. **RISKS AND DISCOMFORTS/CONSTRAINTS:** It is important to note that, in exploring your own experience of sponsorship at the IFS, some feelings of anxiety or other strong emotions may arise. If this is the case, you can, at any time during or after the interview, ask the investigator, who is a trained and licensed marital and family therapist, to halt or reschedule the interview, or ask her to help you process your feelings arising from the interview.

   Any conversation or account of the situation due to such request for help will not be recorded as part of the audio transcript. You will also be given a set of phone numbers listing nearby individual and family counseling services and community programs where you can process these feelings in greater detail.

   Although the risk is minimal, it is also possible that your regular activities may be affected by participation in this study. Your daily routine may be impacted due to inconvenient timing of the available slot for interviews. You may miss, for example, timing of meal(s) or sleep. In order to minimize inconveniences to your daily schedule, the investigator will make efforts to schedule the appointments for interviews at your convenience and preference.

9. **UNFORESEEN RISKS:** Participation in this study may involve unforeseen risks. If unforeseen risks should occur, the Office of Regulatory Research Compliance will be notified.

10. **BENEFITS:** There may be no direct benefits from participating in this study. However, there may be benefits to you that may include, but are not limited to, feeling of satisfaction that you may have contributed to advancing the knowledge on the CCM family therapy approach, of which you are or have been a female sponsor, and gaining greater personal insights on your own therapeutic process or on your life in general. You may also be able to gain your own greater understanding of the methods and effects of the CCM family therapy approach as a result of participating in this study.
    If you would like a copy of the findings of this study, the investigator will be happy to provide one for you.

11. **ALTERNATIVE PROCEDURES:** The alternative is <u>not</u> to participate in this study.

12. **REASONS FOR REMOVAL FROM THE STUDY:** You may be required to stop the study before the end for any of the following reasons:
    a) If all or part of the study is discontinued for any reason by the investigator or university authorities.
    b) If you are a student, and participation in the study is adversely affecting your academic performance.
    c) If you fail to adhere to requirements for participation established by the investigator.

Subject Initials_____

13. **VOLUNTARY PARTICIPATION:** Participation in this study is voluntary, and you can refuse to be in the study or stop at any time. There will be no negative consequences if you decide not to participate or to stop.

14. **STIPEND/REIMBURSEMENT:** You will not receive stipend or compensation for participating in the interview for this study.

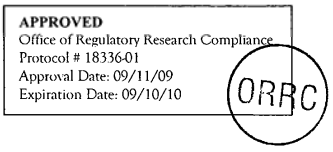
15. **CONFIDENTIALITY:** All information gathered for this study will be kept confidential. This means that only the investigator and the dissertation committee will have access to the information provided. While your responses will not be identified unless specifically requested, it is possible that responses may be quoted verbatim in the dissertation and possible subsequent publications. You will also have the opportunity, if you wish to read the dissertation and provide feedback, or ask that changes be made. You are not obligated to review the dissertation, however.

    The audio tapes and transcripts from the tapes due to your interview(s), and any material generated upon analysis of the tapes or the transcripts that may reveal your identities, will be kept in strict confidence. Also, for the purposes of confidentiality, you will be given a pseudonym and be referred by it throughout this study. All materials will also be stored in a secure and locked place accessible only to the investigator and her advisor. A backup copy will be made of the material and will be stored in a separate, different secure and locked place, again accessible to only the investigator and co-investigator. Both the original and the backup copy of the material will be kept securely for 7 years, and then will be destroyed completely.

    This study will be shared with my dissertation committee and other appropriate members of the Drexel University community. The dissertation that results from this work will be published in hard copy and microfiche, which will be housed at the library on campus. Your identity will not be disclosed in the dissertation or any other article or presentation that is published as a result of this study. Instead, a pseudonym that cannot be traced to your identity will be used in the dissertation as well as any future publications.

    There is a possibility that records which identify you may be inspected by the Drexel University Institutional Review Board (IRBs) for this study. You consent to such inspections and to the copying of excerpts of your records, if required by the representative(s) of the said IRB.

    Confidentiality will be broken in case of suicidal or homicidal intentions or presence of abuse of minor performed by you.



Subject Initials_____

16. **OTHER CONSIDERATIONS:** If you wish further information regarding your rights as a research subject or if you have problems with a research-related injury, for medical problems please contact the Institution's Office of Regulatory Research Compliance by telephoning 215-255-7857.

17. **CONSENT:**
- I have been informed of the reasons for this study.
- I have had the study explained to me.
- I have had all of my questions answered.
- I have carefully read this consent form, have initialed each page, and have received a signed copy.
- I give consent voluntarily.

DO NOT SIGN THIS INFORMED CONSENT AFTER THIS DATE 9/10/10

_____ _____
Subject or Legally Authorized Representative **Date**

_____ _____
Investigator or Individual Obtaining this Consent **Date**

Videotaping: Yes No **Audio taping: Yes No**

Signature _____ **Signature** _____

List of Individuals Authorized to Obtain Consent

Name	Title	Day Phone #	24 Hr Phone #
Carolyn Y. Tubbs	**Principal Investigator**	**215-762-2258**	*XXX-XXX-XXXX*
Eunjung Ryu	**Co-investigator**	*XXX-XXX-XXXX*	*XXX-XXX-XXXX*

.

APPROVED
Office of Regulatory Research Compliance
Protocol # 18336-01
Approval Date: 09/11/09
Expiration Date: 09/10/10
ORRC

Subject Initials_____

APPENDIX L: DEMOGRAPHIC INFORMATION FORM

Please tell me about yourself.

1. Age: _____
2. Race: _____
3. What is your ethnic origin? _____
4. Were you born in the U.S.? Yes_____ No_____
5. Number of years living in the U.S. _____
6. Years of education: _____
7. Marital status:

   Never married_____ Married _____ Separated_____

   Divorced_____ Widowed_____
8. How many children under the age of 18 reside primarily in your household?

   _____
9. Are you working? Yes FULL-TIME_____ or PART-TIME _____

   No _____
10. How would you rate your class?

    Working class _____ Middle class _____

    Upper Middle class _____ Upper class _____
11. How would you describe your social location according to the social location pyramid that is used as part of the IFS socio-education?

12. What were the concerns that brought you to IFS?

13. Who referred you to IFS?

14. Which other family member(s) have participated at IFS with you?

Thank you very much for your participation 

APPENDIX M: SEMI-STRUCTURED INTERVIEW QUESTIONNAIRES

To participant at beginning of the interview:

The purpose of this interview is to gain a better understanding of your experiences as a sponsor. I have some questions related to this topic, but feel free to add information I do not cover.

As discussed earlier, this interview will last no longer than two hours. If you need to take a break during the interview, we can take time to pause and then return to the interview.

Throughout the interview, there will be opportunities to take a break and talk about any negative feelings you might have. If you feel uncomfortable with a question, feel free to say that you would like to skip over it. If you are unclear about the intent of a question, we can discuss it or I will try to re-phrase it. If at any point, you wish to stop the interview entirely or wish to withdraw as a participant, you are under no obligation to continue. We will stop the interview and provide you an opportunity to debrief.

Shall we begin?

1. What brought you to IFS?
    a. Who told you about or referred you to IFS?
    b. How was IFS described to you? What did the person tell you about IFS?
    c. Was there a particular issue or problem that required you to seek therapy?
    d. Why did you think IFS was a good fit for you?
2. What has been the process of change for you?
    a. Had you been to other therapies before you came to IFS?
    b. If you did, has this been different from other types of therapy or support that you have experienced?
    c. What parts of the therapy works for you?
3. What are the changes that you have seen happened throughout the process?
4. Before we go on to the next question, I am going to give you this sheet of paper, some drawing tools, and some markers. I am going to ask you to create a map or

timeline of your journey to sponsorship, as well as to where you are today. Start from when you first came to IFS until now. It will take about 15 minutes. Once you finish, I am going to ask some questions.

a. Tell me about your journey to sponsorship.
    i. How long have you been a sponsor?
    ii. What was the process of becoming a sponsor?
    iii. What has been your experience with sponsorship?
    iv. What other roles have you had as a sponsor?
    v. Identify 3 critical moments in your process to becoming or being a sponsor.
    vi. How would you describe what sponsorship means to clients and the staff of IFS?
    vii. What meaning does sponsorship have in your life?
    viii. How long do you expect to be a sponsor?
    ix. Have you ever considered stopping your role as a sponsor?

5. Who were three sponsors who worked with you the most? (Please give the person's first name only.)
6. What date or timeframe did you become a sponsor?
7. How does interacting with other sponsors or clients affect you in your own process?
8. How does being a sponsor for others affect you in your own process?
9. Have you had any negative experiences in sponsorship?
10. What is it like for you to interact with therapeutic staff in the capacity of sponsor?

11. What are the gains and/losses that you have made in this process?
12. How has your work as a sponsor affected your relationship and your life outside of IFS?
    a. What examples come to mind when you think about how your sponsorship affects relationships and your life outside of IFS?
    b. Who in your life noticed the effect of IFS and sponsorship on your life?
    c. Who was most affected by the impacts of IFS and sponsorship on your life?
    d. Are you involved with other change activities outside of IFS?
    e. What do you think a male sponsor would say about his sponsorship process?
    f. Do you think they would say that their experience is different than that of yours?
13. Given your journey to and time as a sponsor, how would you describe the kernel/or most important learning from this experience?
14. Is there anything else you would like to add before we end this interview?

APPENDIX N: COMMUNITY MENTAL HEALTH SERVICES

Affinity Counseling Group
688 Nassau Street
North Brunswick, NJ 08902
(732) 249-3737
* Provides individual, couple, and family therapy

Catholic Charities
Diocese of Metuchen
319 Maple Street
Perth Amboy, NJ 08861
(800) 655- 9491
* Community mental health agency

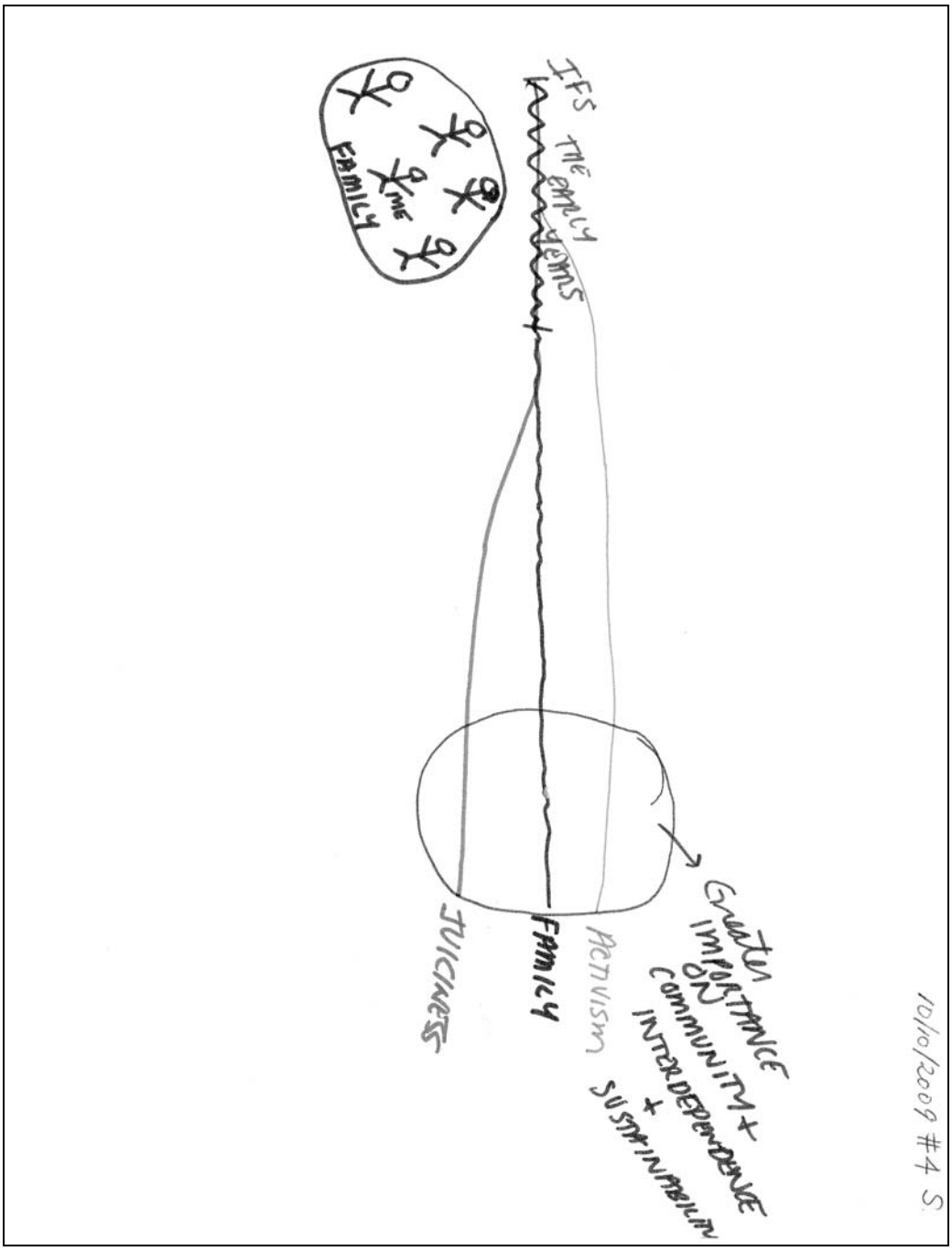
Coordinated Family Care
100 Metroplex Drive Suite 301
Edison, NJ 08817
(732) 572-3663
* Provides referrals for community resources

Institute for Family Services, Inc.
3 Clyde Road, Suite 101
Somerset, NJ 08873
(732) 873-1663
* Provides individual, couple, and family therapy

Raritan Bay Mental Health Center
570 Lee Street
Perth Amboy, NJ 08861
(732) 442-1666
* Community mental health agency

University Behavioral Health Care
671 Hoes Lane
Piscataway, NJ 08855
(800) 969-5300
* Community mental health agency

APPENDIX O: EXAMPLE DRAWING BY PARTICIPANT



APPENDIX P: EXAMPLE OF RESEARCH MEMO

1/19/2010 3:46:27 PM

Theoretical memo:

> "And I accompanied her as an ally? A White ally? For many different things, I spent time with her and I went with her to support her in her process where she was supporting her children, strategizing and also reporting…."

The term, a White ally, struck me in this interview with Jennifer. Most people would not use this term, ally, in relationship with people of color. In the traditional sense, when white people reach out to people of color, it is usually from a position of superiority, maybe she could have said, 'I helped a woman of color in the community…' or even refer to her as an "African-American", "Asian", or "Hispanic" woman, but she used the term ally as if she is collaborating with someone to provide support as an equal. This can be considered as an example of having developed critical consciousness and lending her white privilege to support a woman of color. Also, I should be able to use this as an example of influences of post-colonialism.

Vita

Eunjung Ryu was born in Korea and immigrated to the US in 1990 in order to pursue higher education. She has master's degree in social work from the University of Pennsylvania and her emphasis was family. She worked at various social work settings since 1993, and has maintained a private practice since 1998. She had completed three-year post-graduate family therapy training from the Multicultural Family Institute in 2001. She is currently a Ph.D. candidate in doctoral study in couple and family therapy at Drexel University. While in the program, she had published a journal article entitled 'Spousal use of pornography and its clinical significance for Asian-American women: Korean women as an illustration', in *Journal of Feminist Family Therapy* in 2004. She also co-authored a book chapter entitled 'Korean Families' in *Ethnicity and Family Therapy* (3rd Ed.) in 2005. She has given numerous presentations on topics such as working with court-mandated youth and their family, Cultural Context Model, family therapy with Asian American families, and domestic violence in Asian American families. Her interest is women's issues, social justice, and models of therapy based on social justice theories and practices.