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**Negotiating agency and personal narrative in clinical social work practice : a qualitative study investigating how clinicians' experiences of multiple narratives influence their clinical work**

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Emily Rebecca Fischer  
Negotiating Agency and  
Personal Narrative in Clinical  
Social Work Practice: A  
Qualitative Study  
Investigating how Clinicians'  
Experiences of Multiple  
Narratives Influence Their  
Clinical Work

## ABSTRACT

This exploratory qualitative research study investigated clinical social workers' experiences negotiating agency and personal narrative in their clinical work in community mental health centers (CMHCs). Through three broad research questions, the researcher gathered narrative data which explored the influence of organizational context on clinical work. The study was informed theoretically by organizational systems literature and psychodynamic literature regarding functioning in organizations, and methodologically by narrative theory concepts. Open-ended, naturalistic interviews were conducted with twelve clinical social workers who worked in CMHCs. Three broad themes emerged in the findings: 1) participants' perceptions of agency narrative; 2) participants' narratives about themselves, their clients, and their work; and 3) participants' negotiations of the interplay between agency and personal narratives, and the influence of this negotiation on clinical work. The findings generally support the notion that social workers' experiences in CMHCs are complex and evocative, due in part to ideological and sociopolitical shifts in the mental health service context and wide splits between organizational subsystems. Generally, participants articulated that organizational context influences the way in which social work services are delivered in CMHCs,

although factors such as experience level, the strength of the worker's personal narrative, and awareness of conflicting narratives mediated this influence to some extent.

NEGOTIATING AGENCY AND PERSONAL NARRATIVE  
IN CLINICAL SOCIAL WORK PRACTICE:  
A QUALITATIVE STUDY INVESTIGATING HOW CLINICIANS' EXPERIENCES  
OF MULTIPLE NARRATIVES INFLUENCE THEIR CLINICAL WORK

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

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2008

## ACKNOWLEDGEMENTS

I would like to thank my research participants, who invited me in to hear and experience their narratives. Each participant provided rich and honest material for my research, and I am indebted to them all. However, I am more deeply grateful on a far more personal level. As I listened to participants' stories, I realized that one of the unintentional outcomes of this process for me was to gain, in deep yet succinct doses, the collected insight of clinicians who have remained committed to their clients, their organizations, and their own development over their often long and distinguished careers. I have been informally mentored through this process, and am truly grateful.

Additionally, I wish to thank all of the individuals and organizations who influenced my interest in this topic. My experience at Incarnation House taught me about the destructive and restorative powers of collegial relationships in social work practice. I am grateful in particular to Michelle and Katie, who walked with me along an edge of relational learning. I would like to thank Adin de la Cour and Fred Newdom for consulting with me in the very early stages of this project, as well as Joan Laird, whose initial enthusiasm for and subsequent consultation on my thesis topic encouraged me to deepen and broaden my thinking. My research advisor, Bruce Thompson, was unfailingly precise and efficient, and able in critical moments to help me push my conceptual understanding of the literature and data to new levels. Thank you, Bruce.

Although in a fit of self-determination (which I may come to regret), I did not ask my mother (a professional editor) to proof this manuscript, her presence—technical, stylistic, and maternal—assisted me throughout this project, as did my grandmother's, whose love of words has influenced mine. My father's deep passion for (and ambivalence about) care-giving work has most certainly influenced my path; my admiration for him and the kind of formal and informal caring relationships he maintains is contained in these pages as I struggle to define my own narrative as a social worker. My brother Toby helped me remove myself psychologically and physically from this project with a hair-raising drive through snowy mountains in May of 2008; although I didn't articulate it then, I am always grateful to him for our unspoken communications. Finally, I am deeply indebted to Kate, whose beautiful thesis research in 2007 inspired and catalyzed me, just like so many other aspects of her have, do, and, I am confident, will.

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## CHAPTER 1

### INTRODUCTION

Theorists in social work and related fields have long posited a relationship between the organizational context in which social workers practice and the clinical services they provide (Crandall & Allen, 1982; Gitterman & Miller, 1989; Hasenfeld, 1992; McLeod & Machin, 1998; Menzies Lyth, 1988; Obholzer, 1987). More recently, researchers have studied this relationship with the intention of improving services for clients and job satisfaction for workers (Glisson & Hemmelgarn, 1998; Hemmelgarn, Glisson, & Dukes, 2001; Kacen & Bakshy, 2005; Parker, 2002; Schow, 2006; Yoo, 2002). Gitterman and Miller (1989) propose that “[a]lmost all, if not all, clinical decisions represent agency policy and organizational imperatives in action” (p. 151). Yet, little research exists that describes and/or bears out the theory and process through which clinicians’ clinical decisions come to represent their organizations’ imperatives. Indeed, social work education and values explicitly highlight the obligation to provide services according to a framework of ethical practice, as defined by social work boards and by the profession.

Referring to methods of analyzing social workers’ processes of clinical decision-making, Obholzer (1987) suggests that “there is...no conceptual difference between our approach in understanding an individual, a couple, a family, or an institution...the unconscious processes in all these settings have identical origins.” He goes on to ask why our knowledge of these unconscious processes “seems to be of such relatively little use to

us in our everyday institutional functioning?” (p. 201-202). Reinforcing Obholzer’s query, John McLeod and Linda Machin (1998) believe that the “contextual factors [of counseling] have been largely ignored in counseling theory, research and practice....” They suggest that “increased attention to context has the potential to contribute to the creation of more responsive and effective counseling services” (p. 325).

In consideration of the dearth of research that illustrates the theoretical link between clinical practice and organizational context, the researcher undertook a qualitative study of clinical social workers in outpatient community mental health settings in order to direct specific attention to the mutually influential spheres of individual practice and organizational context. Using a narrative approach to elicit information on the research questions, this qualitative study explored:

1. How social workers absorb, experience, and are influenced by the organizations in which they work, i.e. what are their perceptions of the explicit and implicit narratives at work in their agencies?;
2. How they define their individual clinical practice, i.e. what are the personal and theoretical narratives which guide their clinical social work practice, and what are the “stories” that they have about their clients and work?; and
3. What is their sense of the ways in which the implicit and explicit agency narratives and the individual narratives are similar and/or different, how do these similarities and/or differences get resolved, and with what result for the clinical relationship?

The researcher chose a narrative approach to research because of narrative theory’s privileging and honoring stance toward individuals and their stories (Parry &



Doan, 1994; White, 2000). For the purposes of this research, the term *narrative* will be defined as “the emphasis that is placed upon the stories of people’s lives and the differences that can be made through particular tellings and retellings of these stories” (The Dulwich Centre, 2000). Gitterman and Miller (1989) argue that “by the nature of their ordinarily low organizational rank, clinicians function in relation to administrative staff from disadvantaged positions, i.e. limited ascribed authority, insufficient information, and inadequate structural opportunities to place their experience and day to day knowledge into organizational processes” (p. 155). In this research study, participants were asked to differentiate individual narratives from organizational narratives, inviting a “re-authoring” process which in some senses is an implicit challenge to authority and structures embodied by the organization. In this way, the research methodology was generative and co-constructive, and located in a postmodern understanding of the intersubjective processes between researcher and participant. At the same time, flexible methodology allowed for the participants’ narratives to guide the data collection process within the bounds of the research topic reducing bias in the study results (Anastas, 1999). The researcher’s reflexivity and self-examination regarding her own professional and personal narratives may further reduce bias in the data collection and analysis processes.

Two main bodies of literature, organizational systems theory and psychodynamic theory, shaped the formulation of the interview guide (see Appendix A) and the interpretation of the data. From the large body of literature on organizations comes the idea of the organization as a system of interacting parts, each with an implicit or explicit charge to complete certain tasks. Organizational systems theory highlights the idea that change in one part of the organizational system will ripple through the other parts of the

organizational system, sometimes with unintended and unanticipated outcomes for clients, clinicians, or administrators (Crandall & Allen, 1982). The field of organizational studies also identifies several key variables which have a demonstrated effect on the satisfaction, organizational commitment levels, and functioning of workers in human service organizations. These variables include organizational structure, organizational/psychological climate and organizational culture, and characteristics of leadership figures and supervisors (Glisson & Durick, 1988). Psychodynamic theory has informed a broad range of writers on the topic of organizational work, including the influential Tavistock Clinic in England. Influenced by the ideas of Klein (1952, 1959), Bion (1961), and Menzies-Lyth (1960, 1988, 1989), these writers emphasize the unconscious processes at work in the life of the organization, with particular attention to the ways that organizational practices arise out of a need to defend against the anxiety of working in human service organizations. They also employ psychological concepts such as parallel process and transference/countertransference to the interpretation of organizational behavior.

Several qualitative and quantitative studies demonstrate the connection between individual clinical practice and the organizational context of this practice, although most often they take residential/inpatient/hospital settings or child welfare agencies as their subjects (Glisson & Hemmelgarn, 1998; Hemmelgarn, Glisson, & Dukes, 2001; Hinshelwood & Skogstad, 2000; Menzies Lyth, 1960; Yoo, 2002). This study is expected to contribute to this body of research literature by exploring the relationship between the individual clinician and the organization in outpatient community mental health centers (CMHCs). CMHCs are both particularly ubiquitous as a way of delivering mental health

services, and also particularly vulnerable to the forces – specifically managed care and decreasing governmental support – that are changing these services in our society today.

Social workers at all levels of organizational practice may find this study useful, particularly insofar as it attempts to articulate subtle, unspoken processes of negotiation and adaptation. By illuminating these processes, we may find ways to more deeply take into consideration the mutually influential spheres of organization and clinician as we continue to participate in, and make clinical decisions about, the lives of our clients.

## CHAPTER 2

### LITERATURE REVIEW

This chapter presents and analyzes literature that provides a framework for understanding the mutually influential spheres of organizational context and clinical practice. The first two research questions this study asks address these spheres separately. In an effort to understand the sphere of organizational context, this study seeks data regarding *how participants absorb, experience, and are influenced by the organizations in which they work, i.e. what are their perceptions of the explicit and implicit narratives at work in their agencies?* In an effort to understand clinical practice, the study seeks data regarding *how participants define their individual clinical practice, i.e. what are the personal and theoretical narratives which guide their clinical social work practice, and what are the “stories” that they have about their clients and work?* The final research question addresses the processes of influence and negotiation between these spheres: *what is the participants’ sense of the ways in which the implicit and explicit agency narratives and the individual narratives are similar and/or different, how do these similarities and/or differences get resolved, and with what result for the clinical relationship?*

Organizational systems theory provides one framework for understanding stories at the “macro” level of the “system” in organizations; e.g. management, workers, and client population. Psychodynamic theories allow for an understanding of stories at the level of the “self” in organizations; e.g. supervisor, clinician, client, workgroup. Both

organizational systems and psychodynamic theories and research have tacked back and forth between these two spheres, weaving a complex picture of relatedness. This literature review will follow a similar trajectory.

The first section describes and illustrates frameworks for interpretation within organizational systems theory and introduces key constructs like organizational structure, task/technology, organizational/psychological climate and organizational culture, and leadership. The second section describes and illustrates frameworks for interpretation within psychodynamic theories about organizational functioning, and introduces key concepts like the unconscious, anxiety and social defenses (two central and related constructs), workgroups, institutional countertransference, and parallel process. Both theories propose paradigms for understanding the relationship between organizational context and clinical practice; in this way, the first two sections also provide a framework for interpreting data related to the third research question. In order to contextualize the research, the third section of this review briefly presents an historical overview of CMHCs and the underlying economic and political forces that characterize work in these types of organizations.

#### *Stories at the Level of the Organization: Organizational Systems Literature*

Organizations have been empirically studied for at least half a century (Glisson, 2002, p. 236), and this research has identified several key constructs that are relevant for this study. These include organizational structure, the core task(s) and technologies of the organization, organizational/psychological climate and organizational culture, and leadership. Many researchers believe that these dimensions of organizational life have the power to shape the context of service delivery in mental health organizations (Glisson,

2002; Glisson & Durick, 1988; Glisson & Hemmelgarn, 1998; Hinshelwood & Skogstad, 2000; Jaskyte & Dressler, 2005; McLeod, 1994). Speaking to this power in the realm of children's mental health services, Glisson (2002) writes that "multiple social networks [in organizations]...encourage or constrain certain behavior, affect perceptions, and establish expectations for the individuals who function within them" (p. 233-234). In addition to shaping context, these themes of organizational life also shape outcomes for clients, as many researchers have shown in quantitative and qualitative studies (Glisson, 2002; Glisson & Durick, 1988; Glisson & Hemmelgarn, 1998; Parker, 2002; Yoo, 2002).

To understand organizational structure, theorists have developed various conceptual models. One of the most widely used models is open systems theory, developed by Daniel Katz and Robert Kahn (1978). Open systems theory has been applied across disciplines, including the life sciences; when applied to the study of organizations, it theorizes that organizations are systems of interrelated parts, each of which affect one another and in turn are affected by their broader context (Crandall & Allen, 1982). Evolving out of a more static model of organizational life that emphasized hierarchy and allocation of power, open systems theory places emphasis on the interrelatedness of each component of the organizational system. In open systems theory, multiple layers of subsystems cohere, more or less efficiently, into an organizational structure.

The basic premise of open systems theory – that changes in one part of a system affect all other parts of a system – is an implicit challenge to much research into the clinical encounter, which places great stock in the dyadic relationship between clinician and client. As McLeod (1994) states, "it might be concluded, from the lack of research,

that those who carry out research into counselling and psychotherapy assume that an effective counsellor can construct a therapeutic space during the therapy hour which effectively screens out any influence of the agency or organisation [sic]" (p. 5). Open systems theory encourages a consideration of the influence of the goals, operations, and structure of any one subsystem on other subsystems: for example, administrators may respond to increasing fiscal constraints by increasing financial demands on social workers, which may impact the social workers by increasing their caseloads, with implications for the clinical encounter.

Open systems theory also provides a schematic rendering of the organizational system. At a basic level, it holds that all organizations *input* raw material (clients and resources in CMHCs), *throughput* the material according to the organizational mission using a specific technology (various forms of therapy), and *output* changed material (healthier clients) (Crandall & Allen, 1982; Mcleod, 2003). This equation highlights the importance of the "throughput" process; i.e. what is the task of the organization and what technologies are used to perform this task?

#### *Core Task(s) and Technologies: Throughput*

Katz and Kahn (1978) suggest that the "throughput of an organization is its response to the objective task posed by the needs of the environment" (p. 245). Based on this definition, the task of the CMHC is to meet the mental health needs of its environment. This definition has limited applicability, however, when one considers the complex nature of most CMHCs. Indeed, Katz and Kahn go on to say that their definition of throughput "takes little note of the conflicting definitions of different constituencies,

[and] may fail to describe the motivations of management” (p. 246). Hasenfeld (1985)

points out that CMHCs are subject to internal and external variability and volatility:

A key characteristic of the attributes of the people served by CMHCs is that many are volatile, unstable, and unpredictable. More important, the raw material is vested with values and, therefore, the organizational technologies of CMHCs are embedded in moral systems. Consequently, the services and technologies of CMHCs are value laden. Second, they function in a task environment that is characterized by turbulence, conflicting interest groups, and fragmented and uncertain resources. Third, the goals of these organizations are inherently ambiguous, contradictory, and unstable. Fourth, they tend to operate indeterminate technologies that lack systematic or complete knowledge on how to attain desired outcomes. (Hasenfeld, 1985, pp. 655-656)

The implication is that the basic schema of open systems theory may not be complex enough to capture the complicated nature of “task” in CMHCs. Nevertheless, CMHCs attempt – through mission statements, publicity, and internal directives – to define the primary task of the organization. The inconsistencies which arise between stated task and actual task in CMHCs relates directly to psychodynamic concepts of task and anti-task behavior in groups (Bion, 1961), and may lead to confusion and difficulties for members in all subsystems of organizations (Zagier Roberts, 1994).

In order to complete a “task”, an organization must identify “technologies.” CMHCs use therapy technologies like pharmacotherapy, psychodynamic psychotherapy, cognitive behavioral therapy, and group therapy. However, with the possible exception of pharmacotherapy, these technologies are highly idiosyncratic (Hasenfeld, 1985) and “soft” (Hemmelgarn, Glisson, & James, 2006, p. 77). Indeed, as Parker (2002) points out, in some mental health settings, “the social system [itself] may...be the technology. In such organizations, the objective of healing, learning, or change is often achieved through the interpersonal relationships that organizational members form with their clients” (p.



279). In keeping with research into workgroups and leadership, the interpersonal relationships *among staff* may also contribute to the accomplishment of these objectives.

The choice of technologies in CMHCs sometimes illuminates conflict among organizational subsystems: individual constituents, clinicians, supervisors, management, clinical leadership, insurance companies, funders, and constituent groups all may have differing ideas about how best to accomplish the organization's task. Crandall and Allen (1982) argue that within these subsystems, one emerges as most powerful. The agency, they argue, formulates "treatment demands", and then provides the structure of a "treatment modality" with which to meet these demands:

[T]he treatment structure of the agency will have several effects on the behavior of the counselors and others in the agency. The treatment structure will specify, either clearly or covertly, the degree of autonomy afforded the counselors in the planning and implementing their therapeutic endeavors. (p. 435)

Similarly, Gitterman and Miller (1989) argue that the hierarchical nature of human service organizations privileges more powerful components of the organizational subsystem in this process, and that this privileging of the powerful may lead to dissent among less powerful staff:

Administrators and supervisors do not always have greater technical competence than their subordinates; rules are often arbitrary and irrational in effect; and a predictable and stable distinction develops between how things really get done and how they are supposed to get done. (p. 153)

If this "predictable distinction" exists between subsystems of an organization, then what is the result? How well does any given organization mediate these distinctions related to task and technology, and what are the mechanisms through which this is possible? In their efforts to answer this question, organizational theorists and researchers

have discovered the relevance of two variables – organizational/psychological climate and organizational culture.

### *Organizational/Psychological Climate and Organizational Culture*

Organizational/psychological climate and organizational culture are distinct dimensions of organizational life that have been proven to partially account for the wide variety of worker responses to challenging organizational circumstances. Both concepts appear frequently in the organizational literature of the last several decades (Glisson, 2002). Referencing a content analysis of the literature on organizational culture and climate, Glisson (2002) provides clear definitions of organizational culture and climate:

The core concepts described “climate” as the way people perceive their work environment and “culture” as the way things are done in an organization...Using this distinction, climate is defined as a property of the individual and culture is defined as a property of the organization. [Climate can be further broken down into] psychological climate and organizational climate...psychological climate is the individual’s perception of the psychological impact of the work environment on his or her own well-being. When workers in the same organizational unit agree on their perceptions, their shared perceptions can be aggregated to describe their organizational climate. (p. 235)

Psychological climate is a subjective, perceptive, individual account of the work environment. Hodgkinson (2003) speaks to these qualities of psychological climate in an article describing the interface of cognitive psychology and industrial, work, and organizational psychology. He states that individuals operating in organizations

are limited in their ability to process the rich variety of stimuli contained in the external world....Consequently, they employ a variety of strategies in order to reduce the burden of information processing...[which results] in the development of simplified representations of reality that are encoded within the mind of the individual....individuals internalize their knowledge and understanding of organizational life in the form of a simplified representation of reality. (p. 3, 5)

This cognitively-oriented account of psychological climate suggests that despite simplification, these mental models of organizational life are nevertheless powerful in their influence over individual behavior. Psychological climate is communicated, not always consciously, through “interpersonal interactions and social learning processes” (Hemmelgarn, Glisson, & James, 2006, p. 78) which form aggregate definitions of organizational climate. These processes raise the question of how the individual’s social identities (race, ethnicity, personal experiences, age, gender, sexual orientation, and ability) contribute, consciously or unconsciously, to perceptions of psychological climate.

“Climate perceptions...evoke feelings of satisfaction and identification with one’s job or organization” (Hemmelgarn, Glisson, & James, 2006, p. 78); furthermore, these perceptions have been tied in quantitative research to both outcomes for clients and to the successful adoption of new technologies by mental health providers. In a study of children’s service systems, Glisson and Hemmelgarn (1998) showed that organizational climate was the primary predictor of positive service outcomes for children receiving services, as measured by their improved psychosocial functioning. Yoo (2002) used a case study model to explore the impact of organizational characteristics on client outcomes. She found that certain organizational characteristics are causally correlated with client outcomes, and that direct service providers are conduits for this influence. She also points out that other organizational buffers, like peer support for workers and altruistic engagement with clinical work, lessen this impact. In a review of the literature, Hemmelgarn, Glisson, and James (2006) show that organizational climate and culture “are especially important factors in determining the successful adoption of new

technologies” (p. 84) including the evidence-based technologies that are increasingly demanded by insurance companies.

As Glisson (2002) suggests, organizational culture is distinct from climate in that it is a system of shared beliefs and behavioral expectations. The concept of organizational culture draws from sociological thought and, in particular, the work of Clifford Geertz (1973). McLeod (2003) captures the spirit of Geertz’s notion of culture when he says that “there are always many layers and levels to a culture, and...describing it is never a simple matter” (p. 4). Culture has been described as “thick” by Geertz (1973) and as “deep” by Glisson (2002) – suggesting that culture has a layered and rich quality. How is this thickness and depth communicated to organizational members; i.e. what is the process of acculturation to any given organizational system? Several authors propose answers to this question:

New organizational members are taught through observation, modeling, and personal experiences the “way things are done around the organization,” as well as the rewards, punishments, and expected outcomes that follow from one’s work behavior (Hemmelgarn, Glisson, & James, 2006, p. 75).

The culture of an organization is reflected in the use of language within the organization....There may be shared images of the agency of unit that express a sense of organizational culture: the agency may be a ‘family’, a ‘team’, a ‘sinking ship’ (McLeod, 2003, p. 5).

[Using intergroup relations theory,] in caregiving organizations, the group identities of care seekers and care providers contain powerful cues about appropriate in-role behavior. Care seekers are often called patients and expected to be passive and compliant, while care providers are accorded high status and expected to be confident experts who maintain a certain objectivity toward care seekers (Parker, 2002, p. 280).

Other authors, especially from a narrative tradition, highlight the importance of listening for organizational myths, stories, fantasies, jokes, and secrets as a way to understand culture (Martin, 1982; Sims, 2004; Kacen & Bakshy, 2005). These types of cultural cues

relate to another strong current of thought in the analysis of organizational culture: the presence of unconscious processes in organizational life.

Like organizational climate, organizational culture has been linked to client outcomes in qualitative and quantitative research. In a 2006 qualitative study of a domestic violence agency, Schow showed that contradictory messages were communicated to direct-care staff: explicitly, the agency espoused calm, equality-based decision-making processes, while implicitly staff members were expected to tolerate hierarchical decision-making, inconsistent accountability, and chaotic procedures. This contradiction in the explicit and implicit messages created a culture of submission among staff and clients that was antithetical to the stated mission of the organization. In another study, Hemmelgarn, Glisson, and Dukes (2001) combined qualitative and quantitative research methods to study the relationship between emergency room culture in four hospitals and the adoption of the emotional support component of a treatment protocol called family-centered care:

The results of this exploratory study describe differences among hospital ERs in the emphasis placed on providing emotional support to the families of children who receive emergency care. Staff descriptions of the emphasis placed on emotional support were found to be a function of the ER in which they worked and not of their experience, profession, or sex....The differences in emotional support provided by the four ERs in our sample describe different organizational cultures. In the cultures of Hospitals 1 and 2, emotional support to families is more valued and considered the norm. In Hospitals 3 and 4, it is less valued and not expected of staff....[Further analysis of the findings reveal two points:] First, staff who work in ER environments that emphasize emotional support for families also provide more emotional support for one another. Second, staff in ER cultures that emphasize emotional support receive intrinsic rewards for the support they provide (p. 103-104).

Numerous quantitative studies exploring the relationship between culture and client outcomes give strength to Hemmelgarn et al.'s 2001 findings. Indeed, researchers have

developed quantitative measures of organizational culture, and use of these measures has shown that cultural norms like innovativeness, aggressiveness, and cultural strength are related to the successful adoption of innovations by organizations (Hemmelgarn, Glisson, & James, 2006).

In CMHCs, the relationship between clinician and client is a core technology in the treatment. Organizational culture and climate have tremendous influence over the behavior and attitudes of the clinician, which in turn influence the dyadic relationship between the clinician and client: “[c]ulture and climate mold the nature, tone, and focus of the relationships and interactions between service provider and service recipient” (Hemmelgarn, Glisson, & James, 2006, p. 75).

### *Leadership*

In the literature, the personality and style of leadership figures are sometimes identified as core variables in organizational effectiveness, although notably much of the literature previously reviewed here leaves out leadership as a variable in the study of organizations. Exploring this, Yoo points out that “leadership...has been recognized both theoretically and empirically, as a major influence of organizational success...[yet] the social work profession...appears to not have considered leadership very captivating as a research subject” (Yoo, 2002, p. 43).

Perhaps not surprisingly, much of the literature supporting the claim that leadership is a key factor in organizational effectiveness comes from a human services administration perspective (Jaskyte & Dressler, 2005; Schin & McClomb, 1998). These authors often use the differences between two primary leadership styles, transactional and transformational, to account for organizational innovativeness and success (Reinhardt,

2004). Transformational leaders possess and use characteristics like charisma, inspiration, future-orientation, the ability to provide intellectual stimulation, and a strong vision that are thought to facilitate the leader's ability to "manipulate the culture in the organization to allow for shifts of focus and new viewpoints" (Reinhardt, 2004, p. 22). Transactional leaders, on the other hand, preserve bureaucratic imperatives and accomplish management tasks without emphasis on change (Reinhardt, 2004).

Certain leadership styles and practices (e.g. charisma and ability to involve organizational actors in decision-making processes) are believed to contribute to an empowerment orientation in organizations (Hardina, 2005); similarly, supervisory qualities like client-centeredness and empathy have been shown to improve outcomes for clients (Poertner, 2006). Given these research findings, leadership becomes an important, though under-researched, factor in the analysis of organizational narratives.

#### *Stories at the Level of the Self: Psychodynamic Theories*

Walton (1997) suggests that one must consider three aspects of organizational life: the formal ways of working, the informal ways of working, and the unconscious or unacknowledged ways of working. Organizational theories provide a framework for understanding the first two dimensions, but rarely speak to the third dimension. In the study of clinical practice in organizations, psychodynamic theories offer the possibility of understanding these unconscious/unacknowledged dynamics which so often characterize organizational life (McLeod & Machin, 1998; Menzies Lyth, 1988; Obholzer, 1987; Walton, 1997). Indeed, Hemmelgarn, Glisson, and Dukes (2001) – some of the most prolific researchers on the organizational context of mental health delivery – found in their study of emergency room cultures that "even those [organizational] members who

are most vocal about the negative aspects of their work environment can be the most resistant to changes that threaten their adaptive patterns of survival behavior” (p. 106). Psychodynamic theories can help account for these types of resistances and patterns by looking to the group and individual unconscious.

While an exhaustive review of psychodynamic literature is far beyond the scope of this research, this section will explore those psychodynamic theories that specifically address the conscious and unconscious thoughts, feelings, and behavior evoked by work in organizations. The rich tradition of applying psychodynamic thought to organizations began in the middle of the twentieth century with the work of Isabel Menzies-Lyth (1960, 1988, 1989). Her work borrowed from and deepened the ideas of Melanie Klein (1952, 1959) and Wilfred Bion (1961). In the latter part of the twentieth century, psychoanalytically-oriented writers from the Tavistock Clinic and elsewhere have taken up and applied these authors’ ideas (Gould, Ebers, & McVicker Clinchy, 1999; Halton, 1994; Obholzer & Zagier Roberts, 1994; Smith, 1997). Several key constructs have emerged from theory and research: the unconscious, anxiety and social defenses, workgroups, institutional countertransference, and parallel process. These constructs and relevant research are presented here in order to provide context for the discussion of the second research question regarding clinician’s experiences with personal and theoretical narratives in their work.

### *The Unconscious*

In thinking about functioning in CMHCs, it is useful to consider the unconscious of both the individual and the group, and their inter-relatedness (Obholzer & Zagier Roberts, 1994). Freud first provided a language for understanding the unconscious of the



individual, and proposed that unconscious material *remains* unconscious through the use of defenses until the subject may safely integrate it into his or her consciousness (Halton, 1994). Obholzer (1987) proposes that to understand organizational life, one must extend this awareness of unconscious material to institutions:

...no-one in their right mind would believe that they are objective about their own mental functioning without having had some outside help; many of us have undergone years of therapy...in order to get some perspective on the institution called one's own mind. Yet somehow when it comes to one's functioning in other types of institutions, other than one's own mind that is, we fall into a pattern of hoped-for objectivity that by definition...is impossible to achieve even in its most relative sense, without the same attention to analysis and training that we demand for individual work...the basic individual minima [e.g. principle] should be an understanding of one's own particular valency [a Bionian concept] when caught up in group and institutional processes and some opportunity to work at its modification (p. 202).

Relationships in organizations, therefore, can become fertile grounds for “acting out” unconscious conflicts. Perhaps one of the most evocative relationships individuals encounter in organizations is with power and authority: Obholzer (1994) argues that responses to authority are prominently affected by the “nature of [the individual's] relationships with the figures in their inner world” (p. 41). These ideas are reminiscent of attachment theory, which highlights the continuing influence of early relational experiences on interpersonal functioning. Parker (2002) used the language of attachment theory in her research on the relational dimensions of workgroups in a hospital setting. She writes that “the existence of [supportive] workgroups is essential in providing care providers with a secure base from which to perform their very difficult work” (p. 295). This language suggests the utility of considering relationships to authority figures at work through the lens of attachment and object relations.

Unconscious material also exists at the level of the group, as Gould, Ebers, and McVicker Clinchy (1999) describe:

[G]roups come to share collective, unconscious assumptions about other relevant groups that constitute their social/organizational environment. These assumptions are manifested in both conscious and unconscious processes, including projections, attributes, and stereotyping which shape the ensuing quality of their intergroup relationships. (p. 700)

In research and theory, Menzies-Lyth (1960, 1988, 1989) identifies anxiety as a core individual and group experience which leads to these assumptions and the ensuing projections, stereotyping, and attributions.

*Anxiety and Social Defenses: Contributions from Isabel Menzies-Lyth and Melanie Klein*

Organizational theorists and psychodynamic theorists agree that the main purpose of institutions is to perform tasks. The theories diverge in their understanding of the individual and group dynamics involved in the performance of the institutional tasks. Drawing particularly from the work of Isabel Menzies-Lyth (1960), psychodynamic theorists emphasize that

inherent in every task...there is the anxiety, pain and confusion arising from attempting to perform the task; and that institutions defend themselves against this anxiety by structuring themselves, their working practices and ultimately their staff relationships in such a way as to unconsciously defend themselves against the anxiety inherent in the task (Obholzer, 1987, p. 202).

Isabel Menzies-Lyth (1960) “discovered” the central and unconscious role of anxiety in institutional functioning in her seminal study of a nursing service in a general teaching hospital. Menzies-Lyth’s research goal was to account for the high level of stress among the nurses in this particular hospital, and in the course of exploring this question she discovered a vast “social defence [sic] system” that the nursing service had unconsciously

constructed to cope with the intense and primitive anxieties aroused by their difficult work.

Nurses in the hospital Menzies-Lyth studied had the primary task of caring for sick people who could not be cared for at home. Predictably, this task provoked incredible stress in the nursing staff, as they routinely encountered patients with incurable diseases, performed intimate tasks like feeding and bathing that required physical contact, and dealt with death and suffering. Drawing on Kleinian theory, Menzies-Lyth (1988) argued that these stresses unconsciously evoked infantile longings in the nurses which, in conjunction with the other responsibilities of the job (caring for the physical and psychological needs of patients, their families, and colleagues), put nurses “at considerable risk of being flooded by intense and unmanageable anxiety” (p. 46-50). She theorized that in response to these high levels of stress, nurses developed a particular structure, culture, and mode of functioning which was unconsciously aimed at alleviating the anxiety of their work. She postulated that the “social defence [sic] system develops over time as the result of the collusive interaction and agreement, often unconscious, between members of the organization as to what form it shall take” (p. 51).

Among the nurses she studied, Menzies-Lyth identified several defensive techniques used to alleviate anxiety. Some of these techniques included the “splitting up of the nurse-patient relationship,” in which nurses shifted the focus of the work off of individual *patients* and onto individual *tasks*, such as feeding and bathing. Related to this, she found that nurses used depersonalization defensively, referring to patients by their illness rather than their names and dressing in uniforms that depleted their own individuality.

Menzies-Lyth argued that the defensive techniques used by the nurses (and supported by the institution at large) failed to successfully identify and deal with the anxiety inherent in the work, which resulted in extremely high stress levels and burnout rates among staff in the hospital. This led her to conclude that “the success and viability of a social institution are intimately connected with the techniques it uses to contain anxiety” (Menzies Lyth, 1988, p. 78). It is valuable to note that this proposition strongly resembles a thread in organizational theory, in which the culture of the organization has been connected to that organization’s innovativeness and resilience. Just as nurses defensive techniques seemed to decrease their ability to effectively carry out their work with clients in Menzies-Lyth’s study, Hemmelgarn, Glisson, and James (2006) cite research that found that “organizations with particularly strong shared cultures were found to be less innovative, explained by possible resistance to change of well-established norms” (p. 76).

Melanie Klein (1952, 1959), whose work informs Menzies-Lyth and whose concepts have been usefully applied to the study of organizations, considers the ability or inability to tolerate anxiety, and the resulting defenses, central in the development of the ego and the personality (Halton, 1994). Her theory of individual development holds that early in life, children use the primitive defenses of projection and splitting to cope with unpleasant feelings: this is called the paranoid-schizoid position. Through integration of these separated feelings, individuals ideally achieve depressive position functioning, a state in which complex and conflicting feelings have been successfully integrated into the self (Halton, 1994). Psychodynamic theories widely support the notion that in therapeutic treatment, clinicians and organizations often become containers for the projections of

clients (see in particular Gabbard, 1994). However, these processes occur among staff as well:

In the helping professions, there is a tendency to deny feelings of hatred or rejection towards clients. These feelings may be more easily dealt with by projecting them onto other groups or outside agencies, who can then be criticized....Sometimes the splitting process occurs between groups within institutions. Structural divisions into sections, departments, professions, disciplines and so forth are necessary for organizations to function effectively. However, these divisions become fertile ground for the splitting and projection of negative images. The gaps between departments or professions are available to be filled with many different emotions – denigration, competition, hatred, prejudice, paranoia....Emotional disorder [such as this] interferes with the functioning of an organization, particularly in relation to tasks which require co-operation or collective change (Halton, 1994, pp. 14-15).

Eileen Smith (1997) describes her experience with these processes in her work in a university counseling service under tremendous pressure from the university administrators and other outside forces impacting mental health service provision. She writes that in the current culture of scarcity and deprivation, “it is extremely difficult [for counselors] to maintain depressive position functioning” (p. 118). Drawing on Hasenfeld’s (1992) political-economic model of organizational development, Smith (1997) discusses the impact of the “redefinition of the primary task in purely economic terms,” arguing that this redefinition causes overwhelming “fears in managers and other role holders” that result in functioning from a paranoid-schizoid position “as a defense against being engulfed by these feelings” (p. 122). Smith uses the anecdote below to illustrate these fears *and* the simultaneous unconscious tendency to split them off. She also beautifully illustrates how these fears can arise from the unconscious symbolically:

We can act as if transference and infantile longings were afflictions of everyone else in the institution rather than phenomena that even counselors might share. I would suggest that looking after others stirs up quite a strong wish to be nurtured ourselves which may be enacted over seemingly trivial matters. I am struck by

how much tension has at times centered around coffee cups and kitchens and the role of secretaries in my workplace. A whole paper might be devoted to such interactions and the meanings they carry but the overriding unspoken question seems to be ‘Who is going to attend to *my* needs?’ (p. 127-128).

Both Smith (1997) and Halton (1994) allude to the difficulty members of human service organizations face in maintaining depressive position functioning when both their economic survival and their sense of self-worth are threatened.

Drawing on Klein, Menzies-Lyth (1988) gives centrality to the notion that the underlying anxieties inherent in organizational tasks, when not consciously understood and worked through, result in maladaptive defensive techniques that lead to activities that undermine the primary task of the organization and worker. Wilfred Bion’s (1961) work is premised on the same notion, although he more actively takes into account the role of group processes in these dynamics.

*Workgroups: Contributions from Bion and modern applications*

According to Menzies-Lyth (1989), Bion saw membership in groups as an inherently conflictual experience: “Bion emphasizes how difficult it is for human beings to relate to each other in a realistic way in a joint task...the human being [is] a group animal [who] cannot get on *without* other human beings. Unfortunately, he cannot get on very well *with* them either” (p. 27). Fundamentally Kleinian in orientation, Bion emphasizes that the group is at once the all-encompassing soother and the frustrating withholder. Groups, therefore, give rise to powerful experiences. In the context of organizations, these experiences can either contribute to the completion of the primary task (work-group mentality) or engage the group in anti-task activities, which obfuscate the primary task, and instead work to meet the unconscious needs of group members

(basic assumption mentality) (Stokes, 1994; Bion, 1961). Bion delineates three different assumptions (dependency, fight-flight, and pairing) that groups make when they are out of work-group mentality, and argues that these assumptions contribute to the formation of anti-task work cultures which further distance the organizational members from their primary task (Stokes, 1994).

Victoria Parker offers a modern day application of Bion's theories in her 2002 case study research with two care-giving workgroups in hospital settings. Her research is based on an assumption from psychodynamic theory that "relationships [between care-givers and care-seekers] are likely to be influenced by the unconscious processes of both members; because the care provider is an organizational member, it is quite likely that he or she will bring unconscious material related to this membership into interactions with care seekers" (p. 280). She highlights the influence of workgroup characteristics on task accomplishment: groups "help workers stay in their roles by providing an outlet for stresses that might otherwise cause a worker to step out of role (e.g., by complaining to a care seeker)...[Alternately,] inadequate or nonfunctional support systems may make it impossible for direct contact workers to effectively maintain relationships with care seekers" (p. 281). Her research finds that workgroups, when functional, provide an important function for their members:

Health care systems and their workers are containers of powerful anxieties...[and] staff turmoil is inevitable unless provisions are made for dealing with these issues. The findings in this study suggest that the existence of workgroups in which care providers can construct shared interpretations of troubling events in their work with care seekers is a powerful preventive measure of such turmoil. (p. 294)

It is clear from both Bion's theories and the research described above that workgroups play a central role in containing and understanding the powerful anxieties

experienced by workers in human service organizations. The stance adopted by the groups Parker describes allows them to assist caregivers in sorting through their own and their clients' emotional responses to care-giving work, not unlike the well-known psychodynamic concepts of transference and countertransference.

### *Institutional Countertransference*

Organizational processes and tasks can have a potentially powerful influence on the emotional life and behavior of their members. This influence can remain largely unconscious throughout all levels of the organizational system. Various authors have suggested the usefulness of listening for these unconscious elements in order to understand the core anxieties present in organizations and their members. Similarly, psychodynamic therapists have often been trained to “listen” for their own conscious and unconscious emotional responses to clients – their countertransference – and to use these responses as cues in their work with patients. Clinicians' emotional responses toward their agency, colleagues, workgroups, supervisors, and other actors are also potential influences on countertransference.

Obholzer (1987) pleads with therapists to recognize the illusion of organizational objectivity by recognizing that they may be “enrolled in the process of performing some unconscious task on behalf of the institution” (p. 202). Other powerful voices in psychodynamic theory urge therapists to “trace [their countertransference reactions] back to the special properties of the patients with whom they work” (Eisenberg, 1997, p. 238). Glen Gabbard (1994), a highly influential theorist and clinician in the field of psychodynamic psychotherapy, implies that staff members' countertransference reactions are ideally immune to forces outside of the therapeutic dyad. He describes the function of



staff members on an inpatient psychiatric unit where hospitalization ideally works “via projective identification, [where] patients attempt to reestablish their internal object world in the milieu. Staff members contain these projections and provide new models of relatedness for reinternalization” (p. 190).

Eisenberg (1997) proposes, however, that clinicians must proceed with an awareness of “the extent to which countertransference in institutional staff may be aroused more by the institution itself than by the patients within it” (p. 239). A small but important body of literature has addressed this interpretation, although primarily in the context of milieu-based mental health treatment (e.g. inpatient hospitalization and residential treatment). Eisenberg (1997) summarizes these ideas succinctly:

The social structure [in institutional settings] plays on and exploits the personal vulnerabilities and conflicts of all members of the community, catching them up in the throes of feelings that in other settings might lie dormant or unsolicited. The result is a loss of the “conflict-free sphere of functioning.” The social milieu, by its very structure, stimulates inner as well as outer conflict, restricting opportunities for the unconflicted functioning so necessary for effective performance of demanding tasks...A major impediment to thoughtful treatment of patients is thereby built into the institutional structure, insofar as significant portions of staff time and energy are drawn to the task of maintaining personal equilibrium in the provocative hierarchichal atmosphere. (p. 252)

Yet hierarchical structures and provocative work atmospheres are not limited to milieu-based treatments. Organizational theory has quantitatively linked leadership styles (which may be more or less hierarchical and therefore provoke unconscious reactions) with staff and client outcomes. Psychodynamic theory has suggested that work environments can be extremely provocative and subsequently elicit splitting and projective processes in staff members. RoseMarie Perez Foster’s (1998) concept of cultural countertransference gives more credence to the highly subjective and multiply

influenced feelings that therapists cope with in relation to their clients. She emphasizes the intersubjective nature of the clinical process, and with this in mind, defines cultural countertransference as the clinician's set of beliefs and attitudes about their own culture and other cultural groups which may enter the therapeutic dyad via unconscious discomfort, anxiety, identification, and anger (Perez Foster, 1998). Similarly, the feelings evoked by one's specific experience as a staff member in an organization are potential fuel for unconscious countertransference reactions to clients, or institutional countertransference. It is useful, then, to extend a consideration of this dynamic to all organizational settings where mental health services are provided.

### *Parallel Process*

One of the clinical mechanisms through which institutional transference and countertransference may manifest is *parallel process*, or the notion that experiences in the clinical encounter between therapist and client will be mirrored in other encounters in the organization, and particularly in the encounter between clinical supervisors and therapists-in-training (Crandall & Allen, 1982; McLeod, 2003; Mothersole, 1999). Parallel process is perhaps most commonly thought of as originating in the therapist-client dyad, and moving up through organizational subsystems. McLeod (2003) gives an example of this:

For example, in a marriage counseling agency that works a lot with couples, counselors often come across the combination of one rational, unfeeling spouse with a partner who is the emotionally sensitive, feeling but illogical one. This splitting of logic and feeling can become inherent in the agency itself, perhaps through managers and administrators being perceived by counselors as unfeeling insensitive bureaucrats, and the counselors being perceived by administrators as disorganized and unwilling to make decisions. (p. 6-7)

However, the reverse process of the one described above can also take place. In that situation, dynamics originate in organizational subsystems *outside* of the therapeutic encounter and are transmitted or enacted *in* the therapeutic encounter. In his review of literature on the topic of parallel process, Mothersole (1999) quotes from M. Doehrmann's 1976 doctoral research: "An even more telling respect in which the reflection process [Searles' 1955 theory about parallel process] is too limited is that Searles considers the parallel process as always working in one direction-the therapist carries his patients' problems into his work with his supervisor. In this study the most impressive evidence was that the parallel process works in the other direction" (p. 109). McLeod (2003) echoes this possibility: "in an agency with an authoritarian and directive management style, where counselors are told what to do, counselors may find themselves becoming more structured and directive in their work with their clients" (p. 7).

Using these ideas, Crandall and Allen (1982) suggest that there are often striking parallels between organizational and client issues. An awareness of these parallels contributes to the clinician's ability to locate the source of difficulties experienced by the client, which may sometimes be the agency itself.

*The Context of the Story: Contemporary Perspectives on Work in CMHCs*

For the last seven decades, CMHCs have played, and continue to play, a crucial role in providing mental health services to people in the United States. In the early 1960s, tremendous advances in psychosocial and psychopharmacological treatments for mental illness, along with increasing alarm at the quality of mental health services traditionally provided by state hospitals, spurred the government to pass legislation that supported the development of CMHCs. In the 1960s and 1970s, CMHCs flourished, and mental health

service provision shifted from largely inpatient settings to largely outpatient settings. In these decades, CMHCs were financially supported in large part by government programs like SSI, SSDI, Medicare, and Medicaid. At the same time, CMHCs began to provide services not only to the severely and persistently mentally ill population, but also to a broader spectrum of the population. Today, CMHCs are defined by most authors as organizations which provide outpatient clinical services and at least one other kind of service (partial day treatment, inpatient, residential, home-based) to a defined geographical community (Hadley, Culhane, Mazada, & Manderscheid, 1994; McLeer, 2006).

The CMHCs under study here, and generally, are extremely heterogeneous in terms of task, services, technologies, and clientele. Managed care, however, is a uniform manifestation of the political and economic context in which CMHCs function right now in the United States. Changes in the health care system and financing over the last three decades have dramatically impacted the financial organization of community mental health centers. “Faced with the high costs of treatment for individuals with serious mental illness, state mental health authorities have increasingly turned to capitation and other forms of managed care to contain the costs of services in the public sector” (Morris & Bloom, 2002, p. 71). These financial changes have resulted in organizational structure changes, particularly as clinicians transition from salaried pay to fee-for-service pay in which they are essentially paid per clinical encounter rather than for the totality of their work for the organization.

Researchers, theorists, and clinicians have addressed the transition to managed care and its impact on mental health service providers and recipients from various angles.

Particularly among social workers who must adhere to a core ethic of social justice, there is a sentiment that the transition to managed care has created ethical dilemmas and threats to the profession that have yet to be negotiated (Bransford, 2005; Furman, 2003; McWilliams, 2005; Ware, Lachicotte, Kirschner, Cortes, & Good, 2000). Some excerpts will help to capture these conceptualizations of the threat posed by managed care.

Reporting on their qualitative anthropological study of a CMHC, Ware et al. (2000) write:

Finally, managed care as it is now constituted—not as a national health service but as an array of competitive and market-oriented corporations—represents the triumph of economics in a field that is intimately tied to the very survival, integrity, and self-worth of people. It has made the language of costs and benefits, of efficiencies and productivity, integral to the landscape of health care. At the same time, it also represents the triumph of the disease models and symptomatic treatments over models of well-being and a therapeutics that seeks to create, beyond impairment, the competencies for self-renewal and growth....It is not the case that clinicians at Wayside see no value in managed care, in medical models of psychiatric disorder and modes of treatment, or even in the management agencies themselves....Wayside clinicians dread managed care, then, because it threatens the vision of good mental health care to which they are committed. (p. 20-21)

In his article delineating the value discrepancies between social work and managed care, Furman (2003) writes:

One of the consequences [of managed care systems] is that many of the policies and programmatic decisions of MMHOs [managed mental health organizations] have created ethical dilemmas for social workers. All practice decisions in social work involve ethical decision-making, placing social workers in situations where they must choose between the values and ethical mandates of the profession and the imperatives of behavioral health care companies....Social work core values are autonomy, confidentiality, and client self-determination. But MMHOs' core values are cost containment, efficiency, and accountability. (p. 39)

And finally, in a scathing and passionate assessment of the “problem” of managed care, McWilliams (2005), a renowned psychodynamic author, writes:

In supervision and consultation meetings where practitioners once brainstormed to determine the best possible treatment for a given client, they now spend their time comparing notes on how to approach the relevant insurance company so that the client has some chance to get any treatment at all. Rather than immersing themselves in the work for which they underwent a long and demanding training, they devote inordinate time to haggling with bureaucrats and writing vapid reports full of insurance industry's favorite buzz words. What used to be a rich professional lore and various intervention strategies has turned into a shared expertise about the idiosyncrasies of different insurance plans. The stress of all this on the identity and self-esteem of therapists has been severe. (p. 144)

Each of these authors proposes that providing therapy in CMHCs under managed care impacts the way that therapists provide clinical care. As suggested in the first two sections of this review, both organizational theories and psychodynamic theories can provide frameworks for interpreting what are perceived by these authors as changes in clinical care.

Morris, Bloom, and Kang (2007) write that “[a]ddressing the service needs of diverse consumers in community-based mental health care settings is...extremely challenging, particularly in light of current fiscal constraints, and requires a high level of commitment, tenacity, and resourcefulness on the part of program administrators and staff” (p. 243). By highlighting perspectives on managed care here, the author hopes to contextualize some of the organizational and psychodynamic forces at work on the participants in this study.

### *Summary*

This literature review addressed each aspect of the research questions by first providing frameworks for interpreting organizational narratives in CMHCs and then providing frameworks for interpreting individual and theoretical narratives among clinical social workers. Throughout, the review described qualitative and quantitative

research which bears on the intersecting and mutually influential spheres of organizational context and clinical work. The history of CMHCs, and the current mental health service climate, was described.

Much like the research questions, the literature review has oscillated between analysis on an individual level and on a systems level, as Obholzer (1987) suggests, and has presented organizational systems theory and psychodynamic theories which relate to organizational functioning. It has presented theoretical frameworks that emphasize the importance of the complex organizational and environmental contexts in which the social workers function in CMHCs. These conceptual frameworks are used to interpret participants' narratives related to the research questions.

## CHAPTER III

### METHODOLOGY

This qualitative research study explored the ways in which social workers' experiences of multiple narratives influence their clinical work; i.e. how do clinicians negotiate agency narrative and personal narrative in clinical social work practice in organizations? Specifically, the researcher used open-ended interviews to elicit narratives that explored these research questions:

1. How social workers absorb, experience, and are influenced by the organizations in which they work, i.e. what are their perceptions of the explicit and implicit narratives at work in their agencies?;
2. How they define their individual clinical practice, i.e. what are the personal and theoretical narratives which guide their clinical social work practice, and what are the "stories" that they have about their clients and work?; and
3. What is their sense of the ways in which the implicit and explicit agency narratives and the individual narratives are similar and/or different, how do these similarities and/or differences get resolved, and with what result for the clinical relationship?

This study used flexible research methods to elicit participants' personal and theoretical narratives as well as their subjective experiences of their agency's narratives. The narrative lens informed the methods of data collection and data analysis. A narrative



approach to research in organizations has been used and promoted by theorists who study the organizational context of mental health services (Martin, 1982; McLeod & Machin, 1998; Bakker, Blokland, May, Pauw, & van Breda, 1999). Generally, narrative theory and narrative therapy promote the honoring and privileging of personal experiences as they are articulated through the stories, or narratives, that individuals use to make sense of, and construct meaning in, their lives (Parry & Doan, 1994; White, 2000). This stance is congruent with what people in the field of social work have called “empowerment practice”. Frans (1993) provides Solomon’s 1976 definition of empowerment: “[empowerment] refers to...skills in the exercise of interpersonal influence and the performance of valued social roles” (Frans, 1993, p. 312). Some authors propose that, although social workers’ ethical principles and broad theoretical narratives encourage empowerment practices with clients, social workers have historically perceived themselves and have been perceived by others to varying degrees, as individually and professionally powerless (Bransford, 2005; Frans, 1993; Gitterman & Miller, 1989). By eliciting individual narratives from social workers, this study seeks to document and collectivize the authoring processes of the participants under study here, which is considered a core component of empowerment practice (Frans, 1993, p. 313).

The narrative approach used in this study relies on concepts from narrative theory, including implicit and explicit narrative. For the purposes of this study, *narrative* is defined as “the emphasis that is placed upon the stories of people’s lives and the differences that can be made through particular tellings and retellings of these stories” (The Dulwich Centre, 2000). *Explicit narratives* are “characterized by full, clear expression so that there is no room for ambiguity or reason for difficulty or individual

differences in interpretation. Examples of explicit forms of communication include quantitative figures, rules and procedures, and abstract policy statements” (Martin, 1982, p. 257). *Implicit narratives* “allow for ambiguity and individual differences in interpretation. In implicit communications, the point of the message is often left unstated, the conclusion to be drawn by the information receiver. Stories are one of the many forms of implicit communication used in organizational settings” (Martin, 1982, p. 257).

Additionally, *authorization* and *de-authorization* are narrative concepts that informed the methodology in this research. Bransford (2006) writes:

Authorization has been defined (at least within work settings) as the process by which people are encouraged to act from their roles by “supporting, joining in, and reinforcing behaviors that conform to norms and expectations” (Kahn and Kram, 1994, p. 44). In contrast, de-authorization refers to “withholding such encouragement, support, and reinforcement” (p. 44) (p. 47)

When social workers are authorized, their perceptions are supported and they feel more ability to act according to their perceptions. In contrast, de-authorizing practices minimize social workers’ abilities to act within their roles. Bransford (2006) conducted a qualitative study of these processes among a small group of social workers, and found that “the exercise of authority within the task force appeared to be associated with a number of factors, including collaboration, perception, gender, age, and early socialization processes” (p. 59). This is an important finding for this study both in terms of the degree of authority felt by participants in their agencies, and also because it encourages an awareness of the authorization and de-authorization processes present between the researcher and the participant.

Finally, the researcher listened for instances of “evaluative clauses” in participants’ narratives. McLeod and Lynch (2000) present the idea that in narratives,

speakers often anchor their stories with “evaluative clauses”, which “explain to the interlocutor the moral significance of the action” (p. 390). These instances can provide useful windows into participants’ moral views of themselves and their behavior, and particularly their perceptions of the ways in which these moral views may or may not fit into the organizational systems in which they work.

In the spirit of narrative theory and the concepts described here, and in keeping with flexible method research design, the researcher engaged participants in as “naturalistic” an interview as possible (Anastas, 1999, p. 62) within the framework of the interview guide (see Appendix A). The study sought to elicit and interpret the meanings that “the experience holds for those in the situation studied” (Anastas, 1999, p. 62). Furthermore, the researcher strove to collect rich, rather than representative, data. Therefore, the researcher used a snowball sampling process to recruit participants, and the interviews often generated decisions about methodology that were fed in to later interviews (Anastas, 1999, p. 62).

The narrative data was interpreted thematically with regard to both content and process. In other words, the researcher collected and analyzed data related to the core research questions: 1) clinicians’ perceptions of agencies’ implicit and explicit narratives; 2) clinicians’ own personal and theoretical narratives, and 3) clinicians’ perceptions of the similarities and/or differences between these narratives, and their perceptions of the ways that these similarities or differences get resolved in the clinical relationship with clients. In addition, attention to narrative constructs like implicit and explicit narrative, “evaluative clauses” used by participants, and authorizing/de-authorizing processes guided the examination of the data.

Because the psychodynamic theories which shaped the researcher's thinking are rooted in the conviction that unconscious processes partially guide behavior among organizational members, the researcher faced the challenge of listening not only for conscious narratives but also for clues to unconscious narratives and processes in interviews with participants. The narrative perspective used in this research was well-suited to listening for these elements, as it emphasizes the stories, myths, jokes, and secrets of the participant and her organization (Martin, 1982; McLeod & Machin, 1998; Obholzer & Zagier Roberts, 1994; White, 2000). To this end, the researcher attempted to remain poised "on the boundary between conscious and unconscious meanings" (Halton, 1994, p. 12) while conducting interviews and analyzing data.

#### *Sample*

Twelve clinical social workers who met the inclusion criteria were interviewed. The inclusion criteria required that: 1) participants were employed by their agencies for at least one year, and at least .25 full-time equivalency (FTE); 2) participants' job responsibilities at their agencies included at least 50% outpatient psychotherapy; 3) participants did not hold a managerial or administrative position in their agencies aside from supervision; 4) participants had graduated from their MSW school at least two years ago (prior to 2006); and 5) participants spoke English fluently.

The researcher used snowball sampling to obtain participants for the study. Colleagues, fellow students, and other social work professionals were contacted in the Boston area to obtain referrals for social workers who met the inclusion criteria. An email was sent to the National Association of Black Social Workers Boston chapter (see Appendix B). In addition, the researcher used the Smith College School for Social Work

Alumni Association to obtain participants (see Appendix B). Participants then contacted the researcher by phone or email. The inclusion criteria were discussed over the phone, and if the participant met the criteria, an appointment was scheduled in a safe, private setting convenient for both researcher and participant (most often the participant's professional office). At the interview, the researcher asked the participant to review and sign the Informed Consent (see Appendix C), and the Demographic Questionnaire (see Appendix D) was administered prior to the beginning of the audio-taped interview. Additionally, confidentiality measures were verbally explained prior to beginning the interview because of the potentially sensitive nature of the data collected.

#### *Data Collection*

After HSR approval was received in January 2008 (see Appendix E), the researcher began recruitment. When participants were identified, the researcher offered each participant an opportunity to review the informed consent prior to the scheduled interview. For those participants who requested it, the researcher emailed the informed consent; in most cases, the researcher provided the participant with the informed consent at the scheduled interview time. Prior to beginning the interview, the researcher and participant reviewed and signed the informed consent. Participants were asked to fill out a brief demographic questionnaire (see Appendix D). The researcher then began the audio tape recorder.

The interviews lasted between forty-five minutes and 90 minutes, with an average length of one hour. The researcher first clarified the research topic, and defined key terms including narrative, implicit narrative, and explicit narrative (see interview guide, Appendix A). Generally, the interviews covered three areas: organizational narrative,

personal narrative, and the interplay of the two. In many cases, these three areas intermingled and participants addressed various aspects of the research questions in a non-linear fashion. The researcher attempted to follow narrative threads throughout the interview, while also striving to cover the major areas outlined in the interview guide. The researcher took field notes during each interview; these notes were stored with the participant's audio tape and listed only the participant code number.

Once the interviews were complete, the researcher transcribed the audio tapes in full. Audio tapes were coded with a number, but no other identifying information was on the audio tape. The code number was linked to the demographic questionnaire, which did not list the participant's name. The informed consent forms were kept separate from the audio tapes and demographic questionnaires in order to ensure confidentiality. The audio tapes, informed consents, field notes, and demographic questionnaires were kept in a locked filing cabinet, and will be stored there, in accordance with federal guidelines, for three years (until 2011).

Throughout the body of this thesis, utmost attention is paid to disguising identifying information about the individual identity of the participant and about the participants' employing agencies, bosses, supervisors, colleagues, and clients. While this document quotes extensively from each interview, the participants' names have been changed and quotes that directly or indirectly identify specific agencies or agency personnel are carefully disguised. The only other person besides the researcher who had access to full interview transcriptions was the research advisor.

### *Data Analysis*

The interviews took place between March 18, 2008 and May 2, 2008. The researcher transcribed the interviews shortly after each interview was over. The transcribing process facilitated “closeness” with the data that became the start of the data analysis. In this way, themes that emerged in earlier interviews may have informed both the interview process and the data analysis in later interviews. Anastas (1999) suggests that this aspect of flexible methods research is appropriate but can also potentially lead to biased analyses. Every effort was made to be aware of bias, and listen for disconfirming data throughout the interview processes.

After all of the interviews were complete, the researcher moved into more formal methods of data analysis. The researcher analyzed the interview transcripts thematically with regard to content about the research questions, and also in terms of narrative concepts like implicit and explicit narrative, evaluative clauses, and authorizing/de-authoring processes. Each of the transcriptions were read multiple times and in different order in order to counterbalance the order in which the interviews took place. Extensive notes were taken about emerging themes, both in terms of content and narrative. Words, sentences, quotes, and chunks that were illustrative of emergent themes were then compiled and sorted, and the researcher began the process of naming the themes. Throughout the interviews and data analysis, the researcher also “listened” – through words, emotional experiences, and body movements – for forms of latent or symbolic communication. Anastas (1999) writes that “flexible methods research is often described as ‘experience-near’ ... [H]owever, words are symbolic communications, and the same word or term may be used when quite different things are meant or implied” (p. 417).

This idea became particularly relevant as certain words began to appear in multiple narratives with obviously different emotional responses elicited by the experiences these words, and their speakers, attempted to capture.



## CHAPTER IV

### FINDINGS

This qualitative research study explored clinical social workers' experiences of multiple narratives in their clinical work in community mental health centers. The primary research questions addressed were:

- 1) How social workers absorb, experience, and are influenced by the organizations in which they work, i.e. what are their perceptions of the explicit and implicit narratives at work in their agencies?;
- 2) How they define their individual clinical practice, i.e. what are the personal and theoretical narratives which guide their clinical social work practice, and what are the “stories” that they have about their clients and work?; and
- 3) What is their sense of the ways in which the implicit and explicit agency narratives and the individual narratives are similar and/or different, how do these similarities and/or differences get resolved, and with what result for the clinical relationship?

The researcher engaged twelve participants in open-ended, loosely-structured interviews about the issues presented in the research questions.

Data were collected on each of the three research questions and then organized thematically. Within the first broad theme of participants' perceptions of agency narrative, four distinct subthemes emerged: a) participants' experiences of implicit and explicit agency narratives; b) the influence of workgroups and social networks on

perceptions of agency narrative; c) narratives of agency as family: “where we live, and how we nourish ourselves;” and d) influence of broader systems on agency narrative.

Data is presented within each of these subthemes.

The data in the second broad theme of participants’ narratives about themselves, their clients, and their work, revealed three subthemes: a) emotions elicited in participants by experiencing agencies’ narratives; b) participants’ narratives of loss over time in agencies; and c) clinical work as personally sustaining independent of agency narrative.

Within the third broad theme of participants’ negotiations of agency and personal narratives, and the influence on clinical work, several distinct subthemes emerged: a) the felt dissonance between administrative narratives and clinical narratives; b) the felt impact of agency structures, policies, and procedures on clients; c) clients’ narratives of loss in the agency in clinical work; and d) the presence of the agency’s narratives in the therapy room. This final subtheme was further analyzed to reveal three subthemes: i) the therapy room as the “insulated organizational subsystem”; ii) how participants’ anxiety regarding organizational functioning is contained in the therapy room; and iii) parallel processes, or “what clinicians get, clients get.”

### *Sample*

Twelve clinical social workers who met the inclusion criteria were interviewed. The inclusion criteria required that: 1) participants were employed by their agencies for at least one year, and at least .25 FTE; 2) participants’ job responsibilities at their agencies included at least 50% outpatient psychotherapy; 3) participants did not hold a managerial or administrative position in their agencies aside from supervision; 4) participants had graduated from their MSW school at least two years ago (prior to 2006); and 5)

participants spoke English fluently. The participants were recruited via snowball sampling and represented eight different agencies in the geographic research area.

The twelve participants ranged in age from 31 to 70. The mean age was 48, the bimodal ages were 36 and 41, and the median age was 46. Nine participants identified themselves as female (75%); three identified themselves as male (25%). All participants (100%) identified their race as either white or Caucasian; ethnically, one participant identified as bicultural (Venezuelan-American). Participants had worked at their agencies for between one (1) and thirty (30) years; the mean length of employment was 11.75 years, and the median length of employment was 8.25 years.

The demographic questionnaire also collected data on income and type of employment (i.e. salaried, fee-for-service, or other). Six participants (50%) were salaried at their agencies; 3 participants were fee-for-service (25%); and 3 participants are paid via a combined salaried and fee-for-service arrangement (25%). Participants reported that they had graduated from their MSW program between 3 and 48 years ago; the mean number of years since graduation was 18.75, and the median number of years since graduation from their MSW program was 15.

The racial homogeneity of the participant pool is a limitation in this study because all of the participants identified racially as Caucasian.

#### *Participants' Perceptions of Agency Narratives*

#### *Participants' Experiences of Implicit and Explicit Agency Narratives*

The researcher solicited narrative data regarding participants' experiences of the implicit and explicit narratives at work in their agencies. Frequently, participants drew a distinction between administrative narratives and clinical narratives. Sometimes, this

distinction also manifested itself in terms of the way in which the narrative was communicated and understood: participants tended to perceive narratives in the administrative organizational subsystems as more explicitly communicated, while narratives in the clinical organizational subsystems were more often implicitly communicated.

Not surprisingly, given the history and explicit purpose of CMHCs in the United States, participants frequently identified serving the mental health needs of a specific community in their responses to questions about agency narratives:

[Within the mission statement,] I think the part about providing mental health services, um, to clients, or providing an array of services, um, and being part of the community [is what I feel to be the mission here].

To serve...the people within the community and to provide a welcoming environment, to serve their mental health and medical needs.

Within the data on agency narratives, there was distinction made between explicit and implicit narratives in the agency, as distinguished from personal narrative. Several clinicians shared that while they were not specifically familiar with the explicit narrative of the agency, they experienced the agency's narrative through implicit means of communication—for example, through meetings, traditions, stories, and relationships:

[My sense of the agency narrative is that we are a] community agency that has been around a long time. The director...sort of symbolizes...the unit, in that, she's you know an old time social worker, she's always talking about what it was like back in the day...I mean it's obviously changed enormously, but a lot of the people are still here, we have staff who have been here for twenty-five or thirty years, so there's a real sense of people staying on, and really loving the work.

I haven't heard [the mission] explicitly, but, it's very, very strong implicitly...that people are ...very motivated by caring...the clinicians are, I guess, by the way they select, or just hire, just a great bunch...to the extent that you can sort of get a picture of other people's work, sort of extend themselves for their patients and you know, I like the way they work, so, um, it seems like it points to a mission of

providing you know very good caring mental health services for this low-income population in X town.

I think what's generally understood is that we are an agency that's very committed to serving residents of [the community], um, and that we take pride in serving folks that [have] um, sort of, not found a match of treatment anywhere else, so sometimes, this is obviously not written in the mission statement, but sort of last-stop shopping, I mean that sounds horrible, but people who have been refused other places end up here...I think [there's] a lot of pride in that, we really serve a function, in seeing people when we're not sure where else they would be seen.

I work in a place that provides mental health services to adults with chronic mental illnesses in which I work with a very committed staff and provide quality services to people who are really in need, and that the work is challenging and rewarding, and that I'm often tremendously sort of struck by the resilience of the people I work with, the clients that I work with, and um, sometimes the work is sad or tragic, and sometimes challenging, and given the nature of the experiences that these people have had, and yet at the same time I'm also sort of, like I said, struck by the resilience and the perseverance of them...And, you know, the other thing about [the story of] this agency, is that there's a lot of other agencies that just don't want support this population, I mean they're too sick, they're too challenging, they're too costly, or whatever...

Uniformly, participants reported “hearing” more explicit narratives emanating from administrative subsections of the agency system. These explicit narratives (often couched as missions, mission statements, or imperatives) were often dissonant with narratives espoused most often implicitly by more clinical organizational subsystems. Data regarding administrative narratives frequently focused on the perceived drive for financial survival above all else:

Well the mission in this part of the agency is to give high quality clinical services and to uh, as much as possible, minimize risk which means to the clients and the agency – through a lot of procedures – and to uh, survive, which is not a small one.

I think if they [administration] didn't have to think about money, [the clinicians' narratives and the agency's narratives] would be [the same]. You know, I think that...outpatient is mostly funded through insurances, and, you know, we don't get reimbursed enough!

I mean, the explicit mission, if you ask the director of agency X, would be to see x number of patients and generate x amount of revenue, and...that's not what happens.

Administrative wise, I think there's a different agenda [from the clinical staff] entirely...let's make as much money as we can, um, which doesn't make for the best practice....

Some participants' understanding of the broader context emerged, which seemed to allow for a more complex view of the multiple demands on agency administrators:

[Administrators probably articulate the mission in the following way:] we have limited resources to pay because we're already losing hundreds of thousands of dollars, and we appreciate the fact that you do good work, we are just limited in what we can give you in a climate service [sic] that maybe doesn't always support this, but we're supporting it more than most people, and we really care about you guys and we do the best we can under the circumstances.

I think it gets harder and harder, because I think on the one hand, I think the funding on federal and state levels make it harder and harder for people who run agencies like the one I work for to provide the services to the degree that people want, to provide, you know, that, so...I think sometimes the level of the commitment of the clinicians and what they're willing to do exceeds the level of funding that are provided now from state and federal level for poor people, and so I think it creates a conflict sometimes, and then it creates a conflict within agencies between clinicians and management, because sometimes of course the perception is that management is not doing enough and management might say well we're doing the best we can to keep the doors open, so...

One participant's narrative about the explicit organizational mission implied a felt distance from administrative subsystems of her organization: the phrase she used to describe the administrative components of the agency system (a "big machine") is a linguistic cue to her perception that these components of the organization are somehow less human and more mechanistic:

I don't think I paid too much attention to the bigger picture of what the agency really was, what their mission was, and how they would impact me over time....Um, you know, I sort of, I guess I felt more disconnected from the bigger picture, the higher-ups...I felt more disconnected, sort of their, they don't really have much to do with who I am and what I do here at X clinic...for the most part over the years....You know, they seem to be a big machine up there that works

and operates and trickles down to us in various ways and depending on...but I haven't, I haven't really interacted much with them...which is, you know, for the good and the bad.

Participants frequently related their perceptions of implicit or explicit administrative narratives to the pay arrangements for clinical staff, implying that pay arrangements were a way to interpret administrative levels of commitment to clinical work. On the subject of salaried work, two participants said:

[There is a commitment in administration] to continue having these uh, services provided by a salary. [The fact that the agency is salaried means that] people stay around. Longer, the longer uh, commitment, sometimes you can keep quality people somewhat longer under that circumstance, and you can ask people to go to different meetings, and be available to do certain kinds of things, under that kind of a framework, more cohesive group, otherwise, it's hard to get people to special meetings to do certain things...

I really think that there is a commitment to being able to provide better services to clients and that you do that with a more committed staff, and that's what you get when you have a salaried staff.

One participant shared the difficulty of sustaining social cohesion under a fee-for-service system:

...Taking the time to stop to talk to someone in the hall doesn't really cost anything, and yet in a fee-for-service world, it does.

Participants who worked in agencies with productivity demands for salaried staff spoke to the strain this puts on clinicians:

[The kinds of] pressures are for example uh, seeing a certain number of people, which is not giving me a whole lot of extra time, so you need to chose what you're willing to do and what you're not willing to do.... Over the thirteen years [the pressure to see more people has] increased, enormously.

Clinicians can't stay...like we've already lost some people...that just couldn't produce the intensity of work, you know, meet the demands of the work at the pay rate.

In a response which explicitly links pay arrangements with perceptions of administrative narratives, one participant said (somewhat jokingly):

Well I'm all knowing and I'm kind of conscientious and I can realize that there are a lot of pressures and it's a very complex world, so therefore I'm not uh, discontent as some people. Of course I have, ah, for varying historical reasons, I get paid better. Which might or might not be right. You can justify it or, deconstruct it all you want.

His response suggests a relationship between the ways in which the agency "takes care" of him and how he feels about the agency.

#### *Influence of Workgroups and Social Networks on Perceptions of Agency Narrative*

Participants' experiences with administrative narratives were frequently contrasted with their experiences in social networks among other clinical staff. Moreover, participants frequently framed clinical workgroups (or teams) as an aspect of organizational life which allows them to continue providing a certain quality of clinical care:

[When we stopped using a team approach during one of the agency's transitions,] we didn't have the family cohesiveness, and it took years, I was like on a personal mission to get teams back, because I feel like we have too many fragmented part-time people who...haven't been brought up the way they should be!...[And] we now have teams....I think it's helped....we've worked really hard to have those be nourishing places...[The team is] a mini version of the pressures on the agency you know, in terms of how do we use this time – you know we have to meet these [certain goals], and they're important, we also just need to support each other and have a chance to share work.

I think [clinical workgroups] are great. I can't imagine doing this work without that. Because a) I'm not getting, even if I had individual supervision which I would like, but in the absence of that it's the only chance I get to talk to people about cases – and there's so many that we share...so it's really helpful to talk about it...I think [having the clinical groups] just makes [the work] bearable, makes it more fun, it makes it...[during] one the groups, there's usually food... And I think we do better work, because it's more planned, we have more creative ideas.



I think [the mission is realized] through team meetings. We have [multiple] team meetings...we're all very involved with the patients. It's a pretty, at least I find it to be, a very tight community...I think chief administration may be out of it, um, so the communication, amongst providers, I mean we work very well together. I feel included...

Generally, the data suggest that clinical workgroups not only have the potential to improve clinical work, but also to nourish and include participants. Some data, however, complicate this view of workgroups as a uniformly supportive factor:

...My original team was just amazing, um... [The clinicians were] so solid and wonderful and insightful and intuitive, and all these great things, and you know, things shift, people come and go, schedules change, and now my team is a drag. It's really a drag. I don't like the way people think about their work – that's been...that's very – it'll probably get better later.

I think in a way the clinical team, where a lot is shared about client interaction, and um, I only talk about certain clients there, and so, and I don't know if that's a way of keeping the agency out of certain therapeutic relationships, because there are a lot of ideas and thoughts shared about, you know, what to assess for risk, or ways to, that kind of muddy my head sometimes with the client I am talking about.

[Having an inexperienced team leader] has united the team...in terms of trying to do something about that as a group...it's provided cohesion for the team, but also a lot of frustration...When I say cohesion, [I mean] we can talk to each other. And I think that's an enormous help.

Workgroups were reported as sources of learning and support for participants, although participants sometimes found them unpredictable in their efficacy or incompatible with their own narratives about clinical work.

The data revealed that participants often draw immense strength from the social networks available to them within their agencies, even in the face of challenging environmental circumstances or agency narratives that sometimes erode these collegial relationships:

Now it feels I think with fee-for-service, you just do the work, there's really not a lot of time to think about it, you don't really collaborate, you know you get in

your groove, and hopefully it's a reasonably effective groove, but not necessarily, you just...there's not a lot of time to reflect at work. And I think people have second jobs you know, they're burnt out, so it feels as though there's...and that's not to say that people are not – with staff – are not wonderful and committed, I mean it's the staff that holds it together, against all odds.

I think that [the clinical work] would be just be too much if you didn't have the relationships with the colleagues or the lightness that kind of gets you through the day, you have to, you know, there's so much trauma, that, um...people just spill over.

I cope with [the morale “rollercoaster”] through relationships...here at the clinic. You know, we've always sort of put that first...just the people I work with have been just so important and a big part of my life...I just think we've given a lot of care to our work and to our clients and a lot of responsibility, been extremely thoughtful to them and to ourselves, trying to provide the utmost sort of professionalism, to be a strong...clinic out there ...it's just good quality [psychotherapy], because we care about what we do, we know what we're doing, we share what we do, we learn from what we do, and so that's what we're all about. And we're not a disjointed group, we're not a group that's kind of, where there's a lot of disconnect...You know, we're not a group that is disgruntled with each other, and I think that's very important, you know, we're not – there's a sort of a respectability of all of us.

Clinicians look to each other a lot for support [when dealing with changes in the agency], and I think that they feel they get more support from each other than they feel they get from above. So that has been a helpful source, but that gets challenged too, because clinicians have less time to be with each other. In a fee for service model, no one stops to have lunch, um, you know, most people are seeing clients, and some clinicians are seeing clients every forty-five minutes so they don't stop at all, um, and you know, they aren't attending as many meetings together, because they aren't getting reimbursed, and they don't have as much time and they want to focus on the clients...

The importance of group affiliation is evident in participants' narrative data, as are the challenges to maintaining this affiliation.

*Narratives of Agency as Family: “Where We Live, and How We Nourish Ourselves”*

Six participants spoke about the concepts of family, space, and feeding, illustrating the intensity of relational connections which participants often felt to the

workplace. Speaking to the idea of work “families”, three participants described their work cultures as such:

I think it’s very busy [at the agency], but it can be relaxed in the sense that we do take time to talk amongst ourselves in the hallway, people have a good sense of humor most of the time, planning you know, parties, fun things. I think there is a...even though everyone’s really hard-working, I think there is a culture of – it sounds corny – but family. You know, taking care of each other, and making sure that when we are too busy and we stop talking to each other that somebody notices what’s going on....I somehow feel a little bit more connected here and less alone.

...The staff, and my coworkers, and the other providers – wonderful. It’s like a family. I mean I come to work, and I love being here...from the front desk to the medical director, everyone is just really, really nice. What highlights it for me, is...our Christmas party this year...we had like potlucks during the staff meeting, people brought in five bucks and a dish to raise money to pay for [the party]. We had it on a [weekend] night, I think probably X% of the staff attended, it was wonderful, people danced all night, and after that I was like, I really like where I work, it’s really great that people can really have this much fun together, you know, and sort of walk that line between – you know, people are pretty good here at walking that line between professional and personal, you know, able to joke around and sort of step right back into sort of providing critical care for people.

Well, we [the staff at the agency] often call ourselves a crazy family. And I think that’s not so off the mark, I think there’s definite roles that people have in the family, um, and, there’s not a lot of conflict encouraged the culture, even if it’s conflict that could bring about change, um, and there’s again a sort of a real emphasis on the ways things have been done and the pride in how they’ve been done but maybe to the Nth degree, or to a place that might actually disturb the time, in trying to keep up with the times, or with insurance mandates, or technology.

The narratives of agency as family were often tied to data relating to frustrating experiences with food and space in the agency. Sometimes these experiences related to participants’ own experiences in their agencies, and sometimes they related to the image that the physical space of the agency conveyed to their clients, or the “story” the space tells:

Every single party we’ve ever had is potluck. And there’s frustration in that.

We always had a coffee machine, and now they don't pay for a coffee machine, and you know these are sort of details...not that we can't afford to go to Starbucks, but we... there's no coffee machines, and that was always a big issue.

Because we have no money, the place looks like a shambles. Just that, just that itself [is a way the agency comes into clinical work]. The walls are dirty, they're not being painted, the carpets need cleaning, the chairs in the waiting room are all stained, and you think, what kind of an impression is that? It makes me feel not very good, and I don't like the way that sort of presents, I don't like the way I sort of represent that...

I think [the physical space of the agency] feels unkempt and I think, you know...how the environment works is an externalization of sort of an internal feeling, and it sort of reinforces it and confirms that...

On a good day I think it's a cozy place, and we're a family in a house, and uh, it sort of furthers that whole idea, and on a bad idea, [I think,] gosh our clients deserve better, you know, there's stains on the chair, you know, this is disgusting, and you know it's sad, to have people come in to do something so important in a place like this.

One participant eloquently described her agency's shifts in focus over time from kitchens (food) to offices (space), and suggested that these shifts parallel the decreasing ability of staff (family members) to rely on their agencies (families) for support:

[This agency] used to be an incredible, um, work family...and, when we had the consultant come in to try to talk about what's not working, why is it that people are so angry, this is during one of the takeovers, and everybody kept saying we don't have a kitchen...[and] we said, that's true, we don't have a kitchen but we have a microwave, and we had, um, a basement office with a little refrigerator, but no place to really hang out...I feel the message was like, we're a family but we don't have this place to feed ourselves adequately. Nobody talks about kitchens anymore, so now it's trickled down to office space, and I'm having an interaction the other day, and I'm realizing that the percentage of our ground floor offices...that are administrative has completely changed. And we have a lot more administrative staff than we did – which I guess we need to, but it's really interesting to me that the clinical work, a lot of it is being done in the basement, and not on the ground floor, and so the discussion came up around shared space, and how should space be allotted. And I realized, nobody's talking about kitchens, we're just down to like, where can I have a place that I can hang something on the wall, it'll still be there next time...Where's my place in this family?

### *Influence of Broader Systems on Agency Narrative*

The data revealed a strong theme that related to participants' awareness of the impact of the broader context and systems on their work in agencies. This might be called the current community mental health "metanarrative", or the large, overarching story of mental health service provision in our society today (Lee, 2004; Omer & Stenger, 1992).

One participant describes this metanarrative, and its implications for him, as such:

The managed care environment is not getting easier...I have to really think about, you know, how many hours can I work, and not collapse, and can I support my life on those hours, and you know. How is this going to get better?...I'm very aware of like shrinking options...[it] put me in the mind-frame of you know, scurry and grab, and like, you know, don't, like, it really lowered my expectations, maybe even too much so [when I was looking for a job]...if I had felt like the world was a more generous, easy-going, yeah, hospitable [place], I might have lingered, and said, well, oh, what would be a better thing for me?

Several participants specifically addressed the issue of shrinking access to and affordability of services as a result of changes in the outside environment:

I think the agency originally was, you know, a community-based mental health agency who tried to see people who needed mental health services, and those services tended to be, were funded by [state and federal monies], and so there was a commitment to seeing the neediest of people, and...providing quality mental health services to those people, and, and, um, while I think there is...that is still a commitment, I think it's definitely more funding driven.

I mean up 'til ten years ago, the kind of outfit clients had through [this agency] was really regardless of what they could afford or not afford, and the sliding scale really allowed us to see anyone for a five dollars a session...

Now...our minimum fees are \$55 an hour, they used to be \$2, for students we had a lot of students who were seen for you know \$5 or \$10...so this is no longer affordable psychotherapy at all.

Additionally, some participants experienced their agencies as placing more emphasis on adapting to these changes in the outside environment than on preserving the original mission and narrative of the agency:

We're marketing ourselves as a child and family agency, which we've always done, we've always had a balance, but I find it ironic that once again because of funding the money's been put out here, and so we're trying to retool ourselves and yet we don't have what we need to be able to do that.

I remember in social work school, uh, a teacher saying "follow the money." And I think it is [a certain segment of the clinical population at agency X who] are really calling the shots right now. And, they're the ones that are, you know, services are for them...

Finally, two participants addressed specifically the ways in which changes in the outside environment challenge clinicians' abilities to meet their own, or their agencies', standards of quality clinical care.

I think [not being able to see people for affordable rates because of changes in state funding] also affects the morale, because I think it then becomes, you know, [clinicians who are] committed to the mission of serving people who can't afford it, who really deserve equal care to you and I, and we have good insurance so I think it, um, erodes, well...how would you put it...It really erodes the disparity between what one's personal mission is, and how it's affected by these external forces, and you basically have to survive, and it's basically run by a CEO, who gives most of the power to one person who is a financial advisor, so decisions really seem to be made much more on the, you know, the financial necessity, rather than the clinical needs of the client, and certainly the needs of the therapist, so that's that's, uh, that's mostly a morale issue.

[O]ur standard of care policies are really strong...but the problem is trying to support the staff who have to do the work to meet the standard of care, when a lot of things [financial and programming resources] have been pulled out, [for example,] people who have time to write a good discharge summary and remember to call you and say, "Oh, your patient's leaving, the one you hospitalized against their will and who's angry with you?"

### *Summary*

The findings suggest that participants experience agency narrative explicitly and implicitly, and as emanating from all parts of the organizational system— from the broader systems and context, or metanarrative, to the administrative subsystems of the organization, to the level of workgroups and social networks within the agency. Some participants used metaphors of food, space, and family to describe these narratives,

symbolizing the extent to which the agency is, or at least has been, a source of nurturance for some participants.

*Participants' Narratives about Themselves, their Clients, and their Work*

*Emotions Elicited in Participants by Experiencing Agencies' Narratives*

For the vast majority of participants, a telling of their own stories as workers in CMHCs entailed an account of difficult emotional responses to agency narratives, and particularly administrative narratives; indeed, the amount of data related to feelings evoked by work in organizations constituted its' own theme. Participants' stories about their individual clinical work were frequently informed by the experience of carrying out this work within the context of agency narratives. In this way, data regarding personal narratives was frequently inextricable from data regarding agency narrative. As one participant said:

I've been here for so many years that I don't know if I can separate it [i.e. the agency's narrative from my own narrative].

Participants' narratives frequently included experiences of anger and frustration in response to explicit and implicit messages coming from administration:

[The director] just...she pretty much has her own agenda, she sticks to it, she doesn't budge one way or the other. People know that, get irritated, frustrated, um, uh, don't feel valued, a lot of times.

[The pressure to see more clients] is extremely frustrating.

[Dealing with insurance companies is] just a big pain, it's a big pain, and it's so frustrating, and it makes you want to bang your head against the wall, because sometimes people will get billed and they shouldn't be getting billed, and they don't know why they're getting billed and so they ignore them...and [the process] just makes me totally enraged! But, I don't have that burden all on my self. We have the billing person – but...she doesn't know the patient and care about the patient in the way I do...

It costs money to advertise the job [we need to fill]...I don't think they [administration] put as much resources into it as is needed...[And that is] frustrating, like when somebody comes in, like yesterday I did an intake and the next appointment I could give them was in three weeks, and you know, somebody who needs to be seen every week, and probably the next time after that would be another three weeks. So that's very frustrating when I know that there are people who need to be seen more than I have time to see.

I think what I noticed over time is that my morale and other people's morale was just a gradual decline, and I sort of correlate that with, uh, well I think things like, there's no money in the budget...And you know it always seemed to be a roller-coaster ride. You know, you're working really hard but then you hear [from administration] um...you're not really making much money...and that would become very frustrating, because we're working very hard...why are we doing well, why are not doing well? If we're not doing well, does that mean we're going to get fired? Are we going to be let go? It was always, not a lot of clarity, to why it was good and why it was bad.

Additionally, participants reported a range of emotional responses to feeling undervalued, uncared for, and unappreciated:

I think there are certain kinds of uh, resentments that boil over within the agency that we are underappreciated, overworked... [Some people feel that] they don't get enough support from people above. There's a fair amount that they [administrators] expect – and the pay is not enormously high.

I feel as though, if I care about what I do, and I do care about what I do, and put a lot of energy into what I do, and am pretty autonomous too, I don't need a whole lot – I don't know if that's good or bad, there are both sides of that I think – but it would be nice to be cared for. You know, have a sense of being cared for, appreciated, or valued, to get back to sort of the values, the values of the mission, by you know by an agency, by who I work for. And I think there's a big contrast between that. I think their mission is lost – I just don't feel their mission. I feel my work for the clients, I hope they feel something back from me, I don't feel it for the agency, and I don't feel it back from them. Which came first? I don't think I got it from them first. I think I was willing to be open to working with them and negotiating some things and getting you know, I'll do this, you do that, but I just don't feel like I feel anything from them, in terms of being cared for or valued.

[There is a feeling] that partly they're [administration] going to take care of themselves and we're not, and so it feels as though there's a...I don't know, to use an extreme word, sort of a demeaning or a lack of respect. Yeah, you know, appreciation...I mean none of us is naïve enough not to know that they're not just doing it purposely, the way that they were treated as related to, you know, what



the insurance companies reimburse and the lack of funds being contributed to the agency, but it does feel, um, but it does feel, like a lack of caring.

I think [the emotional experience of not finding cohesion with the management's mission] makes it harder to do the work, it sort of, it's just conflictual, I think it forces you, it can force individuals to again get it from other sources, where there's a feeling of not being appreciated, and um, you have to, you have the choice to go somewhere else, where you think it is, or where is it coming from, is it just the nature of the funding, or also of the leadership, um, but yeah, I think it can be very disempowering, it can make you feel resentful or whatever, but I think again if that happens you have to find other ways to either again find something somewhere else, or then, find other ways to reimburse [sic] something positive in yourself and in the work, because otherwise, you just get burned out, or whatever you want to call it.

This last response suggests that in the face of overwhelming feelings of resentment, clinicians need to find other ways to derive positive meaning from themselves and their work; the data presented in the first section suggest that often workgroups and social networks in organizations provide participants with this positive meaning. However, it was revealed in the data that some participants have found the feelings evoked in response to their agencies so overwhelming that they have become “burnt out”:

I have a lot of frustration about um, sort of what certain people [within the agency] are assuming about this place, and um, willingness or lack of willingness for change....I think to make change at a larger place with the agency takes a lot of individual energy, and you really have to believe in a cause, and promote a cause, and be vocal about a cause, and on and on and on, and I think being creative with individual clients also takes energy and time and thinking, and so, um, we sometimes become the sort of – on both ends, with the agency and with the clients – a fatigue, or sort of a tiredness, of always kind of being the engine and maybe not getting so refueled.

Those of us that are part-time, you know, we're in there and out of there, and we don't mess with all of this [agency dynamics]...those that are there five days...I don't think I could. (She mimics washing her hands.)

I feel like I put my years into battling the system, you know, been vocal in staff meetings, and tried to express things that I think are important and things that I think need to change, uh, we had Head Administrator X come...here once, and I was very vocal during that meeting...and you know, after a while you just kind of get a little silent around things, and you just see all these things that you talk

about and you just don't see much change. You know, he was supposed to meet with us [again] after our first meeting, and we've never seen him again. Big message.... "I will come down. We will meet again. We will go over these issues, see what's changed, see if anything's changed." Asked him to come down, waited for him to come back, set the date for him to come back. He's never been back.

It should be noted that some participants' personal narratives included concern about and ambivalence toward organizational narratives:

I think it's just a really good-hearted organization, started in this really hopeful period of deinstitutionalization, and ample budgets for community mental health, and it's struggling to keep in existence in a meaningful...[sic] and like, partially depending on the good will of it's staff to keep ends meeting as reimbursements drop. Right now, I feel like we have a really – we do have really committed management team. I wonder why – I really want to know why they're so committed, it seems like they pour their hearts out. Yeah...for now, we're still making it, but I'm nervous about the future.

I love the agency, I love lots of things about it, but hello, it's hard. Yes. And I'm not particularly happy about the direction it's moving in, and I don't like that it's give me your money, and uh, services here I don't like at all, but it's bigger than I am, but I'm not quiet about it either.

### *Participants' Narratives of Loss over Time in Agencies*

Many participants' personal narratives, particularly those who had been at their agencies for more than ten years and were themselves over the age of fifty, included stories of significant loss across a number of dimensions in agency life. The data revealed that participants had experienced the loss of certain ways of thinking and certain ways of doing clinical work:

I think that originally when I started working here we had a really healthy work family and so issues that came up, there were less pressures – those pressures about the work were the same, but the funding was there, so if I had to spend a day and go meet a client at a hospital who was paranoid to get them to agree to sign themselves in, I would do it, and I felt like that was part of my job, and you know it was supported financially here, um, and that has changed drastically, so all the worries and the time to think about the work, that existed then – 'cause that was all—that was the whole thing. You need time to think about the work you're doing or you won't be doing it well. You need your own therapy, you need supervision, you need team meetings, peer consultations...But the time pressures

and the money pressures have meant that that's been really boiled down. And I don't think it's been managed really well because I don't think it could be...

There are fewer and fewer people, and there are fewer and fewer opportunities to really think about the work and talk about the work....and people who somehow think about the work from a more psychodynamic point of view...

Additionally, the data showed that clinicians have faced losses in terms of the quality and amount of social contact with colleagues in their jobs, which seems to have been a sustaining and vital experience in the past:

With the amount of people we see it doesn't leave a whole lot of time for socializing. I'd say I don't see a lot of people around.

We've gone from a community health center, to much more corporate....People spend their time behind doors, you know, working, working, working, working, [sic] and it's all about work, and unbelievable amount of work, um, and uh, people don't socialize as much. You know, and that is part of the climate out there, managed care, insurances, changes, all sorts of things, people are at their computer all of the time, all of the time. The other day we had [a consultant come in and she said,] "What people need to do is socialize more." And I mean, of course, but you know, not here! It's not healthy! The other day I was in the lunch room, and guess who's in the lunch room? All of the Latinos. And none of the Americans....It used to be much more collaborative...I think people are really unhappy, and the morale is on the floor....I call this my job of mutual exploitation...I used to take much more interest in the interns. You know, some of them, I don't know their names. You know, it hurts me in my heart, but I gotta do what I gotta do [sic], because there's been so much loss.

People...who have only been in this [more recent] model [of mental health service provision], it's the only thing you know, you don't quite know the community, you know, you don't have lunch with my colleagues [sic], and to have people on the same page, because they don't want and need from an agency what I used to get, but now is really a thing of the past...although I think people don't know they're not getting it, and it's part of what makes them unhappy, because they don't have the community, but they don't kind of expect it, and see it in perspective. So, it's a different sense of disappointment for them, whereas for me it's much more of a sense of a loss.

The data on loss also revealed that some participants have lost opportunities for professional contact and collaborative relationship-building:

We've had so many things taken away – being paid to go to staff meetings, paid for trainings – it just goes on and on. There's always a chipping at – this is what you're not going to get, this is what we [the broader agency] give you.

There's not as much incentive [from the agency] to do, um, the sort of cohesive things that might be happening within the agency...so what happens as a clinician, it gets harder and harder, and...its puts a drain on morale for staff, and makes them sometimes have to choose between a level of commitment to a population or an agency that they like or working with clients that they like, and yet having to find something else that may be, that may pay them more...

One thing that used to provide...a sense of community was the trainings. And it's really interesting, because [the training] rooms used to be packed with fifteen or twenty people. And here consultant X couldn't be better and there's what? Seven people in the room, of which four or five are students? And...I think that both makes people think less about the clinical work, and it provides less of a sense of continuity, or um, collaborative relationships.

The prevalence of these losses, as well as the emotions aroused by them (two participants cried while describing loss), represents an important and somewhat unexpected finding in this research. The emotion and strength of language used to describe losses in the agency was also a notable narrative cue. For example, participants described colleagues leaving in the following terms:

...we had an *exodus* of seventy percent of the staff in a year...

...all the female therapists leaving...a *hemorrhaging* of...

In a poignant illustration of the unconscious ways in which these losses can influence clinicians on professional *and* personal levels, one participant drew a parallel between her experiences of loss in her personal life and her experiences of loss in her agency:

This hemorrhaging of people is similar [to losses in my personal life] and that's very hard for me...I am, these are my family members, you know, I'm very attached to, *very* attached to my colleagues, and invest a lot in those relationships. So it has a sting for me because of, you know, [my own losses]. [Like] a family that was incredibly dysfunctional, but here I am, you know, incredibly resilient, you get caught up in that.

### *Clinical Work as Personally Sustaining Independent of Agency Narratives*

Participants' personal narratives as social workers frequently revealed an engagement with the clinical work, and specifically clients, independent of their agencies' narratives that provided sustenance on a personal level. Within this, and not surprisingly, there was little uniformity in participants' descriptions of their own reasons for pursuing social work. However, participants' responses in this section made clear that they found sustenance and fuel for the clinical work through an understanding of what brought them to it in the first place. Representative excerpts are presented here:

I feel like I've always been a social worker. You know, I just feel like, my whole life experiences, I just feel like I've always been conscientious of myself a little bit and uh, kind of the idea of caring for other people, so um, I feel like I've always had that mindset.... So I guess at the risk of sounding corny, sort of an innate sense of who I am, I just have really pleasure and joy in what I do.

I was always interested in working with people, and having my own therapy myself made a huge difference, and I sort of wanted to do that too....I felt...I could be more helpful on a personal level, rather than doing policy stuff. I guess I felt like that was my strength and my interest.

I think, over the course of my lifetime...I just came to understand that I wanted to work in direct service with people...[At one point I had the opportunity to do international work, but realized] I couldn't remove myself from the world in a way, or that I didn't want to...be so disconnected, but I still wanted to be part of working with people or poor people who needed care and support and help, so that was sort of a narrative of that...sort of helped me...redirect myself in um, doing...social work, but...in direct service ways, and it also helped me after I for a while was doing management, human service management programs, and I just felt this sort of void, that I didn't, that I missed the direct service work...

Some participants alluded to a responsibility to help people, as related to their own lives in particular:

I always felt like it wasn't fair that I grew up in this very middle class family, and I had things that other people didn't, um I think it always didn't feel fair to me, so I think I always wanted to work with more underserved kinds of community – we used to say underprivileged and I hate that word – but you know, people that don't have as much.

[I am part of a marginalized population myself, and I have mentally ill family members; therefore,] my purpose as a social worker is to work with marginalized populations helping them advance to levels that I know they're capable of getting to if they have the right resources, um, the right people advocating for them, so I feel responsible to be one of those people.

Healing...in a non-healing environment.

The personal gratification, emotionally and intellectually, came across as well:

I'm not sure that uh, I really uh, thought of myself as a do-gooder. One reason is that I don't have that kind of interest, and [for me] it's more about problems, and the issues that make [people] crazy, and I'm not going to save the world, but I do think that I find joy in doing the work with people I do, it's sort of problem-solving thing, maybe akin to uh, unlocking something, and there's something satisfying about that, and what I find in private practice and even in the agency, people who are fascinating sort of grab intellectually and emotionally...

Through being in therapy myself...and loving it, and just loving the questions, the way of looking at the world, the whole thing, the changes that I've found for myself – I just thought I want to do this. And um, and I feel like, honestly, I feel like, I don't think there's anything else I can do, like I really want to do this, and I could have other jobs, but this is just what I want to do, to be a therapist and a group therapist, think about this stuff and read about this stuff.

I got into this field because I knew in some ways I could be good at it, and it's always very important that I'm good at what I pursue, I tend not to do things that might have some failures along the way, so I'd gotten enough, a fair amount of influential adults in my teenage years, that let me know that I would be good at this, or that I was a good listener, or I was mature for my years, or whatever it was, so I think I do take some pride, and I think I am good at it, and I think that sustains me a little bit...

It was notable that several participants distinguished between clients and their agencies as the force that kept them at the agency:

I like working in the community... it's the clients that keep me here basically. You know the families I work with, I really like that.

I think there is something about the people I see that sustains me, more so than the place I work for, um, or the people I work with.

I suspect, in some cases, there was a range of things [that kept people at this agency despite the difficult situations their clients faced]...I think for most people there was a level of commitment to working with this population, or you know,

perhaps a personal mission, or personal reason, for which they stayed, or it was personal betterment, because they found [the clinical work] gratifying or satisfying...

A narrative analysis of the data reveals a small but important theme related to participants' use of evaluative clauses when articulating their personal narratives in relation to agency narratives. These evaluative clauses appeared when participants described breaking with agency policy in order to provide the kind of clinical care they deemed necessary, as will be described in the third theme of this Chapter. For example:

I feel like, you know, you hired me for a reason, to provide a certain type of care, and that's what I'm going to do....So I can be a little *irreverent*, at times, just *not very compliant*, but I feel like, I'm providing good clinical care, so that's sort of...

My perspective is quite feisty, uh...from the beginning I was *feisty*, it's the uniqueness of my position of being bicultural, in this very dominant medical model. Um, so from the beginning I was feisty.

These evaluative clauses suggest a dilemma for participants, in that they seem to perceive themselves to be behaving outside of the explicit or implicit norms of behavior in the agency, and yet they are maintaining a fidelity to their own personal narratives.

### *Summary*

Narrative data related to participants' stories of themselves, their work, and their clients reveal evocative emotional experiences in agencies as well as significant losses over time. However, participants experience their clinical work as sustaining independent of agency narrative.

*Participants' Negotiations of Agency and Personal Narratives,  
And the Influence on Clinical Work*

*The Felt Dissonance between Administrative Narratives and Clinical Narratives*

Analysis of authorizing and de-authorizing moments provides a narrative approach to understanding participants' felt dissonance between administrative and clinical narratives. Participants frequently used narrative devices that expressed this dissonance implicitly or explicitly. For example, a high frequency of participants (more than 50%) referred to the administrative components of their organizations as "they".

One participant in particular, when asked to clarify, said:

Administration..."they" [laughing]....Well "they" is always...who the hell is "they"?

His quote suggests that addressing administration as "they" creates a distance between administrative narratives and clinical narratives. Related to this finding, there was an almost equally high frequency of data in which participants stated that administration just "didn't get it":

So there's this new person coming in [in a management role] and there's also a fairly new top administrator, so um, I think that sort of frustrates a lot of us, in that he doesn't get a lot...

Administration doesn't get it [how hard the work is]...she just doesn't get it. It's like very separate – separate entities.

I am one of the voices of multiculturalism. They don't get it, they don't get any of it.

I mean I think there's really much more this polarity, of us and them. You know, that they don't get it...they don't get it...

These sentiments seem to suggest that participants perceive a de-authorizing process at the hands of administrators; i.e. participants frequently felt that as a result of



administrative actions, they were not able to continue to act within their clinical roles (Bransford, 2006).

In further evidence of the felt dissonance between administrative and clinical narratives, the financial survival of the agency and the survival of staff and clients are perceived as opposing issues in the life of the agency as a whole. Some participants emphasized either an unplanned or purposeful split from the administrative workings of the agency in order to perform their clinical work:

I mean, the explicit mission, if you ask the director of agency X, would be to see x number of patients and generate x amount of revenue, and...that's not what happens. I mean our mission in mental health is to provide quality clinical care; and can we do it, seeing x number of patients and generating x number of revenue? Probably not.... I'm going to fault towards quality clinical care, and if they don't care for that, then I don't have to be here. I mean that's my perspective, but I'm not going – I feel very strongly that I'm not going to sacrifice the quality of clinical care for numbers that are arbitrary...I'm not here to make money for this organization, I'm not here to increase the volume of patients that we see, um, and I think that, it's seen by the administration as a numbers game, and not seen so much as wow, this is the kind of service that we're able to provide here in this community, and it hasn't been provided here in the past.

I think that the staff is very, very caring toward the clients...We're there for 'em through thick and thin...this is really refreshing to see....Administrative wise, I think there's a different agenda entirely...let's make as much money as we can, um, which doesn't make for the best practice....

[Our agency recently redid the mission statement and] you know the last sentence in the mission statement was about if something approved through third-party, or insurance, you know, so we of course hit the roof, that there was one sentence about psychotherapy, where we've always seen [psychotherapy] as sort of the core sort of mission of serving an underserved population...regardless of what [clients] could afford or not afford...

Several participants spoke directly to the ways in which agency administrators' focus on financial survival evoked confusion and polarity in all parts of the organizational system:

I'm curious; like, are we [the agency] there to survive financially, or are we there to provide services to people? Obviously some of both...

[Administrators] don't get it...that is, what are the needs of the clients, and what are the needs of the staff, to survive, for the needs of the clients, and I suspect, in their view, they don't think we get the reality, of the fact that reimbursement...has not gone up in eleven years...You know, so it feels as though, you know, there's a seismic issue of how people perceive the polarized positions...

Participants sometimes described clinical directors as individuals who are able to successfully mediate clinical and administrative narratives, pointing to the effect of leadership qualities on clinicians' sense of agency:

I feel like she [clinical director] advocates for us and that sort of sets the tone.

You know, throughout all this, there's the personality of the clinical director...she's a big part of the agency for me, and when I think of – I have no idea what the hell makes her tick. She works her ass off, she's great, she's smart, she's effective....

[The clinical director] is great, really advocates for what we need, you know, may not always get it, but really understands it, gets it, she's done trauma work in the past, she really gets the work...

#### *The Felt Impact of Agency Structures, Policies, and Procedures on Clients*

Participants' narratives included significant reflection about the ways in which they feel that specific agency structures, policies, and procedures impact their clients. Most often, participants described this impact as somewhat *separate from* the actual clinical hour, although some data about the impact of agency structures on risk management processes and the therapists' own time constraints is presented in this section. Examples of structures, policies, and procedures which participants feel impact clients include the frequency, availability, and timing of services for clients through the agency, and intake processes and paperwork at the agency. Related to this, participants also shared varying perspectives on engaging the agency's policies directly with clients during the therapy hour.

Many participants perceived constraints on the availability of services for clients. These constraints were felt as *potential* impacts to the quality of clinical care, although in many cases participants overrode these agency constraints in order to provide what they felt was quality care:

I think that people for the most part, um, have a commitment to the community... [but it] doesn't always play out the way it should, like we don't have enough staff, we're down staff, the hiring is, like we're all overwhelmed right now, and um, they say they're going to hire, but it doesn't seem like they do enough to make that happen, and so people, there are people – you know, clients that are underserved at this point... There's a lot of frustration with a lot of things. You know we don't have enough staff, not enough supervision. But I think in terms of clients, I think most of us are pretty good, and I think I'm pretty good at, you know if I was in the room with a client, and can feel the frustration when I have to go get them their next appointment – not enough staff.

[Because we are down staff], the majority of my clients would be new, I'd meet with them for half an hour, the next time I'd be able to see them would be two months down the road. It's just really consistent poor practice. But, the administrators want to make as much money as they can. So, "Let's just keep putting people in, get as many new people as we can." Which, number one, it's poor practice, and also, it burns out the therapist. I mean I see, on Thursday I'll see fifteen clients – get 'em in and out – make as much money as we can.

Two participants specifically addressed a shortage of mental health interpreters:

I had a kid...um, raped by her uncle, spent a week at [a program], cutting, discharged, saw her, the next available appointment with an interpreter was 3.5 weeks later – that doesn't work – you know, um, and when you tell them, that doesn't work – um, it's oh, well we're going to do it this week, and I'll try to find this – and I'll just schedule her, and I'll find an interpreter, and you can decide at that time which visit is more important if the interpreter's with someone.

Maybe the clients don't feel valued because there [are not enough] interpreters...if all the interpreters are taken, for example if I need one, um, I'll have to tell the client to go home, sorry, no interpreters are available right now, make another appointment, and that's poor practice. Um, and that just infuriates the clients, it infuriates me.

Some participants faced situations where their agency's imperatives are in direct conflict with their clinical judgment regarding a particular client:

Well I have to sort of wiggle around [the agency's imperatives or structures] and not let [them] interfere. Like yesterday...I had just [talked to] a client with heavy poverty and Latino [sic], and [I said,] "If you don't show up for your appointment we have to bill," and he says, "I can't do it, and I'm like X, let's...if there's some days you can't come, and we have the demands of the agency. All we have to do is, if you feel like you can't get out of bed, call me and we'll talk on the phone, and I'll go do the paperwork, let's make it work!" Because he was ready to throw in the towel! Um, you know...he's complaining about [the agency] and I'm like, "I know, but don't throw it all away, let's find a way to keep it working."

I might have somebody who I see once a week, and who's pretty high-functioning, but, um, still has a lot of issues, and I feel like, oh maybe I shouldn't be seeing them, once a week...for the [sake of] the agency. But I feel like, I like to see him once a week! He's like one of the most interesting functioning people I have, and if I'm only seeing people who are like complete disasters I'm going to be a mess. So that's where I feel like, huh, maybe this isn't right, somehow.

This theme arose as well with the issue of risk management, and the ways in which agency policies and procedures related to risk management impact participants' clinical decisions as well as emotional involvement with those decisions:

[The way that the agency influences my clinical work] is probably less conscious, so that maybe in some cases, you are much more quick to throw somebody in the jug [hospital than I was in private practice. In other words, maybe personal biases in terms of taking a risk and not hospitalizing, are in contrast with [the agency's] very high susceptibility to risk, emphasis on it, that puts you in a place where you could really get in trouble, or it makes it more conscious, hospitalization, when you pull the trigger and put somebody in. Sometimes I'm protecting myself and sometimes I'm protecting the agency and it's up in the air if it's in the person's best interest. So it's kind of the risks you take on behalf of the individual versus what risks are on me if something goes on.

I think [forms and procedures related to risk management] were created to put a distance between the – they're not separate from the clinical process, but they sort of, they're protective for us...so I feel like we've created a whole set of paperwork to sort of provide legal protection but also I think to give the illusion of protecting ourselves from feeling liable. Responsible.

A theme emerged in which participants felt rushed or preoccupied, either because of demands on their time or because of emotional responses to events taking place in the

agency. Participants reported that these feeling influenced their psychological “presence” with their clients during the therapy hour:

Sometimes, I feel pressured and rushed with a patient, because I know that, you know, they paged me, there’s somebody upstairs in some kind of crisis, um, you know, I’ve got another twenty minutes left in this visit, and I know the next person has already shown up for the next visit, so in that sense, I feel rushed, I feel like, I have to do it, I have to get it in, and I feel like I’m compromising the care of that particular patient sitting in front of me, because I know I have to be upstairs, and somebody’s waiting, so sometimes in situations like that, I feel like I rush through, or cut somebody short, and that doesn’t feel good, or you know I’m not completely present for that person because of the other directions I’m being pulled in the moment.

I think that I do a fairly good job of once I close the door to my office I pretty much of doing what I do, but you know, I can’t say that I’ve never been preoccupied by something that I just really want to think about, something I just heard about in staff meeting, or something coming down, you know, change, something taken away from us...So I can’t say that it never doesn’t sort of preoccupy me at times a little bit, you know just feeling walled up about something, you’re upset about it. Or you know, why am I doing this, you know, it’s not going to get any better...

I think that my emotional response with what goes on with the culture [of the agency] comes into session, um, and there’s days that people certainly don’t get the best of me, not because of personal stuff, but because of a meeting I came from that really annoyed the hell out of me, and I just...you know, that happens. But um, I have the sense that I’m worn down a lot...

Almost all participants spoke specifically about intake processes and clinical paperwork as both subtle and practical influences on clinical processes. Participants addressed the issue of specific formats and requirements for clinical documentation:

Coming into the agency, um, it has done things to increase the paperwork, and of course if you’re working in an agency you feel the pressure, or in continuing pressure of paperwork, getting the TOPs form, and the changes made every month, and of course doing your treatment plans within a certain kind of problematic format because of medical necessity...I think probably it’s a little bit more behavioral kind of slant in the charting and going back to the treatment plans, pushing us that way, I think maybe that’s a difference.

[T]he biggest sort of challenge is insurance companies, and all that they’re demanding of us...for example, having to do treatment plans on every patient,

having to do outcome studies on all patients – all these things, as she says are unfunded mandates. We still have to do it, even though maybe the individual believes that it's ridiculous and impossible.

...A lot of the work I do has not changed drastically, and yet if you had our training list or like who comes in to speak, it's really – it would be really funny because we did psychodynamic, long-term work, we focused on, um, empowering people to make their own changes, then managed care started, and so then we were doing behavioral management...and we struggled with learning all the terminology and paperwork, and then that kind of backed off, and then a lot of the insurance agencies outsourced, then you're on the phone [getting treatment approved]...

[The agency's policies around closing cases are] more loose. I don't really close cases here, I probably should, but it's not the same requirement as I had at the other agency, so that's a big difference I think in how I do my clinical work too because I...[S]ince I don't really close cases that much, even though maybe I should, it's not a requirement, so it doesn't happen in the same way.

With regard to intake processes, participants addressed increased paperwork requirements as a burden to clients and a potential deterrent to treatment:

It feels like as soon as people come in, you know, I'm going to need insurance. It didn't used to be that way, it was much more inclusive of you know, people who weren't able to pay, you know, they were attended to. It doesn't feel that way any more, it's much more, meager, and funding is... And I get furious that...[with] Latinos, there are systems in place that weed them out, that make it more difficult for them to come in and get services, that are less welcoming. One very basic one is...we had this intake document, to send this bunch of paper out to someone that is seeking help, and ask them these very intimate questions, without a support, I didn't like that at all. I didn't think it was mindful of...you know, to ask someone about family dynamics...without someone there to, you know, contain this, uh, but it went out, and then for years, okay...what about my Latino clients that are illiterate?

There's a package they [clients] get when they come in, and it's getting thicker and thicker and thicker, and they're told come a half-hour before your hour...you've got a rule of paperwork to fill out, and you know, wow, it's people coming in just to get therapy now, and it's getting more and more difficult! There's more and more roadblocks to coming in and just sitting down with a therapist.

[T]hings have drastically changed philosophically, financially...there's more screening done because of that, not just for clinical appropriateness and triage but for insurance and financial purposes...when a client calls and they go through

intake. The process shifted from being a really thorough clinical evaluation and setting a reasonable fee, or helping somebody get insurance if they didn't have insurance, and now basically we are much more concerned about clinical risks because we have less psychiatry here...[S]o the clinical piece is still really important, but there's a thorough insurance screening done before anybody comes in the door. [With regard to the clinicians' intake processes, we used to focus on] really at the beginning asking all the questions and setting up a treatment that makes sense, [but that] has shifted...it's moved from a narrative sort of summing-up without opening up to much a story – to checkboxes, risk assessment, and getting it done.

An array of perspectives arose on the issue of whether the agency and its policies, when influential to the clinical process, ought to be discussed directly in the session.

Some participants were more comfortable bringing this “third presence” into the room:

[The agency implemented a system to keep track of no-shows, and] I have one client with OCD who keeps asking when the next...report is coming out, and it's four months overdue now. So, he's like, “have they just given up on this?” And I said, “Well, it still works for you and I [sic]!” And he often – you know, he calls it the blacklist, you know, he's often sees sort of this sense that there's people above me that are making policy, and it's sort of interesting, the push for certain things, and then there'll be policy, and when I start to implement something, and I think a policy on attendance really impacts clinical work, um, and then sort of how well do I follow through and how well does the agency follow through?...[So] I think it's reassuring to have an agency policy, like around something like missed appointments, because it doesn't become, um, it doesn't become about the relationship, and how much I like you or don't like you, and how much I'm willing to let you no-show...

A few years ago, the agency, the prescribers...used to see clients every half hour. [Then,] the agency's like, “We don't get reimbursed enough for this; you have to see them every twenty minutes.” So sometimes clients will say, “I don't have enough time with my psychiatrist.” Then you have to say, “Well, of course you don't,” you know, in a way, um, at the same time, trying to explain that the nature is that the prescribes or doctors are there mostly for medication, and the therapy's done with the clinician...other times in managed care model, clients become stable and you don't see them every week anymore, and so you go to every other week, your clients might say, “Well I want to keep seeing you every week,” and you say, “Well, let's talk about this, or you know, the nature of the agency and we can help and be more helpful to more people as other people become well, or better, and as you feel better we need to see those people less.” Some clients don't care; other clients would rather not do that. And so that's how – and again, there's

a narrative above the agency that puts pressure on the agency to do that, but that's how it comes into the therapy room.

Other participants emphasized the dyadic nature of the clinical interaction, preferring not to discuss the agency and its policies:

I don't think I'd talk about the agency. It's between me and that person. It would just be justifying, or getting me off of the hook, which I think is not helpful, in terms of working something out, I don't think the agency really has affected my decision, its in the context of my relationship, the I and thou relationship. And the agency is a distraction in this situation, so I would not go there.

I mean, sometimes [having a lot of ability to dictate the way I practice] makes it harder because you can't fall back on, well this is our agency policy, blah, blah, blah, but I feel better having that power to make decisions.

#### *Clients' Narratives of Loss in the Agency in Clinical Work*

Just as participants frequently discussed their own experiences with loss in agency settings, many participants described their clients' either direct or absorbed experiences with loss at agencies. Many participants spoke about clients who had been at their agencies since their founding, living through many changes in personnel, working style, funding, and management policies. Data in this section related primarily to the loss of relationships at the agency, either with specific staff members or with the "agency community." Two participants made a connection between clients' experiences of losing relationships and a shift in the philosophical orientation toward clinical work:

So my value is in the relationship. And it can take a lot of different forms, but I'm always challenging people to not underestimate that...[sometimes supervisees will say,] someone's symptom is better, by saying, you know, so I think we're going to terminate – [then I say] that's a whole different thing...I'm still committed to long-term work...I think that's more important than what you call the – intervention – we think we're giving for people...

Now that we [have a new mission statement], it's much more of a rehabilitative model, with less emphasis on relationships...



Data revealed that participants feel that clients are directly impacted by losses in the agency:

I've had clients who have been here through all [the multiple, dramatic changes], I mean I have one who recites everyone who's left, everyone who worked at the front desk who left, everyone [sic] psychiatrist that she's seen in that time...

I think the clients do know that clinicians have come and gone and that their own experience is that they can't really count on, you know someone being really committed to them. And if this recreates their own history where people weren't there for them, and that this feels as though there's just such change, and they wait five months, [for an intern], and then they say, "well you can't leave me now, I waited five months to get you." And that's the sort of typical story. And I think it seeps into the air and the culture, so, I can project that the clients feel less held and feel less like you're going to be there in the way that they need whether they're able to articulate it or not, I think the environment. I think people can feel that.

Two clinicians shared that these losses were resonant enough with their own losses in the agency that they felt overwhelmed clinically:

[S]ome of the clients...were directly affected. A lot of them lost therapists. I mean, we would never have had what we sometimes have now where someone's presenting a case and I realize it's their third therapist in a year and a half, which is completely unconscionable...so there is an impact in terms of clients who have had multiple providers, and it obviously, that's disruptive, I mean I believe so strongly in relationships that you can't have somebody have three [therapists] in the space of a year and a half and not have them feel less than optimally cared for... and then there's this helplessness too, how do you help somebody deal with this if you're leaving, or if you're staying, and while *you're* dealing with it, wherever you're dealing with it?

[The agency] comes in when, okay, my client's [prescriber] has been replaced three times, uh, and dealing with that aftermath, or you know, when I've had so many transfers, I've put a brake on transfers, I'm up to here, so I'm putting the brakes on that, I don't want to hear that your therapist left, I want some fresh ones. Um, you know that element of this loss is brought into the therapy as well, so you know, keep it out, but it does seep in...

### *The Presence of the Agency's Narratives in the Therapy Room*

The interviews frequently addressed, often at multiple points, the subtle influences of participants' experiences with multiple narratives on their clinical work. A

vast and notably diverse array of data was therefore generated on this topic. Because of the amount of data in this subtheme, it has been further analyzed to reveal the following subthemes: i) the therapy room as the “insulated organizational subsystem”; ii) how participants’ anxiety regarding organizational functioning is contained in the therapy room; and iii) parallel processes, or “what clinicians get, clients get.”

*The therapy room as the “insulated organizational subsystem”*

A theme emerged in which the therapy room was felt to be an insulated space in which the participant and client were able to separate themselves from their individual experiences with the agency and broader systems:

I mean I’m thinking about, ideally, [my feelings about the losses we’ve faced] don’t impact client time.

I mean obviously if you’re seeing an awful lot of difficult cases or boring cases, then that affects the way you work...but I think most people here care about what they do, and work really hard to keep [the agency] away [from the clinical work].

What I do here, I know I can do it, I feel fairly competent in what I do, I’m not trying to brag about that but I do, I’m happy with what I do, I love what I do, and so it does bother me and distress me in many ways, the way I feel treated here by the bigger sort of agency, the big bad guys, um, and it does – I can’t say it’s never affected me in a negative way, but I really feel I have a good sense of boundaries, so when I come into this room and I’m with my clients, I’m working with them, and I have a good sense of what I’m doing, and I enjoy what I’m doing. And so uh, if I’m feeling anger and resentment because a 2% percent raise just came down the line, and it’s a 2% raise, and you might as well burn the paper it comes on, um, you know I can put that in perspective and talk to my colleagues and we can work it out on a certain level, and sort of...

...Once we’re in session, we’re in session, you know there’s always the worry about insurances, but that’s definitely a different matter...Hopefully, I respond to what [the clients] are bringing in...yeah, there is that little awareness, you know the imago [referring to a supervisor’s “presence” in his mind], but I think I don’t stick with that, I move past it...This one client comes to mind...who’s really borderline, narcissistic, a man, but a young man in a post-doc program, in some ways he is uncharacteristic, and in my interactions with him, I’m just, I’m so aware of how my interactions are shaped by *him*, you know, and like me trying to get his world, and me getting pulled into his world, and trying – you know, and

then the person I see after him, is just so different...I really see it as like, the room, and the building, but there's not, maybe there's effects, like paperwork, it's different here and there and it shapes a little bit about how you think, but mostly it's shaped by the patient and what they're up to.

Well, there's a moment where you are...in an environment, that is depleted and hostile. There was a [staff member] that was escorted out...I can't tell you the impact that had. Why was X escorted out? And right after that we lost I don't know how many therapists. So that's what I mean [by] hostile...[but] I love my clients; I am fresh with my clients – that privilege of working with this community. And it's not ideal here, but this is very special, it's very special – the opportunity to work with this community.

Only one participant described the agency as a potential support for the clinical work:

I mean I guess ideally, the presence of the institution behind me lets me do the work.

Some participants made clear connections between practices in the agency and clinical work, suggesting that they feel the room is not as insulated from agency forces:

[In a fee-for-service model,] when a client doesn't come, clinicians don't get paid, and that has an impact on your level of commitment and your level of compassion, and your level of wanting to provide care and services. At the same time, it becomes a very difficult realization sometimes that you're putting in work and not getting paid for it; and that's uh, sort of, then you have to find some sort of clinical piece to either address it with the client, or find some other option.

I think I worry at times, or I go through periods of time when I think there's a real staleness in the clinic, and in the work that I'm doing, um...I think there's this wonderful way that you come here and you pick up a caseload of folks that have been at the agency since it's creation, um, and so you [hear from other staff], "Oh, so and so, you'll just sit with them for half an hour, and just do this and this, and oh, this is what they're going to bring up," and so...you walk into a treatment relationship, and certainly each therapist is different, but um...I realized after I'd been here for a year, "Well why am I doing x?", with so and so, just because I was told to do that when I started? So there's this wonderful way that there's a knowledge of all the folks we see that serves the clients when they're having crisis, or to know their history and their predictable patterns, but I think it also contributes to, um, not doing a lot of, not considering a lot of different things in treatment or not being creative in treatment, um, in the way that I had been in the past. I wonder about a shift from my work, the creative – the way I proceeded in my last job, and some of the staleness I feel here.

There was a clear sense that sometimes the emotions evoked by either the relational or practical strain of working in agencies can come into clinical work:

I think for people that are straight out of school, you know, who do their work and run home, and don't have a way to process how hard it is, I think that [it makes difficult] their own sense of kind of control and growth. I mean, you know, the work is hard, and it takes a lot of work to get good at it, it takes a lot of thought and reflection and support, and running things by people, and it sort of saddens me to think how people can develop a comfortable sense of themselves as a therapist with some kind of confidence, without a lot of support and processing... You know, the issue everybody talks about is... you know, I schedule an hour and do fifty minutes, but some people do 45 minutes and 45 minutes and 45 minutes to get three clinical hours in, uh, two hours [sic].... So what you do is, you know, you're basically recovering from the client you've gone to and then you're thinking about the client you're go to, and then how do you really sit in the hour, when you're struggling to figure out what's going on, when you're emotionally bombarded.

...I mean it was like, "Ra, ra! We're social workers!", you know, "We see the people that no one else will see!", and all this stuff, so I really did not let on that I wasn't sure this is where I wanted to be forever, and I didn't share the same kind of pride, that the family shared. Um, so, and have showed some of that more recently over the last two years, and I think it's changed how people see me here, and how much impact I can have... it's made me a little bit more invisible... [in terms of how that feeling comes into my clinical work,] I think I'm probably drawn toward the clients that are not so much the favorites... I think I'm drawn towards the folks that maybe cause a little bit of trouble, or um, aren't thought of in the same way. But I don't know about in the actual hour, or in the therapy session. I might work harder or fight harder for those people... that are not favorites.... And I might do more thinking outside the session about them, or have more energy.... The more we talk, the more I'm sort of aware that probably the agency is the third person in the room – I don't know, in a good way and a bad way.

Participants clearly identified times during the therapy hour they more or less consciously chose to have their own clinical judgment supersede or override their agency's policies or treatment structures:

I think I try not to think about [the agency's treatment structures] in the sense that I don't think you know, see them, see them short-term, get them stabilized, get them out, see another person, where I think I just think about it in the context of what they want and what they and I feel will be useful, you know what are the

goals that we want...so I basically try to distance myself, and try to work with them to establish a kind of treatment alliance and goals that I think will meet their needs and also my needs in wanting to be helpful, separate from what the agency's view of what I should be doing. And I think it's the only way in a sense to survive, because if you're in an angry position or you feel constrained, or don't value what you're doing, even if your agency might not see it in the same way, and they're not going to see it in the same way, in the sense that I think running a mental health clinic has been hard...I think it's really important to get, to be clear about what you think is right for your client, as much as you're able to control it and establish it with them, and get yourself surrounded by like-minded people who understand and support that.

I think the [recent] no-show policy has not really taken off because it would drastically change our clinical work, because we have always seen these folks who can miss fifty out of their one hundred appointments, and we still see them, so I think there's a lot of wondering in the room when we talk about this at staff meeting, like, "who would we become?", and like, "would people still take pride in who we are?"

I think sometimes individuals have the power of their own narrative or their own mission that can supersede [the agency's imperatives]... or what they communicate or do in the work even though it may not be reflected as much from above.

Related to this, participants had notably strong responses to one of the research questions, in which they were asked whether or not they agreed with the idea that "all clinical decisions are the result of agency imperatives" (Gitterman & Miller, 1989, p. 171):

Not me. I just pretty much make my own decisions, how I think their treatment should be run. If there's [sic] any questions I'll check with my supervisor. I wouldn't say so, no. I wouldn't say so. And even if I had clients, if I have clients that I've seen, or really need to be seen, and I have somebody new in the spot, I will cancel that new person, to fit my client in. No, I don't feel that's the case.

No. No, fire me then! No...No. Um, no. No, no, no, I'm always have my eye on what's best for the client. Always. Research comes in. we have a lot of research and they want us to recruit clients, and I'm like no...because I'm not going to use my power for, you know, because it is an incredibly powerful position, therapists, for the good of the agency, or for the research project, and I'm like no, no, no.

Um, I think when it's consistent with all levels of the agency from upper management through clinical staff, it's a wonderful thing, and it's an ideal.

*How Participants' Anxiety Regarding Organizational Functioning is Contained in the Therapy Room*

Mild dissociative processes, experience level, and processes of self-authorization/re-authoring emerged as themes in terms of how participants manage the anxiety evoked by multiple narratives during the therapy hour. In response to being asked how he continued to provide services in the face of the multiple stressors he had described in his workplace, one participant said lightheartedly:

You want to know about my dissociation?

Another participant echoed this sentiment:

Do I feel I am less there for my clients? I don't feel that I am...I mean there's like, if I don't talk about being angry and upset about the system, in some ways it's better because it just allows me to do what I have to do, to get into that kind of mode...

Several participants discussed both their own early experiences as social workers as well as their rising concern for changes that they see or anticipate in younger clinicians, suggesting that perhaps experience in clinical work is a factor which allows for a kind of insulation from difficult work circumstances:

[W]hen you are a newer clinician, you may be more thinking about outcome studies, you may be more worried about productivity, but um, but I think I don't feel that.

...For someone like me whose been at an agency for a really long time where the narrative in the past used to be much more compatible with my personal narrative – which is to say that it's really an indication of where the field is now...there's been a greater disparity, or separation, between the agency narrative and the personal narrative...that's probably very different for someone like me, you know, who started in the 60s, when the mission was very...uh, uh...similar, to what I felt. It's become further and further away.

[As a beginning clinician, the director's] participation maybe personally and sort of acknowledging the work that I was doing...definitely had a positive impact on

the way I would see myself and the way that I felt as a profession, a professional person, being respected in the agency, being recognized.

One less experienced participant countered this possibility, however, suggesting adaptability in terms of the wider mental health environment that does not necessarily compromise clinical practice:

There's like a lot of psychodynamic purists, who are infuriated that they ever have to justify anything to an insurance company, and I feel like, I'm like, a younger generation, where I'm used to it, and I'll just spin it to the insurance company, that we're modifying their behavior, and you know, it works okay...I hear so much like grieving among, you know, more established clinicians, about how the systems have just tightened up and resources have dried up, and you know, lengths of stay are shortened, and you know, training opportunities have gone away, and so I'm aware of it, and I can see it happening...it scares me, it's awful.

The felt strength of participants' personal narratives, or their processes of re-authoring, in sustaining their clinical practice in difficult settings was evident in many interviews:

My heart's in the right place. I, uh, even all this shit around [in the agency], I – you know, there's a bright spot. Yeah. And I'm not fried to a crisp, I still come in fresh and optimistic, and uh, in a humbleness and privilege of this opportunity, but I'm aware of the other, the dark side...[I reconcile the feelings of the incredibleness of the place and dark side of the place] like a fight. You know what, this isn't gonna get me. Even though it's shitty, there's so much hope here.... coming to this place which is wonderful that it exists, even though it has all its troubles, that this place exists is incredible...

How do we address the fact that we hear horrible stories all the time, and uh, there's less room for that, and so that's part of my commitment...and that won't show up anywhere in a mission statement, [but] I hope it would show up if you interviewed people here, in terms of self-care or how you understand what you're giving people...if I lost the sense of having a...voice in the clinic, then I don't think I could do the work because that's what I'm trying to offer my clients, that this is their place that they have a voice to say whatever it is to say what they need to say...

I think you have to write your own narrative in terms of what works for you, that allows you to do the work in a way that you can feel proud, that really allows you to continue your commitment to the clients that you want to see, but that somehow writes your own narrative in a way that allows you to kind of live with yourself and deal with kind of the compromises, you know, cause you can say, the hell with this, I can't work with an agency that will kick someone out after

they've lost their [insurance], and have one session, after you've seen them for ten years, to find them a therapist, which isn't the case, you know, so how do you live with that, which is so much against you know how you see people and how they should be treated...I guess we all have to in some ways find a way to live with what we do, and take some pride and pleasure in it, if we're going to be able to continue to work. So you struggle with writing your own narrative and not expecting or valuing what you do based on how something external to you sees you. You know. So, you need to separate from that...or you get caught up in something that gives too much power to something outside yourself. And I guess the struggle is how do you hold on to a personal narrative against all odds...I mean it's a balancing act for everyone who clearly goes into it with a sense of what they see as the kind of environment that's necessary for the clients and themselves and then you make some compromises, and how do you find a way to do right by your clients in the limited way that you can...

Participants appear to consciously or unconsciously use several distinct processes in order to manage multiple narratives in their clinical work.

*Parallel Processes, or "What Clinicians get, Clients get"*

Parallel processes seem to have appeared both unconsciously and consciously in participants' narratives. In two interviews, parallel processes were unconsciously revealed in the stories participants told about their clients and coworkers. For example, one participant who works in a "dangerous" neighborhood described a significant amount of violence occurring in the neighborhood. Clearly, this impacted her clinical work, and she shared that almost all of her clients suffered from some kind of loss-related trauma (murder, prison, etc.) in their immediate families both presently and historically. She later described a "myth" about staff members at the agency:

There's a...myth, but there is some reality to it, that people [staff] just disappear from here, that, all of a sudden you come in one day and somebody's not here and you have no idea what happened to them. And I think eventually people figure out, it trickles down, you know what really happens to people, but there are people that are very firm in this belief that people disappear.



The parallel process in the traumatic and sudden losses experienced among clients and the sudden and unexplainable losses experienced among staff was evident. In another example, a participant described the implicit mission of her agency as such:

We take pride in serving folks that um, sort of, not found a match of treatment anywhere else, so sometimes, this is obviously not written in the mission statement, but sort of last-stop shopping, I mean that sounds horrible, but people who have been refused other places end up here.

Later in the interview, she described a myth about staff members:

There's a myth here that it takes a whole lot to get fired, in that kind of we're the last stop shop for clinicians and clients and there's these epic stories [about inappropriate behavior among staff]...

In notable contrast with the frequency and depth of data suggesting that the therapy room is "insulated" from forces in the agency, several clinicians spoke directly to their feeling that, in fact, their experiences with support, empowerment, authorization, and belonging were directly related to their clients' experiences in the therapy room. In other words, they consciously identified a parallel process between their own experiences and their clients' experiences:

I completely believe there's a trickle-down – I believe clients feel as valued as you feel as person and as an employee and as a coworker of a family...If [clinicians] don't feel cared for by me [as their supervisor], or by the agency, um, then how can [they] provide a caring offer of [themselves] to someone? And I think it's that basic.

Patients really appreciate the help they get from the front desk [staff]...noticed and recognized by them. [One man] who's been here for about a year, he knows people's names when they come in, he's already got them punched up in the computer when they get to him in line, at least my patients who are pretty needy, it makes them feel very good, very recognized, valued even. I think that...definitely the relationships between staff, the trust the respect, the humor, is definitely, there's a parallel process between providers and patients, you know, in an appropriate way, but there is this sense, of, you know, more than just coworkers.

I believe that if you're trying to help people empower themselves, then we [clinicians] should be able to be doing that for ourselves.

I do feel very cared for here as an individual, and if you don't feel cared for as an individual you don't have much to give back.

There was sometimes tentativeness in participants' explorations of this idea, or a difficulty articulating a parallel that may feel challenging or sad:

I hate to think that on a clinical level, that if I get less, they get less, I hate to think that that is part of what is happening in the work that they do, and I think that I can isolate that fairly well, but I think that – you know when you have to work more to get less, and you know you do wonder, I do wonder, and I'm not sure how that happens...

I think it's hard to work in an agency in which you feel that you're committed to people's well-being, clients' well-being, if you really feel that there are policies that don't support quality care because it causes you to feel not good about the kind of work you do, which ends up making you not feel good about yourself, and I think people compartmentalize that...

These findings point to an ambivalence about, and perhaps reluctance to consider, the relationship between participants' experiences of agency narratives and personal narratives, and their interplay during clinical encounters.

### *Summary*

This section presented participants' experiences negotiating multiple narratives in clinical work. The data showed dissonance between administrative and clinical narratives, as well as between administrative and personal narratives. Participants named a wide variety of ways that the agency's structures, policies, and procedures impacted their clients, although mostly outside of the therapy room. With regard to clinical work, the issue of clients' losses within the agency system was reported to be a clinical issue, paralleling participants' own experiences with loss in the agency. Finally, a wide range of views were expressed regarding the subtle and concrete ways in which the agency's

narratives enter the “therapy room.” Some data supported the interpretation of the “therapy room” as the insulated organizational subsystem; further data explored the ways in which participants contained the anxiety evoked by organizational functioning in the “therapy room”. However, a theme emerged (almost ambivalently) in which participants and their clients were thought to experience a parallel process in organizations; i.e., what participants get (in terms of support), clients get. These findings point to the richly layered and complex ways in which organizational narratives and personal narratives are experienced as mutually influential in the clinical encounter.

#### *Summary*

This chapter has presented data related to three broad themes, each with subthemes within. Within the first broad theme of Participants’ Perceptions of Agency Narratives, data revealed subthemes including: a) Participants’ Experiences of Implicit and Explicit Agency Narratives; b) Influence of Workgroups and Social Networks on Perceptions of Agency Narrative; c) Narratives of Agency as Family: “Where We Live, and How We Nourish Ourselves;” and d) Influence of Broader Systems on Agency Narrative.

Within the second broad theme of Participants’ Narratives about Themselves, their Clients, and their Work, data revealed the following subthemes: a) Emotions Elicited in Participants by Experiencing Agencies’ Narratives; b) Participants’ Experiences of Loss over Time in Agencies; and c) Clinical Work as Personally Sustaining Independent of Agency Narratives.

Within the third broad theme of Participants’ Negotiations of Agency and Personal Narratives, and the Influence on Clinical Work, the data revealed the following

subthemes: a) The Felt Dissonance between Administrative Narratives and Clinical Narratives; b) The Felt Impact of Agency Structures, Policies, and Procedures on Clients; c) Clients' Narratives of Loss in the Agency in Clinical Work; and d) The Presence of the Agency's Narratives in the Therapy Room. This final theme was further analyzed to reveal these subthemes: i) The therapy room as the "insulated organizational subsystem"; ii) How Participants' Anxiety Regarding Organizational Functioning is Contained in the Therapy Room, and iii) Parallel Processes, or "What Clinicians get, Clients get."

The data presented here suggests a dynamic set of issues that participants encounter in their work in agencies on practical, emotional, and philosophical levels. It also points to a recurrent theme of loss within all levels of the organizational system. In the next chapter, the data are further interpreted and discussed in order to more fully understand participants' experiences with regard to the research questions, and the implications for social workers in CMHCs are discussed.

## CHAPTER V

### DISCUSSION

This study sought to explore clinical social workers' experiences of the ways in which agency and personal narratives influence their clinical work in CMHCs. Data was gathered through in-depth, semi-structured interviews. Three broad research questions guided the interview processes, although within this framework, the researcher was responsive to other emerging narratives. A narrative lens informed the formulation of the research questions, the interview guide (see Appendix A), the data collection processes, and the data analysis and interpretation. The data were organized under three broad themes, corresponding to the research questions:

- 1) Participants' perceptions of agency narrative;
- 2) Participants' narratives about themselves, their clients, and their work; and
- 3) Participants' negotiations of agency and personal narratives, and the influence on clinical work.

In this Chapter, the researcher discusses these three themes, and their nested subthemes, in relation to one another and in relation to the theoretical frameworks and previous research presented in the Literature Review Chapter. The Chapter concludes with this study's strengths and limitations, as well as the implications of this study for theory, clinical practice, organizations, and future research about the influence of organizational context on clinical work.

## *Perceptions of Agency Narrative*

### *Participants' Experiences of Implicit and Explicit Agency Narratives*

Participants' high degree of resonance with the concepts of implicit and explicit narratives in their organizational settings gives credence to both McLeod and Machin's (1998) and Martin's (1982) suggestion that narrative theory can be usefully applied to the study of organizational behavior. The concepts of explicit and implicit narrative served as an entry point for discussing relationships among multiple, and sometimes competing, narratives in the organizational system. Related to this, one of this study's unexpected findings relates to the idea that narratives in administrative organizational subsystems are more often explicitly communicated, while narratives in clinical organizational subsystems are more often implicitly communicated. This may relate to participants' relative distance (in the open systems model) from the functions of the administrative subsystems as compared to their closeness with clinical subsystems; perhaps, as narratives are filtered through organizations, explicit communications are less vulnerable to dilution or erasure. Despite the strength of narratives emerging from administrative subsystems, the data reveals that participants had a stronger identification with, and a better ability to recount, the implicit narratives they experienced in their agencies, particularly those narratives related to clinical work. This finding is a phenomenon which is not described in the literature reviewed for the study.

The data on implicit and explicit narratives can also be usefully interpreted within the framework of organizational systems theory, and more specifically with regard to the related concepts of task, technology, and throughput. These data suggest that there is a felt inconsistency in definitions of "task" and "throughput" in the organization: explicit

narrative data define a task more often related to providing clinical services in the context of pressures related to financial survival, revenue, risk management, and broader funding issues, while implicit narrative data more frequently describe a task related to community involvement, commitment to disenfranchised populations, and feeling of “loving” and “caring” in clinical work. This suggests the difficulty of creating and sustaining a cohesive narrative throughout organizational subsystems. This may be related to the current political and economic pressures on CMHCs as well as the inherently complex nature of these organizations, as described by Hasenfeld (1985, 1992).

This strongly echoes Katz and Kahn’s (1978) admission that the organizational systems model incompletely accounts for the “conflicting dimensions of organizational constituencies” (p. 246). However, while they propose that notions of organizational throughput may “fail to describe the motivations of management” (p. 246), it appears from the data as if the opposite holds true among the participants: that is, participants feel that the explicit narratives sometimes fail to account for their motivations in clinical social work in CMHCs, and emphasize administrative functions too often and too much. This finding also lends support to Gitterman and Miller’s (1989) statement that “a predictable and stable distinction develops between how things really get done and how they are supposed to get done” (p. 153).

Importantly, participants not only described this distinction between stated and actual task, but also communicated that they increasingly felt limited in their ability to complete their tasks. Using a systems lens, it appears as though the organizational system is stressed because of decreasing input. A significant component of this decreasing input relates to broader systemic influences. However, participants also suggested that pay

arrangement became a means of implicit communication regarding this decreasing input. The extent to which workers interpret pay arrangements as implicit communications from administrative components of the organizational system is a crucial question with implications for people in all levels of the organization. In a stressed system, financial payment may become, both symbolically and extremely practically, a final type of nurturance for the worker, especially as other “benefits” like space, time with one another, and even food, are taken away. Perhaps, in the absence of an organizational narrative with which they resonate, participants begin to interpret (more or less consciously) organizational practices such as pay arrangements as communications about the extent to which they are “cared for” by the organization.

#### *Influence of Workgroups and Social Networks on Perceptions of Agency Narrative*

The findings related to the function of workgroups and social networks are consistent with previous theory and research from both organizational systems and psychodynamic theories about functioning in organizations (Bion, 1961; Bransford, 2006; Obholzer, 1994; Parker, 2002). Experiences in groups and in interpersonal relationships with colleagues are clearly and powerfully depicted in the data as the most consistent source of support, learning, and emotional connectedness. It is also apparent that these social relationships are perceived as somewhat under threat; this finding has important implications for program design.

Organizational/psychological climate is defined as the “way people perceive their work environment” (Glisson, 2002, p. 235); perceptions of climate, furthermore, “evoke feelings of satisfaction and identification with one’s job or organization” (Hemmelgarn, Glisson, & James, 2006, p. 78). In the context of these definitions, the data in this study



point to the possibility that affiliation and identification with workgroups and social networks may act as a protective factor as participants work to fulfill their organizational responsibilities. As one participant says:

...It's the staff that holds it together, against all odds.

Although the data gathered by this study cannot make a quantitative link between participants' perceptions of agency climate and culture and their clients' outcomes, many participants voice that they feel this connection to be true. This sentiment supports numerous quantitative studies on this issue (Glisson, 2002; Glisson & Hemmelgarn, 1998; Hemmelgarn, Glisson, & Dukes, 2001; Jaskyte & Dressler, 2005; Morris, Bloom, & Kang, 2007), although it is important to note that many participants in this study stopped short of explicitly connecting their experiences with their organization's culture and climate to the nature of their clinical relationships. As will be discussed in more detail below, this complicates Hemmelgarn et al.'s (2006) finding that "culture and climate mold the nature, tone, and focus of the relationships and interactions between service provider and service recipient" (p. 75).

Menzies-Lyth (1988, 1989) and Bion's (1961) theories, and Parker's (2002) research, about the role and function of workgroups in clinical work is relevant here as well. Group membership and social networks, they argue, are evocative experiences which ideally provide a context for the working through of anxieties aroused by clinical work, although groups can also take up anti-task activity, thereby obscuring this primary focus of the group. Participants in this study reported having both kinds of experiences in their groups, suggesting the continuing applicability of Bion's (1961) theories. The data also seems to extend Parker's (2002) finding about the preventive role of workgroups

when experiencing turmoil related to clinical work; participants appeared to feel that both workgroups *and* social networks and collegial relationships fulfilled this purpose.

*Narratives of Agency as Family: “Where We Live, and How We Nourish Ourselves”*

The data which depicts participants’ narratives in agencies in the language of “family,” space, and food suggests a strong theoretical link to psychodynamic theories which associate organizational roles with the very personal context of people’s lives and specifically families (both present and of origin). Although literature was not reviewed which analyzes organizational functioning from the perspective of family systems theory, the findings in this study suggest that this might be another useful theoretical approach. The centrality and depth of experiences in organizations also mirrors Trethewey’s (1997) assertion that

Although we are often unaware of the centrality of organizations, it is in the everyday practices of organizations that much of our political life takes place....Organizations...are political because they are primary sites of identity formation in contemporary life (p. 281).

Furthermore, the actual or desired experiences of nurturance that participants describe suggest the suitability of concepts from attachment theory for understanding the data. In this regard, the findings in this section clearly connect to Eileen Smith’s (1997) argument that the nurturance needs of clinicians often arise symbolically in the form of seemingly trivial matters like food and space. In other words, one interpretation of participants’ frequent evocations of wishes for food, more space, and family time is that participants desire nurturance in their organizations, and are repeatedly frustrated in this desire. Charting the history of CMHCs, one sees that in their early history, there was plentiful input into the organizational system in the form of money and other material

resources, as well as time spent collaborating; in environments where these forms of nurturance are under threat or already gone, participants describe forms of neglect:

I think that [clinicians] feel they get more support from each other than they feel they get from above. So that has been a helpful source, but that gets challenged too, because clinicians have less time to be with each other.

It is important to ask, then, whose job it is within the organization to hear and respond to the needs of the clinical staff, as well as to consider the inherent difficulties social workers may face when articulating these needs.

Parker (2002) uses the language of attachment in her article, considering the workgroup the secure base for clinicians in the organization. An attachment-informed consideration of the theme of family in conjunction with the theme of workgroups and social networks provides a compelling interpretation of the data. Perhaps, the CMHC is experienced as a deprived environment, in which the relational connections remain precariously intact but the cupboards are bare and the family is cramped together in one small room.

#### *Influence of Broader Systems on Agency Narrative*

Participants identified shrinking external resources as influential to their experiences of agency narrative; indeed, the awareness of decreasing governmental support, increasing costs for clients, and changing mission statements within the agency which conformed to outside funding sources were seen as threats to quality care. The broader systems which influence the CMHCs under study here can be thought of as a part of the current mental health metanarrative – that is, the overarching story within which CMHCs strive to carry out their tasks. In the data, this metanarrative is seen as affecting both organizational tasks and structures:

Now...our minimum fees are \$55 an hour, they used to be \$2, for students we had a lot of students who were seen for you know \$5 or \$10...so this is no longer affordable psychotherapy at all.

I remember in social work school, uh, a teacher saying “follow the money.” And I think it is [a certain segment of the clinical population at agency X who] are really calling the shots right now. And, they’re the ones that are, you know, services are for them...

The data exposes many participants’ conflicts with this overarching metanarrative, and in this way confirms the perspectives and findings of Furman (2003), McWilliams (2005), and Ware et al. (2002) about the effects of managed care on social workers. In this sense, social workers’ ethical dilemmas in caring for their clients may be reframed as conflicts between overarching metanarratives: those of managed care, and those of psychotherapy. Ware et al. (2002) have described the slow process of negotiation between these narratives that occurred among the therapists in the CHMC they studied:

The more clinicians engage the new discourse [of managed care], the more accustomed they become to thinking in terms of the categories and relationships the language of managed care provides. They absorb it; it becomes inscribed as part of their identity as mental health professionals. In the process, that identity is remade...Thus, besides undermining the ability to continue to deliver good services, managed care confronts the therapist with the prospect of being professionally transformed. (p. 19)

This semi-conscious process of transformation at the hands of broader systems seems to impact several participants in this study; as one participant says:

[Changes in funding and subsequent changes in who we can see] really erode...the disparity between what one’s personal mission is, and how it’s affected by these external forces, and you basically have to survive...

The competition between these two metanarratives relates to the earlier finding about the conflict between implicit and explicit narratives within the agency; specifically, some participants’ perceptions that administrative explicit narratives are characterized by

financial concerns suggests that participants feel they may have lost organizational support in their efforts to sustain a broader social work metanarrative.

*Participants' Narratives about Themselves, their Clients, and their Work  
Emotions Elicited in Participants by Experiencing Agencies' Narratives*

The amount and depth of emotion experienced by participants in relation to their organizations is a serendipitous finding which finds resonance in much of the psychodynamic literature. On a basic level, this finding seems to give credence to Menzies-Lyth's (1989) reading of Bion (1961), in which she emphasizes that humans experience group membership as both critically important and immensely difficult. In other words, experiences in organizations (which are a form of groups) are powerful and evocative of universal emotions related to attachment and object relations.

Obholzer (1994) argues that experiences with authority in organizations frequently lead to "acting out" of unconscious conflicts, which are sometimes related to early object relational experiences with caregivers. The prevalence of feelings of frustration with management and administrators among the participants in this study points to the possibility of this process in a limited way: it is important to wonder about the extent to which individual participants' responses to administrators or other leaders are informed by their own early experiences. Needless to say, this is well beyond the scope of the data collected by the researcher. Indeed, a related interpretation might be more apt: perhaps the "neglect" experienced by participants (on behalf of themselves and their clients) at the hands of the broader system is projected onto administrators, who are the closest symbolic link to these broader systems. This possibility has important implications for clinical work, particularly insofar as social workers feel empowered (by

their profession, their organization, their social work schools, their peers, and ultimately themselves) to engage in social action aimed at changing the broader system. Without support for this social work metanarrative from agency administration and the corresponding sense of empowerment, feelings of powerlessness may become overwhelming.

One might also understand the depth of negative emotion toward administrative organizational subsystems in terms of Halton's (1994) theory that helping professionals tend to "deny feelings of hatred or rejection towards clients" (p. 14). He suggests that rather than experiencing these feelings toward their clients, professionals may project them onto parts of their organization: "the gaps between departments or professions are available to be filled with many different emotions—denigration, competition, hatred, prejudice, and paranoia" (p. 14). Again, there is little conclusive data related to this, although it certainly poses a valuable question to workers in organizational settings who are experiencing these kinds of powerful emotions. For example, one may wonder about the extent to which social workers become resentful of their clients, whose needs may be unchanging despite the dwindling resources available to meet those needs. This resentment might be more safely felt toward the organization, which, of course, faces the same pressures regarding dwindling resources, but is a significantly less vulnerable component of the organizational system than clients are. One participant articulates this dual pull toward fulfilling the needs of the clients and fulfilling the needs of the agency, and her subsequent fatigue, when she says:

We [clinicians] sometimes become the sort of – on both ends, with the agency and with the clients – a fatigue, or sort of a tiredness [sic], of always kind of being the engine and maybe not getting so refueled.

Menzies-Lyth's (1960, 1988) theory offers another possible interpretation of the extent and depth of participants' negative feelings toward various subsystems of the organization. The stress and anxiety provoked by working with clients in CMHCs, and more generally by clinical social work, is more or less well contained depending on the organization's social defense system. As organizations tighten their belts, support for collaborative working styles often erode, along with many other ways of working (McWilliams, 2005). The erosion of these systems may let loose anxiety and anger inherent in the work. The implication is that organizations and their members must creatively adapt their methods of coping with clinical work to the support that is available from the current systems, while simultaneously advocating for desired changes in these systems.

#### *Participants' Experiences of Loss over Time in Agencies*

The data has suggested that participants experienced significant changes in their agencies, and moreover, reductions in services for their clients and financial support for their organization. Shifts in social work brought on by managed care, and in CMHCs more specifically, as well as the historical context of CMHCs in the United States, contextualize participants' experiences of change (Bransford, 2005; Furman, 2003; McLeer, 2006; Ware, Lachicotte, Kirschner, Cortes, & Good, 2000). However, a subtly different variation on this idea emerged clearly in the data generated in this study: participants have experienced multiple and profound losses in the context of their organizations.

The findings related to loss constitute an important and unexpected theme which is rarely addressed in previous literature. The presence of this theme in reference to all of

the organizational subsystems and relationships highlights its relevance for the topic. The data illustrate that participants' experiences of loss in the context of agencies are felt on an organizational level, on the level of the social networks in agencies, on an individual level, and in the clinical relationship. Menzies-Lyth (1988) suggests that emotional experiences in organizations are defended against by various social defense systems. Loss may be just the sort of emotional experience that gives rise to such defense systems. Perhaps administrators and clinicians are in a form of mutual projection related to the painful experiences of loss. In this scenario, neither organizational subsystem is able to achieve depressive-position functioning (Klein, 1959) because the organization as a whole is too emotionally unstable or volatile. As Eileen Smith (1997) suggests, "it is extremely difficult to maintain depressive-position functioning in a culture dominated by primitive anxieties about survival" (p. 118).

Orienting contemporary experiences in CMHCs around a theme of loss has the potential to at least provide a greater understanding, if not a change in circumstances, about the nature and causes of perceived organizational instability. The well-known stages of grief and loss – denial, anger, bargaining, depression, and acceptance (Kübler-Ross, 1969) – might provide a useful framework for conceptualizing and making meaning of these losses and their implications. This idea may enhance Ware et al.'s (2000) finding related to the transformations brought about in clinicians through the experience of managed care, exposing the painfulness inherent in this transformation.

One participant's narrative about organizational change and loss specifically engages the corporatization of CMHCs and the subsequent ascendancy of dominant cultural ideologies in the organizational system. She says:



We've gone from a community health center, to much more corporate... People spend their time behind doors, you know, working, working, working, working, [sic] and it's all about work, and unbelievable amount of work, um, and uh, people don't socialize as much. You know, and that is part of the climate out there, managed care, insurances, changes, all sorts of things, people are at their computer all of the time, all of the time. The other day we had [a consultant come in and she said,] "What people need to do is socialize more." And I mean, of course, but you know, not here! It's not healthy! The other day I was in the lunch room, and guess who's in the lunch room? All of the Latinos. And none of the Americans... It used to be much more collaborative... I think people are really unhappy, and the morale is on the floor... I call this my job of mutual exploitation... I used to take much more interest in the interns. You know, some of them, I don't know their names. You know, it hurts me in my heart, but I gotta do what I gotta do [sic], because there's been so much loss.

This rich quote clearly embodies many dimensions in a process of change and loss in organizations. The most unique aspect of the quote with regard to the data set, and the one that bears highlighting here, is the felt influence of ethnicity on the participant's negotiation of the agency narrative. To her, the agency narrative encompasses dominant cultural norms; she affiliates a feeling of "mutual exploitation" between her and her employer with these norms. The data here relate to Meares' et al. (2004) finding from a mixed methods study of muted voices in organizational settings. They write that "certain identities are privileged or muted in the organization [under study]; specifically, gender, ethnicity, and organizational position were clear factors" (p. 21). The extent to which social workers experience loss in their organizations may be connected to their degree of felt and perceived difference; i.e. the degree of social power, as determined by organizational members' social identities, may influence the felt impact of these losses (in addition to their organizational functioning more generally). This finding has important implications for organizational leadership and structure; specifically, it highlights the importance of an anti-oppressive lens in organizations.

### *Clinical Work as Personally Sustaining Independent of Agency Narratives*

Much of the data generated in the theme of participants' stories about themselves, their clients, and their work related to the relationships between participant and organization. However, the personal narratives which bring social workers into the field, and perhaps keep them in the field, are of central importance in gaining a full understanding of the motivations, needs, and goals of clinical social workers who work in organizations. Indeed, in the same sense in which this study examines the influence of the organizational context in clinical work, so too must one consider the very personal context from which the desire to do clinical work arises. Philosophically, this is consistent with a narrative approach: Carlson and Erickson (2001) argue that traditional approaches to supervision of new therapists "encourage a dissociation of the personal from the professional;" they propose an alternative approach "which seeks to bring forth the personal knowledge, skills, hopes, and so on which are central to the new therapist's desire to be a therapist" (p. 203-204).

Admittedly, the data gathered in this study do not even approximate a thorough fulfillment of Carlson and Erickson's guidelines for bringing forth social workers' personal narratives. However, the data on personal narratives can still be usefully discussed. Highlighting the importance of these stories in sustaining clinical practice, participants frequently shared personal narratives that were in sharp contrast to the way they described organizational narratives. For example, in the context of organizations where there are fewer opportunities for collaborative practice, participants uniformly spoke about the joy and fulfillment inherent in collaborating with clients. As well, in the context of organizations in which marginalized populations face increasing difficulties

obtaining consistent services, some participants spoke about the centrality of serving these marginalized populations. Perhaps most importantly, in a mental health metanarrative that increasingly deemphasizes relational work and emphasizes manualized treatments, the very specific relationship between participants and their clients was sometimes communicated as the one aspect of the work which kept participants in their jobs. Participants, in other words, reported finding a source of personal resilience and sustenance in clinical relationships despite the constantly impinging qualities of the environment in which these relationships occurred. This finding seems to support Yoo's (2002) finding that altruistic engagement with social work can lessen the impact of certain organizational characteristics on client outcomes.

*Participants' Negotiations of Agency and Personal Narratives,  
and the Influence on Clinical Work*

*The Felt Dissonance between Administrative Narratives and Clinical Narratives*

Participants in this study spoke implicitly or explicitly about their experiences with authorization and de-authorization in their organizations. Frequently, de-authorization was experienced in relation to administrative subsystems, which privileged notions of mental health care that were antithetical to, or at least in conflict with, participants' values. This very much echoes Bransford's (2005) finding that "social workers...often feel constrained by the regulations of managed care" (p. 409).

Bransford (2005, 2006) specifies the processes through which social workers may come to be or feel constrained and de-authorized, and the processes through which they come to feel empowered and authorized. Generally, the findings of this study support her descriptions of these two processes. Participants' statements that administrators ("they")

“did not get it” express the ways in which participants felt that organizational narratives were not collaboratively determined; i.e. there was a perception that the voices of the participants went literally unheard on administrative levels. This lends credence to Bransford’s (2005) assertion that authorization takes place when “across hierarchical levels of organizations...both superiors and subordinates recognize and acknowledge their mutual dependence on one another” (p. 413). It also may illustrate Hodgkinson’s (2003) assertion that organizational members develop simplified representations of reality, which then influence their behavior in, and interpretations of, events and relationships in the organizational system.

In contrast to findings related to administrative narratives, there was a small but significant theme in which participants seemed to feel more authorized by individuals in the role of clinical director. In relationships with clinical directors, some participant felt a unique recognition of the challenges inherent in their work. Furthermore, they perceived clinical directors as individuals with the capacity to negotiate the contradictions and dissonances between organizational and clinical narratives, and advocate for clinicians at all levels of organizational functioning. This finding resonates with literature related to leadership in organizations; Hardina (2005) names effective leadership as one of the primary characteristics of empowerment-oriented organizations. This finding has significant implications for practice, particularly insofar as clinical directors might be supported as specific actors in a position to negotiate dissonant narratives and encourage collaboration within the organizational system.

*The Felt Impact of Agency Structures, Policies, and Procedures on Clients*

The myriad ways in which participants felt the impact of their organizations' structures, policies, and procedures on their clients supports the fundamental theoretical and practice stance articulated by some authors (Gitterman & Miller, 1989; McLeod, 1998; Obholzer, 1994; Walton, 1997) that clinical decisions are at least partially, if not completely, influenced by organizational context. However, the data suggests a limit to this influence: the clinical session, or the "therapy hour", remains for many protected from these impacts.

The felt constraints on availability, timing, and frequency of services available points to the impact of decreasing inputs into the organizational system, which causes problems as organizational members attempt to complete their tasks. Specifically, the technologies available – interpreters, psychotherapy sessions – were often insufficient to meet the clinical needs of the client as determined by the participants. In this situation, participants more or less formally negotiated between the availability of services provided by the agency and the level of services needed by the client, and frequently filled this gap by extending their own availability or breaking with agency policy:

I had a kid...um, raped by her uncle, spent a week at [a program], cutting, discharged, saw her, the next available appointment with an interpreter was 3.5 weeks later – that doesn't work – you know, um, and when you tell them, that doesn't work – um, it's oh, well we're going to do it this week, and I'll try to find this – and I'll just schedule her, and I'll find an interpreter, and you can decide at that time which visit is more important if the interpreter's with someone.

Newdom and Sachs' (1999) understandings of the contradictions in clinical work are instructive here. They write that social work is, at its root, a value-based profession, in which social workers must learn to act within their personal and professional

frameworks of ethical practice, while understanding the contradictions that this type of practice may uncover between the individual worker and organizations, policies, or broader systems. It was clear from the data in this study that this negotiation of narratives can cause conflicting feelings of allegiance as well:

I might have somebody who I see once a week, and who's pretty high-functioning, but, um, still has a lot of issues, and I feel like, oh maybe I shouldn't be seeing them, once a week...for the [sake of] the agency. But I feel like, I like to see him once a week! He's like one of the most interesting functioning people I have, and if I'm only seeing people who are like complete disasters I'm going to be a mess. So that's where I feel like, huh, maybe this isn't right, somehow.

Clearly an awareness of these contradictions and their implications for clinical decision-making has significant implications for clinical work. Speaking from a social justice perspective which emphasizes dialogical practice, Sachs and Newdom (1999) write that maintaining a

Subject-To-Subject relationship...is particularly difficult in the increasingly hierarchical agency settings in which workers are employed in a system dominated by managed care. A worker's role is frequently to "fix" the clients or to relieve their distress sufficiently that they will no longer seek service. A person does not "fix" an equal, so the commitment to a Subject-to-Subject relationship requires great attention (much reflection) lest the work fall into an "expert" position to meet the needs of the employer. (p. 26)

Although the data suggest some of the difficulties that participants faced as they negotiate competing narratives, the fact that participants were able to articulate these contradictions in their clinical work is a promising finding in and of itself. Gitterman and Miller (1989) argue that the effective social worker in an organization adopts a stance of "sophisticated mediation between the clients' needs, workers function and organizational requirements" (p. 159).

The felt impact of paperwork and intake processes on clients may be interpreted from a number of perspectives. Menzies-Lyth (1960, 1988) might posit that the increasing amounts of paperwork demanded by insurance companies and organizations are an unconscious defense against the anxiety evoked by clinical work. One participant clearly articulates this when she says:

I think [forms and procedures related to risk management] were created to put a distance between the – they're not separate from the clinical process, but they sort of, they're protective for us...so I feel like we've created a whole set of paperwork to sort of provide legal protection but also I think to give the illusion of protecting ourselves from feeling liable. Responsible.

Other participants found that paperwork not only served the function of distancing clinicians from their clinical work, but also served the function of deterring clients from successfully engaging in treatment. Thick and complex intake packets were given to clients without the necessary supports in place to manage the feelings evoked by these intake processes. Hasenfeld (1985) cogently argues that in the current resource-deprived environment in which CMHCs operate, CMHCs may need to find ways to “serve only those clients who enable the organization to procure resources” (p. 657). He develops the idea of the “desirable” client, who can help organizations retain staff (the desirable client's success rates are higher, and thus boost staff morale), counter the tarnishing effects on organizations who work only with very vulnerable individuals, and reduce the volatility of the client population (1985, p. 657-658). This striking analysis presents the possibility that complex paperwork processes (which are more likely to be successfully completed by individuals with higher levels of internal and external functioning) are an unconscious organizational mechanism which weeds out “undesirable” clients. That participants in this study clearly saw intake and paperwork processes as forms of latent

communication implies that paperwork and intake processes ought to be thoughtfully and critically analyzed before being implemented.

Another way of understanding resistance to changes in policies, procedures, and structures like paperwork and intake processes comes from Hemmelgarn, Glisson, & James (2006). They suggest that organizational culture and climate mediate the adoption of new technologies, and specifically that “strong” cultures make the implementation of new technologies more difficult. Given that paperwork and intake processes are forms of technology, organizational administrators might also do well to consider the role of culture and climate as they go about making changes in these technologies.

#### *Clients’ Narratives of Loss in the Agency in Clinical Work*

The simultaneity of losses which participants and their clients experienced is self-evident, and has important implications. This parallel reinforces the broad concept of open systems theory (Katz & Kahn, 1978), in which change in one part of an organization will ripple through to other parts of the organization. In other words, it is perhaps inevitable that clients in CMHCs have not only experienced loss directly (in the form of reduced services, staff leaving, etc.) but also indirectly, insofar as their clinicians are experiencing loss. One participant’s quote can be used to explore this idea:

[The agency] comes in when, okay, my client’s [prescriber] has been replaced three times, uh, and dealing with that aftermath, or you know, when I’ve had so many transfers, I’ve put a brake on transfers, I’m up to here, so I’m putting the brakes on that, I don’t want to hear that your therapist left, I want some fresh ones. Um, you know that element of this loss is brought into the therapy as well, so you know, keep it out, but it does seep in...

This quote might be framed as an institutional countertransference issue: i.e. the desire to “keep [loss] out” of the therapy derives from the participant’s personal difficulty coping



with the losses in her agency. As Eisenberg (1997) suggests, the provocative nature of organizational functioning influences countertransference reactions to an extent not often acknowledged; in the example of clients' experiences of loss, one might wonder about the efficacy with which social workers in CMHCs can help their clients cope with organizational losses if they themselves have suffered such deleterious effects of the same losses.

Clients' losses in the organizational system, therefore, may become a prime site for parallel process enactments. The clinician's sense of powerlessness and pain about loss in the organizational system may be enacted in the therapy room with clients who have experienced similar losses. As has been suggested above, an orientation around loss as a theme in the life of CMHCs in this particular historical moment might help make these parallels explicit and offer the possibility of a more cohesive narrative.

#### *The Presence of the Agency's Narratives in the Therapy Room*

##### *i) The therapy room as the "insulated organizational subsystem"*

The data showed a wide range of responses on the extent to which the therapy room is an "insulated organizational subsystem." This represents a preliminary finding which validates McLeod and Machin's (1998) claim that organizational context is a neglected dimension of training and theory. The range of responses cannot and should not be fully interpreted using one theory or concept; instead, it strongly suggests a need for further research and theory development.

If, however, one considers the therapy room to be an insulated organizational subsystem, this represents a departure from Crandall and Allen's (1982) assertion that change in one part of an organizational system will ripple through to other parts of the

system. Indeed, some participants explicitly describe a less permeable boundary between their organization and their clinical work than between other organizational subsystems:

I can't say [the agency has] never affected me in a negative way, but I really feel I have a good sense of boundaries...

The necessity of a boundary between the organization and the clinical work, in and of itself, communicates implicitly the extent to which clinical and personal narratives are perceived as separate from organizational narratives. Furthermore, the notion of a boundary between the organization and the clinician challenges the idea that all organizational subsystems cohere more or less efficiently in order to complete a given task. Another participant spoke about how the difficulty of maintaining personal narratives was connected to the strength of the agency's culture and broad organizational narratives:

So there's this wonderful way that there's a knowledge of all the folks we see that serves the clients when they're having crisis, or to know their history and their predictable patterns, but I think it also contributes to, um, not doing a lot of, not considering a lot of different things in treatment or not being creative in treatment, um, in the way that I had been in the past. I wonder about a shift from my work, the creative – the way I proceeded in my last job, and some of the staleness I feel here.

This quote suggests that the strength of organizational culture may influence the permeability of the boundary of therapy room.

The idea of the insulated subsystem raises important questions for social work training and education. Educators, supervisors, and students might ask themselves why, when, and how social workers must create a boundary between clinical work and their organizational context, and with what consequences. One might ask if there are harmful consequences to social workers' separation of the therapy room from the organization.

Indeed, an outlying quote in the data set illustrates what might be seen now (sadly) as a nostalgic perspective on the role of the agency in the therapy room:

I mean I guess ideally, the presence of the institution behind me lets me do the work.

*ii) How Participants' Anxiety Regarding Organizational Functioning is*

*Contained in the Therapy Room*

The boundary between the therapy room and broader organizational functioning was differentially permeable for participants. Some commonalities emerged with regard to the techniques, conscious or unconscious, and personal characteristics which mediated the containment of anxiety in the therapy room, including mild dissociative techniques, experience level, and the strength of one's own personal narrative. The use of mild dissociative techniques as a way of managing the effects of working in organizations, while not explored in depth by this study, is an important one that future research might address. Specifically, it is important to ask about the long-term effects to social workers' mental health of using these psychological defenses. Furthermore, it could be argued that the social worker's dissociation from the environment lends to a parallel process in which the client is dissociated from her environment. This may hinder the development of the person-in-context perspective that the social work profession emphasizes. However, one may also interpret dissociation as another mechanism for establishing the boundaries described above between organizational and clinical work.

Data also suggest that experience level may be a mediating factor in the extent to which participants are able to act within their own personal narratives during the therapy hour. This represents an important finding that might be explored further through

research. This finding subtly echoes Bransford's (2006) and Meares et al.'s (2004) research findings that connect a sense of ascribed power to personal characteristics like age, gender, race, and ethnicity. This has particular implications for social work trainees, who have both limited power and are likely in the initial stages of forming personal narratives as social workers. Indeed, one participant specifically addresses this issue when she says:

I think for people that are straight out of school, you know, who do their work and run home, and don't have a way to process how hard it is, I think that [it makes difficult] their own sense of kind of control and growth...

This quote, and the concern expressed in it, highlights the potential value of a narrative approach to supervision and training, as described by Carlson & Erickson (2001). Strengthening this notion is the fact that participants frequently identified their own personal narratives as the framework that they relied on to sustain their clinical practice within the complex environment of the CMHC. There seemed to be an internal resilience – in participants' words, “a bright spot”, “a voice”, “a way to do right by your clients” – that superseded the difficulties of agency work. Finding ways to nurture, support, and encourage this internal resilience has potentially far-reaching effects *if* the paradigm for clinical work in CMHCs is shifting toward the development of an ability to function independently of the organization. However, McLeod (1994) suggests that this paradigm of clinical work has fundamental flaws: “organisational [sic] factors are indeed implicated in quality of service, and...the gap in research knowledge in this area can be attributed to the prevailing individualist philosophy which continues to dominate counselling theory” (p. 5).

*iii) Parallel Processes, or “What Clinicians get, Clients get”*

The conscious and unconscious manifestations of parallel processes articulated by participants in this study seem to confirm Crandall and Allen (1982) and McLeod’s (2003) assertion that parallel process analysis can be a useful entry point into understanding the negotiation between personal and organizational narratives. Indeed, the data related to parallel processes beautifully illustrate the multi-layered and symbolic communications that may occur in organizations. An agency which is the “last-stop shop” for clients later becomes the “last-stop shop” for clinicians, revealing the intertwined nature of clients’ and clinicians’ experiences in agencies. While this analysis may seem like a novelty with little concrete relevance, such narrative and linguistic cues may represent entry points into the organizational culture and dynamics—a moment in which to apply the same clinical acumen to both clinical and organizational functioning (Obholzer, 1987).

There was a quality of ambivalence in some participants’ narratives on the issue of parallel process that suggests a need for further research, and perhaps research with more complex methodology. However, many participants made philosophical and feeling links between their own experiences and their clients’ experiences explicitly clear:

I completely believe there’s a trickle-down – I believe clients feel as valued as you feel as person and as an employee and as a coworker of a family....

I believe that if you’re trying to help people empower themselves, then we [clinicians] should be able to be doing that for ourselves.

Clearly, this has enormous implications for services in CMHCs. Although not generalizable, the results of this study seem to suggest that to some extent clinicians’ ability to provide quality clinical care to their clients is intimately connected to the

quality of care they themselves are receiving from their organizations. This is not to imply a system in which the more powerful subsystems of an organization are in some way responsible for the well-being of the less powerful; indeed, this would be rather paternalistic. Instead, the researcher suggests that clinicians may more or less consciously seek the same kind of Subject-to-Subject relationship (Sachs & Newdom, 1999) from their organizations that clients seek from them: empathic understanding, a strong “alliance”, and effective and collaborative support in meeting goals. Despite the changing characteristics and broadly declining resources available to CMHCs, practices which support collaborative work and strong relationships ought to be more clearly identified and enacted in CMHCs (see Bransford, 2005 for examples of these types of practices).

#### *Summary*

This Chapter has discussed the data from psychodynamic, organizational systems, and narrative theory perspectives. Salient points include the utility of a narrative lens for making meaning from experiences in organizations. Furthermore, the data reveal the pervasive and historically-rooted reality of decreasing input into CMHCs, with resulting conflicts in task and technology definition and implementation. The feelings evoked by these changes are various and strong, and indicate a process of splitting which occurs between organizational subsystems. Much of the emotion experienced by participants specifically relates to loss; it is argued that orienting experiences in CMHCs around loss at this particular historical moment may begin to consciously link the divide between clinical and administrative subsystems to the losses experienced in the organization on all levels. Discomforting changes in agency policies, structures, and procedures are discussed in light of decreasing systemic inputs and changes in technology, but also in

terms of the potential for such structures to unconsciously defend against anxiety inherent in the work. It is argued that as resources decrease, while the necessity for services remains stable or increases, the need for such social defenses increases. Finally, the clinical encounter is discussed in light of all these dynamics, with attention to the varying viewpoints on the extent to which clinical work is influenced by or insulated from agency dynamics.

### *Limitations and Strengths of the Study*

This study has several limitations in design, methodology, and implications. First of all, the researcher's initial framing of the research questions included terms (such as "absorb" and "implicit" and "explicit") which presents problems related to construct validity. These terms are difficult to operationalize, and may have taken on different meanings for each participant as they were introduced in the interviews.

Another methodology limitation relates to the difficulty of studying organizational functioning from the perspective of a single organizational subsystem (i.e. clinical staff members who do not have management or administrative functions). While this certainly does not invalidate the results – in fact, narrative theory specifically emphasizes the telling of subjective individual experiences as a way of exploring phenomenon – it limits the ability to draw conclusions regarding certain organizational processes (see Bakker, Blokland, May, Pauw, & van Breda, 1999, for a particularly artful example of using narrative analysis for understanding individual and collective experiences in organizations.) Indeed, organizational researchers frequently use mixed methods with representatives of all organizational subsystems as informants to address this issue. This was not feasible for this study.

Finally, and most importantly, the sample size and diversity are limitations. This study was exploratory; the results are not generalizable to a broad population of social workers in CMHCs. As well, there was a preponderance of older, more experienced participants which may have biased the results. Most importantly, all of the participants in this study were homogenous with regard to racial identity (Caucasian). This may be seen as a limitation in the study particularly because the participants interviewed were from the dominant racial culture where their “voices” may be less subject to de-authorizing and marginalizing forces which impact social workers interpersonally, intrapersonally, and organizationally. Themes related to gender and sexual orientation emerged in individual narratives as salient for the research topic. This further highlights the importance of considering racial identity, and “perceived difference,” as a factor in adaptation to organizational life. This constitutes a further area of study, which authors have already explored in some organizational settings (Meares, Oetzel, Torres, Derkacs, & Ginossar, 2004).

This study also had strengths related to design and methodology. While the influence of organizational context on clinical work has been explored in theory and in research before, it has been infrequently researched in the context of outpatient CMHCs. Indeed, almost all other studies have been in hospital and inpatient settings. CMHCs are a unique type of organization in the field of social work today, both in terms of the amount of services they provide and also in terms of their unique status as the outcome of a particular social justice and political movement (i.e. deinstitutionalization). Given changes in this political climate, CMHCs could again be caught up in the vortex of



profound changes. This study captures the voices and narratives of social workers who are at the compelling interface of systemic and organizational change and clinical work.

*Implications for Theory, Future Research, Organizations, and Clinical Practice*

Organizational systems theory and psychodynamic theories offer two important tools for interpreting the research questions, but the theory base for understanding the influence of organizational context on clinical practice still needs to be expanded. This study highlights the need for a thorough conceptual frame, especially as social workers struggle to integrate the increasingly disparate values embodied on the one hand by managed care and on the other hand by their professional code of ethics.

Future research on this topic might examine the implications from historical, clinical, and/or organizational perspectives. Certainly the changing nature of mental health services provided by CMHCs since their inception to the present day is a historically relevant topic whose understanding may assist policymakers, organizational leaders, and clinical social workers to guide community-based mental health practice through ongoing significant systemic changes. Clinical research on this topic might attempt to more clearly describe the relationship between organizational context and clinical practice by using therapist-client dyads as participants or parallel analyses of transcripts from team meetings/individual sessions to illuminate any ways in which organizational processes are unconsciously brought into clinical work via the therapist. Organizational research might investigate more clearly the role of the clinical director in organizational processes. Finally, the perceived split between clinical and administrative narratives could be researched along with interventions that might be effective in addressing this split and its consequences.

Individuals at all levels of organizations may benefit from the findings of this study. In particular, clinical directors and administrators may find it useful to explore the idea of loss with their clinical staff as a way of understanding the changes experienced in CMHCs over the last decades. Furthermore, this study suggests the potential of the role of the clinical director as a mediator of some of the tensions between organizational subsystems. This mediatory role is critical if organizations are to find more effective ways of coping with competing narratives. Bransford (2005) suggests the use of microcosm groups as a way of re-authorizing all members of organizations; as this study has shown, participants felt most authorized in their roles in the context of group membership. The utility of microcosm groups, which draw members from all levels of the organizational system together to discuss contradictions and conflicts, should be examined as a method of realigning conflicting organizational narratives while inspiring empathy for the competing demands of each organizational subsystem.

The data in this study which suggest that participants experienced implicit organizational narratives more harmoniously than explicit organizational narratives has important implications, particularly for organizational leadership and administrators. The correlation between explicit narratives and the administrative subsystems of organizations, and implicit narratives and the clinical subsystems of organizations, may be understood in two ways. First, this correlation may relate to the particular subsystem this study's design relies upon—that is, the nuances of implicit and explicit communication in a particular subsystem may be more easily felt from a position inside this subsystem. Alternatively, it may be that administrative subsystems in these CMHCs

rely more heavily on explicit forms of communication. Either way, this finding does seem to illustrate Martin's (1982) statement that in organizations

...a story should have a stronger impact on attitudes, such as commitment, than explicit forms of communication, such as abstract statements of statistics....When an organization wants to communicate information about its culture, its beliefs about process, its philosophy of management...then indirect and implicit forms of communication, such as a concrete organizational story, are more likely to be memorable and believable, and are less likely to be dismissed as organizational propaganda. (p. 269, p. 302, italics in original)

Using forms of implicit communication like stories could potentially lessen the perceived distance and dissonance between clinical and administrative organizational narratives.

Indeed, an important challenge appears to be finding ways to humanize various components of organizations; implicit communications like stories, metaphors, and relational interventions may be particularly useful in fostering this process.

For social workers, this study highlights the potential influence of organizational context on the clinical relationship, and suggests that social workers may become emotionally exhausted or overwhelmed by their organizational functioning. Locating spaces in which one feels authorized to act within one's own personal narrative becomes a key component of sustaining clinical practice that is congruent with one's values. This study also has implications for clinical social workers and other professionals who are experiencing profound splits between clinical and administrative subsystems, which Eileen Smith (1997) interprets as an organizational manifestation of the paranoid-schizoid position. These workers might benefit, Smith suggests, from Hoggett's definition of the depressive position. She quotes:

He [Hoggett] describes it as 'a commitment to the object in spite of its damaged state achieved by keeping inside oneself and inside the group the image of a repaired object, and therefore the possibility of a better future.' He argues that

‘this means harnessing people’s anger to the love that brought them to their work in the first instance’ (1997, p. 129).

In other words, the ability to see, hold, and explore contradictions, which social workers are trained to possess in their clinical work, can potentially be usefully applied to their organizational experiences as well. Hoggett (as quoted in Smith, 1997) offers a more nuanced view of organizational life, a view which Gitterman (1989), Hasenfeld (1992), Obholzer (1987), and McLeod and Machin (1998), along with other authors, suggest is long overdue. But perhaps more importantly, Hoggett seems to suggest that harnessing one’s anger at the failings and inadequacies inherent in organizations and broader systems with one’s love of working within and for these organizations and systems, and the missions they struggle to achieve, has the potential to reinvigorate both organizational and personal commitment.

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## Appendix A

### Interview Guide

Research Topic: Negotiating agency and personal narrative in clinical social work practice: a qualitative study investigating how clinicians' experiences of multiple narratives influence their clinical work

Researcher: Emily R. Fischer A08, Smith College School for Social Work

*Script for defining key terms at the beginning of the interview:* As you know, I'm focusing on *narrative* in this research study, and I wanted to take a moment to discuss what I mean by that term and answer any questions you may have about the way I am using the term. For our purposes, *narrative* refers to the stories of your professional life and the stories, *as you see them*, of your agency – its history, mission, goals, practices, so on and so forth. I'm borrowing here from narrative theory, which you may be familiar with, and specifically from the idea that through exploring, identifying, and naming stories, we can begin to understand the impact that they have on people's lives. So although we won't *only* be talking about narrative, it's important for you to know that it's a concept that guides my thinking and will guide the way I analyze the data. One more clarification about narrative is the idea that there can be *explicit* and *implicit* narratives – we'll talk more about that as we get into the interview. Do you have any questions or comments about this before we begin?

### **Research Questions/Probes**

#### **About your agency**

How would you describe, in broad terms, the explicit mission of your agency?

Does what you just said feel like an accurate description of what actually goes on in your agency on a day-to-day basis?

If yes, what do you think contributes to this consistency?

If no, what do you think contributes to this inconsistency?

How would you describe, in broad terms, your feeling of the culture and/or climate of this agency?

It may be helpful to think about some specific realms here. For example, do you remember what the emotional tone of the agency felt like to you when you started here? What does it feel like now?

How would you describe the functioning of professional groups in your agency, such as staff meetings and case conferences? What is the explicit message about what function they serve? Is this the function that you find them fulfilling? If not, what do you make of this difference?

How would you describe the feeling you have when you walk into a staff common area here? What is your sense of where this feeling comes from?

If you were to “tell the story” of this agency from *your* perspective, what would it be?

From the perspective of one of your clients?

From the perspective of your boss/supervisor?

### **About you as a clinical social worker**

How would you describe, in broad terms, your mission/purpose as a clinical social worker?

Where do you think this sense of yourself came from, generally (i.e., school, training, mentors, peers, family)?

If you imagine the story that one of your clients might tell about you as a social worker, what do you imagine? For example, what is the “service” or “relationship” you imagine them describing? Along these same lines, what story do you imagine the agency might tell about you as a clinical social worker? Are there similarities or differences between the story your clients might have and the story the agency might have? What story would you tell about yourself?

What stories might you tell about your clients, generally? For example, what is your general story, if it’s possible to describe, of why your clients come to see you? What relationship does this story of yours have to theoretical narratives (i.e. psychodynamic, cognitive, etc) and/or personal narratives? And finally, do you

think your agency has the same story about why people come to see you specifically?

**About the interaction of these two lines of thought, or stories**

When you think about the way that *you* think about certain issues or struggles that your clients have, do you see your ways of thinking about these issues and struggles as similar or different from the way the agency as a whole thinks about these issues and struggles? Say more.

How would you describe the process of attachment between you and your agency? What has contributed to the strength, weakness, complexity, of this attachment?

If you think about the narratives you have just described – your own and your agency’s – what similarities and differences do you see?

What is your experience of the ways in which these similarities and differences enter into your clinical work, if they do?

For example, can you remember a time when an explicit or implicit agency narrative conflicted with your own personal/professional narrative when making a clinical decision? What did you think and feel? How did you resolve it?

How would you describe the impact that the agency has on your clinical decisions? Do you believe, as some authors do, that all clinical decisions are the result of organizational imperatives? Why or why not?

**Additional probes/lines of thought if time permits**

What is your experience of how this agency manages anxiety – i.e. individual, social, political anxiety? What are some of the grand cultural metanarratives at work in the agency narrative? In your own narrative as a clinician? How do you find yourself coping with anxiety generated by your work? Do you see similarities and/or differences between your approach and your agency’s approach?

How do things like the architecture of the building, the decorations, and the layout of offices effect your work with clients? What is your sense of the relationship between these aesthetic decisions and your agency’s narrative?

## Appendix B

### Recruitment Letter

Dear Social Work Colleagues, Fellow Students of Smith College School for Social Work, and Alumni of Smith College School for Social Work:

My name is Emily Fischer, and I am a second year student in the Masters of Social Work program at the Smith College School for Social Work in Northampton, MA. As many of you know, second year students conduct research for a thesis as part of the degree requirements for an MSW. I am contacting you with the hope that you, or a colleague of yours, may be interested in participating in my qualitative research study. My research focuses on social workers' experiences with agency narrative and individual narrative, and explores the ways that the relationship between these narratives impacts clinical work. My intention is to interview social workers in community mental health centers in order to explore this topic. The goal of the research is to explore the ways that clinicians in these settings *experience* 1) their agency's explicit and implicit narrative(s) and 2) their own professional narratives. Furthermore, I hope to explore 3) the ways in which these narratives differ, are similar, and/or influence one another and the clinician's work with clients.

**You can help me by forwarding this email to your friends, colleagues, and peers who are clinical social workers doing outpatient work in community mental health settings and who you think might be interested in participating in a one-time interview on the topic described above. Participants need to have graduated from an MSW program at least two years ago, be employed at least one-quarter time, or .25FTE, by a community mental health organization for at least one year, and have at least 50% of their job be providing outpatient psychotherapy services for individuals, couples, or families. I also need participants to work in the greater Boston metro area and speak English.**

I am drawing from psychodynamic and organizational theory for this research. Many people from various psychotherapy disciplines have long theorized a relationship between the agency and the clinical services it provides, and yet very little research bears this out, particularly in outpatient settings. Participants would be helping to produce qualitative research in this area, with the potential to shed light on the complex and mutually influential dynamics of agency, clinician, and client.

I hope that you and/or your colleagues will be interested in participating. Please feel free to forward this email liberally.

If you have questions, please contact me at [efischer@email.smith.edu](mailto:efischer@email.smith.edu) or by phone at XXX-XXX-XXXX.

Thank you.

Emily Fischer

## Appendix C

### Informed Consent Form

Dear Potential Participant:

My name is Emily R. Fischer and I am conducting this research study through Smith College in Northampton, Massachusetts, where I am a student in the Master of Social Work (MSW) Program.

My research focuses on social workers' experiences with agency narrative and individual narrative, and explores the ways that the relationship between these narratives impacts clinical work. By narrative, I am referring to the "stories" of your professional life, and the stories, *as you see* them, or your agency. My intention is to interview social workers who provide outpatient psychotherapy in community mental health centers in order to explore this topic. I will use my findings to complete a thesis and possibly for presentations and/or publications.

If you participate in this research project, you will be asked to fill out a brief demographic questionnaire and engage in an interview with me. The interview will last approximately 1 hour. In order to participate, you must have graduated from an accredited MSW program at least two years prior to the date you contacted me, and be employed by a community mental health center in the greater Boston metro area at least one-quarter time (.25 FTE). You must have worked there for at least one year. In addition, your job responsibilities at your agency must consist of at least 50% outpatient psychotherapy services with individuals, couples, or families. In addition, you must not hold an administrative or management position in your agency (this does not include individuals who act as supervisors to students or unlicensed social workers).

If you meet these criteria and choose to participate, you and I will arrange an interview at a location which is comfortable for you between January and May of 2008. I will take field notes, and the interview will be audiotaped and transcribed by me.

If you participate in this research study, you may face some emotional and/or professional risks as a result of your participation. Emotional risks include the possibility that the conversation between you and I will stimulate unpleasant feelings toward your agency, coworkers, or even your professional self. Every attempt will be made to minimize professional risks by scrupulously disguising your interview data and by protecting confidentiality in the final research report. Your agencies will be disguised, as well as your roles in this agency. Please understand that by signing this form, you indicate that you are comfortable engaging in the research despite these possible risks.

There will also be benefits to your participation, including a chance to explore, describe, and identify strong narratives in your agency and your professional self, and to consider the ways that these narratives interact with one another and influence your work with clients. You will also have the opportunity to contribute to qualitative research

whose purpose is to explore/bear out long-standing and influential conceptual and theoretical ideas about the mutually influential spheres of agency context and professional identity.

Unfortunately, there will be no monetary or gift compensation for participation.

If you choose to participate, your confidentiality will be protected by the following measures (all in compliance with Federal Guidelines): 1) No names will be attached to the data or transcripts; 2) The tapes of the interviews will be kept in a locked strong-box, and will be taken out when they're being transcribed by me. They will be kept locked up for a period of 3 years and then destroyed; 3) My research advisor will not have access to any identifying information on the interview data; 4) All Consent Forms will be kept separate from the interview data and linked through a randomly chosen code number; 5) When the information is summarized in the research study, the stories will be disguised and your real name will never be used.

Always remember, participation in this project is voluntary. This means that you have the right to decline to answer any question, end the interview at any time, and withdraw from the study at any point up until May 15, 2007. If you choose to withdraw from the study prior to this date, all materials pertaining to you will be destroyed immediately.

Please feel free to ask me any questions. You may also contact the Chair of the Human Subjects Review Committee at Smith College School for Social Work at (413)585-7974 if you have any questions or concerns.

Thank you for participating in this study.

Emily R. Fischer  
XXX-XXX-XXXX  
efischer@email.smith.edu

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

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Researcher's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE RETURN ONE COPY OF THIS FORM TO ME IN THE ENCLOSED SELF-ADDRESSED, STAMPED ENVELOPE, AND KEEP THE OTHER COPY OF THIS FORM FOR YOUR RECORDS.**





## Appendix E

### Human Subjects Review Committee Approval Letter

February 4, 2008

Emily R. Fischer

Dear Emily,

Thanks for the copy of your second revision. It is well you omitted the “member checking”. You don’t want to complicate the process any more than is necessary. All is now in order and we are happy to give final approval to your study.

*Please note the following requirements:*

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

**Maintaining Data:** You must retain signed consent documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

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

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

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

Good luck with your project and with the recruitment.

Sincerely,

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

CC: Bruce Thompson, Research Advisor