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CHAPTER 4

Letting Some Air into the Room

OPENING AGENCY SPACE FOR CONSIDERATIONS OF CULTURE AND POWER

▸ LISA R. BERNDT

> How do workers, men and women and people of different cultures in an agency or institution, protect against . . . cultural bias in their work on a day-to-day basis? Furthermore, how do they do this in societies where racist assumptions are an integral part of their upbringing and way of life, as they are in most modern industrial states?
>
> —Tamasese & Waldegrave (1993)

THIS IS A STORY OF ONE AGENCY'S movement to respond to the questions posed above. It is a story of what happened at a time in our history when the status quo became unbearable for enough of us that we were willing to work toward change. It is a story of a process of awakening to the privilege and power that we wield as individuals, as a hospital-based department, and as part of bigger systems; and it is part of an ongoing story of our efforts to use that privilege and power responsibly. It is a story of our efforts to heighten our awareness of the actual effects of our actions and attitudes on the families and communities we serve, and on each other, and our coming to understand how these are not separate constituencies. It is meant to be a part of a wider conversation in the fields of health, mental health, and education about accountability to our mission and to the families who entrust their stories to us.

Because it is an account of attempts to address oppressions, especially racism, between its lines are slow simmers and boiling points, microaggressions (Sue et al., 2007) and gaping schisms, alarm and hope, trust and

disappointment, determination and discouragement, stuck places and turning points. Laurin Mayeno (2010) reminds us that breakdowns can be transformed into breakthroughs, and this reminder has played a crucial part in our journey. There is ample frustration in the story, and there are moments of joy. As we have worked to move beyond multiculturalism to antiracist practice (Greene & Suskind, 2006), we find that issues of culture and power that used to be marginalized in our daily work are now at the center of our conversations, our thinking, and our practice. For some of us, this has meant the difference between leaving and staying. For some, it has been experienced as letting "more air into the room, or space to breathe." Some find it more comfortable, others less so. We are trying to let it be a fertile discomfort.

LEANING INTO THE COMPLEXITIES OF CULTURE AND POWER

At this point in our journey, we see culture as multidimensional and central to meaning making. Using Pamela Hays's (2001) ADDRESSING format, we consider such aspects as age and generation, developmental and acquired disabilities, religion, ethnicity, socioeconomic status, sexual and affectional orientation, indigenous heritage, national origin, and gender (table 4.1). We also

TABLE 4.1 Hays's Multicultural Assessment Model

A	Age-related factors. Actual age and age cohort (generation).
D **D**	Disability/Development. Acquired, visible and invisible developmental disabilities.
R	Religion and spirituality.
E	Ethnic identity. Race, culture (includes people of color as well as Caucasian, white ethnic).
S	Socioeconomic status. Current and former, especially in childhood.
S	Sexual and affectional orientation. Gay, lesbian, bisexual, heterosexual, asexual, kinky, and monogamous or polgygamous.
I	Indigenous heritage. First nation's peoples.
N	National identity. Immigrants, refugees, temporary residents, and their children.
G	Gender. Biological sex, transgender, gender roles, and stereotypes.

Source: P. Hays (2001, pp. 3–16)

recognize the effects of the historical legacies of genocide, slavery, and imperialism on our national consciousness and understand that membership in one group or another can bring protection and privilege, or oppression and danger (Batts, 2002). We try to stay accountable around the power differentials set in place by this history (Tamasese & Waldegrave, 1993). We also try to recognize that given the centuries of oppression and the patterns of racism that have tried to silence acknowledgment of its existence, conscious and continual effort is required to put the values of accountability and respect into practice. What becomes possible when we risk discomfort? How does it improve the quality of treatment when workers are able to bring themselves fully to their relationships with families and coworkers? Here are scenes from recent agency-wide meetings.

A therapist shares her work at a recent all-staff meeting. "I welcome your feedback," she says, "because I'm very close to this." She proceeds to describe the obstacles that an African American teen has faced: poverty, foster care, painful and complicated reunification with mother, intergenerational trauma, and racial discrimination. The therapist describes the teen's resilience, the crisis points where the young woman was able to ask for help, and the ways the therapist has made herself available outside appointed hours. Rage, despair, and grief infuse the young woman's life every day, along with humor and determination. She was on the verge of being expelled from school at least three times, but her therapist advocated with the school and held fast to the student's dreams, even when the young woman herself could not. "I will not let another one of our children become a statistic," the therapist tells us. Listening to her account of this work, many of us are on the edge of our seats. The odds against this young woman's survival and self-esteem have been great. The dropout rate in Oakland, California, is high. The link between foster care and homelessness is high. The risk of sexual exploitation is high. Economic conditions, past trauma, depression, and social conditioning can rob young people of color of any vision for the future (Turner, Finkelhor, & Ormrod, 2006). Yet this young woman has made it to community college.

We reflect together: How had this therapeutic relationship supported her to overcome these odds and claim her right to dream? What did it mean to have this particular therapist available to her? The therapist, an African American psychologist, described herself as being "mother, coach, aunty" to her. She called upon clinical judgment, cultural wisdom, and love—as a

mother, as an elder, as a woman, as an African American psychologist, and as a social justice therapist, to meet this young woman and walk with her in new directions. All of these cultural expressions informed the service she provided and the relationship that these two women formed.

Consider this scene as well: At a staff meeting, the clinical director and executive director opened up space for us to talk about preparations the city and our hospital had been making for reactions to a verdict in a very painful court case. A young African American man had been shot in the back by a white police officer, and the reaction in the city had reflected anguish and outrage. City of Oakland officials were taking measures to contain further demonstrations by closing downtown businesses, including one of our clinics. We were invited by our managers to voice our feelings about the policy, and to address its impact on our clients. What would it convey to clients to have the building closed at a time of such pain? How would we convey support for families in their grief and rage, and our own? What did it mean that many of us would have the option to move away from the neighborhoods that were most affected, while the children and families we serve would not? For staff of color, the man who was killed could have been a son or a brother or a father. At the same time, some of us were of dominant ethnic and class backgrounds where we were trained to think of the police as protectors and the African American man who was killed as "Other," someone to fear. "Look at me," said an African American social worker to her white colleague. "Look at my face. What you are talking about is being afraid of me."

There was passion in the room, and grief and rage and despair and bewilderment. Some expressed concern over property and worker safety. We were reminded that for many of our clients and colleagues—men and women of color, lesbian, gay, bisexual, transgendered, Jewish, or Muslim—safety is an illusion. As one Latina worker said with great anguish, "It sounds as if we are talking about protecting ourselves from our clients." Another Latina worker spoke up, her voice quivering: "It seems like we are forgetting that a young man is dead." This helped move us into speaking from the heart.

These conversations are vital to our work if we are to meet homeless families where they are. Having a workplace that nurtures workers' cultural wisdom and healing traditions is vital to quality treatment. We see antiracist, anti-oppression practice as essential to ethical, respectful practice. We aim to build a culture where we can be present with our passions and our

pain, with honest reactions and responses. What do we mean by respect? How do we operationalize it? How do we sit, bear witness, and go into the areas where we feel most defensive, on behalf of the families who are entrusting us with their stories? These conversations are painful, but what would be the cost if we couldn't have them?

If racism, sexism, heterosexism, and religious oppression had their way, we would not be speaking and listening in this manner. We don't take any of these moments for granted. There have been, and still are, times when silence and superficiality take over.

WHERE WE COME FROM: A WELL-INTENTIONED SILENCE

The Center for the Vulnerable Child was created in 1986. Currently, we serve young people (0–25 years of age) and their families who are living in high-stress environments, including foster care, homelessness, and poverty. From its inception, the CVC has made an effort to respond to children's needs with flexibility and respect and to assign high priority to the value of meeting people where they are, both psychologically and physically. Consequently, in addition to clinic visits, clinicians make home visits, or go to shelters, coffee shops, or schools to meet with children, teachers, and caregivers. This flexibility, along with the intention to resist pathologizing discourses (Madsen, 2003) and to go to any lengths to give children every chance at health and well-being, has always been part of what has emerged as "the CVC way."

The fact that from early days at the CVC, people were hired who understood this suggests that there has long been an overall vision of respect for families and an honoring of diversity (Waldegrave, Tamasese, Tuhaka, & Campbell, 2003). Having people on staff who understand from experience the effects of racism, sexism, and other kinds of marginalization is one thing; actually creating an environment that allows people from marginalized communities to stay and to thrive is another. How have we welcomed and nurtured workers of color, considering the extra toll it takes on them to watch their own community suffer? We value diversity and stand for respect. But how are we at operationalizing these values?

The fact is that this work affects us differently, and that those differences have to do with life experiences, personality, and location in the matrix of culture and power. Some who are trained in oppressive practices remain oblivious to the effects of these practices on others. Racism, sexism, and

heterosexual dominance keep many of us unaware of our own privilege, and of the historical and institutional obstacles placed in the path of others, even getting us to believe in meritocracy and the superiority of our ways. Systems of oppression lead those of us in positions of privilege and dominance to think it's rude to point out differences (Pinderhughes, 1989). Such a code rubs others raw as they endure microaggressions and systemic assaults to themselves and their communities (Sue et al., 2007). A workplace where unacknowledged racism is operating inflicts injury on staff of color, stifles cooperation for all, and allows other oppressions to thrive (Greene & Siskind, 2006).

Many of the children and families we serve have suffered generations of trauma and marginalization. Legacies of genocide, slavery, and systematic marginalization of immigrants have left scars on victims, perpetrators, bystanders, and their descendants, and continue to inform institutions that many of us take for granted. Compared with white youth, African American, Latino, and Native American youth are more vulnerable to being removed from their families, not graduating from high school, becoming unemployed, becoming homeless, and dying young. Medicine, social science, psychology, and many religious ideologies have been used to justify and support brutal and dehumanizing practices (Jackson, 2002; Leary, 2005). We are serving families who have the least protection, and who feel the legacies of historical trauma most acutely. They have every reason to be suspicious of us. How can those of us protected by "mainstream status" know if we are colluding in dehumanizing, colonizing practices (Waldegrave et al., 2003)? We have had to acknowledge the power that we wield as clinicians—the power to define and label, the power to speak for people without understanding them, the power to impose norms that require families to become like the dominant culture and to leave behind traditions and wisdom that have sustained them through years and generations. We have had to consider that privilege has kept some of us protected from and unaware of the suffering that we very well may have been perpetrating. We have had to start listening to, and being guided by, voices from the margins.

CONFESSIONS OF A WHITE SUPERVISOR

This may go without saying, but because there is limited space, and it is my telling, there will be many details missing from this account of our journey,

and my interpretation will be different from those of others. I am a clinical social work supervisor, middle management, of dominant (or white) culture in terms of race, religion, sexual and affectional orientation, and class. Because of these characteristics, I am wrapped in layers of privilege, and that very gauze of "protection" can keep me from seeing things that are all too obvious to others with different levels of insight and life experiences of being marginalized and targeted for oppression (Batts & Brown, 2009).

When I came to work at the CVC in 2002, I felt welcomed and found an environment that was affable and amazingly upbeat, given the pain of the families' experiences. There were laughter and food and good-natured teasing. There were support from management and beautiful examples of workers going to great lengths to meet the needs of families. Yet every so often I would come upon a pocket of silence, a zone of tension that did not fit into these experiences of trust and mutual respect. As best as I could identify it, the dominant discourse of the CVC was this: "We trust one another; we put families first. We know we all have good intentions so we don't question or challenge one another." I wanted to fit in, and to do right by supervisees and right by the children and families who were confiding in me. I wanted to deserve this job, to be part of this remarkable working community.

In my first case presentation, I introduced the question of how to think about the impact of my whiteness on the African American family with whom I was working. My questions fell flat. The consultation team reassured me that the family sounded happy to have me. I wanted to believe this, but I felt uneasy. Instead of recognizing my own participation in cultural racism hiding behind our good intentions, I fell into my own cultural practices of individualizing and self-doubt, and drifted into the familiar fog of niceness. At the time all the supervisors had white-skin privilege, and I timidly asked why we didn't have any supervising therapists of color since we were working primarily with families of color, but I let the issue drop after a few attempts.

CRACKS IN THE SILENCE

What was vaguely unsettling and dissatisfying to me was a source of deep pain, frustration, anger, and stress to my office mate, a young African American woman whose life experience, loved ones, training, and values put her

closely in touch with the experiences of many of the families with whom the CVC worked. While I provided her clinical supervision, it was she who oriented me to the spirit of practical, respectful, and culturally accountable case management. She was willing to tell me what it was like for her to sit in the required CVC clinical meetings, and she conveyed her alarm at the apparent disconnect from families' cultural experience, and what that disconnect implied about the quality of care being provided to families. In supervision and at the meetings, she expressed pain at the disrespect with which families were treated in our conversations. She was alone in bringing this to the group's attention, and that was a double injury (Batts, 2002; Constantine & Sue, 2007).

I saw her passion, and then I saw older clinicians respond in what seemed like dismissive and even patronizing ways. It looked like the racism of not naming racism, and the microaggression of invalidation (Batts, 2002; Chisom & Washington, 1997; Sue et al., 2007). It was so easy for those of us from dominant groups, and even those from marginalized groups who had been at the CVC for a long time, to try to reassure her or to imply that she was overreacting or didn't understand the complexities of the situation.

Many of us didn't see what we didn't see. There were predictable responses to the young worker's observations and pleas: "Say it nicely." "Curb your anger." "You're overreacting." "It's not about race; it's about class." "Our job is to protect children." By minimizing their colleague's experience, and ignoring the present-day expressions of historical, interpersonal, and institutional oppression, these attempts at helpfulness were doing damage.

When another young woman of color came to the agency, she reported similar experiences of physical and emotional pain, and frustration in the meetings. If this was the tone and conversation at the meetings, she reflected, what was happening in the clinical work with families? If we could not acknowledge these wounds—in our clients, our society, ourselves—how could we work effectively as helpers and healers (Hardy & Laszloffy, 1995; Leary, 2005; Vasquez & Macgraw, 2005)?

The three of us expressed our concern to the management, who made funds available for us to organize a staff retreat focusing on culture and power and issues of respect. Maybe all we lacked, we thought, was a way to talk to each other.

We consulted with experienced facilitators, experts in communication across power and difference, who surveyed the staff about perceptions and

recognized the wide range of awareness. They led the staff through a day of training, but the participants were uncomfortable with some of the techniques taught to raise awareness, and saw them as instigating animosity between white staff and staff of color. "We trust each other here" was the message that met the facilitators, as if they had been attacking "the CVC way." It seemed that the facilitators came ready to name and talk about racism, and many of us were not ready to do that. Discouraged, we did not follow up with the facilitators, who felt baffled by the wall of "niceness."

This had not been the first such attempt. Early in the CVC's history, some of the staff of color identified disrespectfulness in a program director. The institution's administrators were recruited to mediate, and Employee Assistance Program (EAP) services were used to intervene. A few years later a staff retreat was organized to focus on diversity. It raised issues about black-white relations, and left individuals in other groups feeling lost and alienated. The facilitator was blamed, and the subject was not discussed openly afterward (Bradley, Miller, Svingos, & Driscoll, 2008). Some time later, several staff attended trainings by the hospital's diversity committee, which included curricula about cultural humility (Tervalon & Murray-Garcia, 1998). Yet these conversations about privilege and power rarely entered into case consultations, program meetings, or staff meetings at the CVC. There seemed to be many obstacles to real change. Leary (2005) refers to the cognitive dissonance of living in the "land of the free" that was built on stolen land and forced labor. For some of us, terms such as "racism" call forth images of brutal bigotry—and we could separate ourselves from that, while remaining unaware of the real effects of historical and political factors, along with the ways that modern racism and internalized oppression operate on many levels: personal, interpersonal, institutional, systemic, and cultural (Batts, 2002; Chisom & Washington, 1997). We could hold liberal values and still perpetrate oppressive practices and microaggressions (Sue et al., 2007). We did not yet have enough people on hand who could hold the long view and could remind us about breakdowns on the road to breakthroughs, or expose the tricks that modern oppression was playing on us. Some staff at the CVC were raised (as I had been) with the message that naming racial categories was itself racist, and so, out of respect, they did not bring up cultural or ethnic identifiers (Bradley et al., 2008). Many of us felt a call to acknowledge racism or other oppressive or insensitive practices as an injury to a relationship, not seeing that the injury had already

occurred and that we had perpetrated it. We interpreted such a call as an end to relationship, instead of as an opportunity to learn, atone, and engage more accountably, and we closed ranks to protect each other from such a risk. In addition, if a conversation went badly, the person already most marginalized was the one who was blamed and targeted, so even allies could be caught in a quagmire of ineffectiveness.

MOMENTUM BUILDS

Despite the obstacles to change, the managers continued to hold the value of providing quality services to vulnerable families, and we were able to hire people of color and white people who were aware of their privilege. They brought fresh eyes, and had a passion for anti-oppression work and respect for families that was based not just on ideology but on shared life experiences and an understanding that those in power need to form accountable relationships with those holding less power. With this reinforcement, an analysis of racism, privilege, power, and oppression gained momentum.

Because of who was now at the agency and the degree of pain that the workers of color were experiencing, there were many hallway conversations about how to deal with the culture of clinical meetings and about how we see and do clinical work at the CVC. More and more frequently in these informal settings, the women of color, who expressed the feeling of vulnerability and the sense of "no room to breathe," were being joined by white staff who wanted to make changes. The women of color were tired of bringing it up and not feeling supported or heard by their supervisors (Lewis, Torres, Orfirer, & DeVoss, 2010). Moreover, they were gravely concerned about the quality of care for families of color that was reflected by this silence, this gap. Yet they continued to name oppression and to invite the staff to see beyond where we had been. They risked speaking of their experience to their white supervisors (Constantine & Sue, 2007). They led lunchtime film series focusing on intuitional racism and its effects on disparities in health, education, and involvement in the child welfare system. Shocked by the absence of talk about culture in case conferences, they continued to raise the issue.

One of the new staff, an African American woman with a doctorate in psychology, introduced us to the ADDRESSING format (Hays, 2001)

(see table 4.1). This format offers a structure for building awareness of our location based on demographic characteristics that can give us power and privilege or marginalization. These characteristics include such aspects of culture as age and generation, acquired or developmental disability, religion, ethnicity, socioeconomic status, sexual and affectional orientation, indigenous heritage, and gender. We can use these prompts in coming to know the families we are serving, making room for their values and honoring their worldviews. Even more importantly, the template is intended as a tool for clarifying our own locations in the many dimensions of culture, and becoming aware of our own biases, and the effects of cultural differences and commonalities on our assumptions and relationships. We thought that this template would give us a way to engage more fully and respectfully with the families we were trying to serve, and to reflect more productively on our own position of power and the impact of that position on the families with whom we worked. We thought it would enrich our work by helping us find words for experiences that had been unspoken or made invisible.

THE TIPPING POINT

The first individual who was invited to use the ADDRESSING format at an all-staff case conference was a white case manager with a keen sense of social justice and respect for families. Unfortunately, we had not prepared her adequately, and instead of using ADDRESSING to identify her own location in terms of privilege, she was using the acronym to identify the demographic characteristics of the family. When an African American colleague questioned one of her attributions, the white case manager was caught off guard and some in the group responded as if she had been attacked. They came to her defense, leaving the woman who had raised the concerns alone, targeted as "the angry black woman." What emerged were heat, and pain, and honest talk about the confluence of racism and class. Some of the women of color began to share their own experiences of being seen as "less than." It was being named, but there were complaints from some in the room about the presenter not being "safe." It was as if our quietness and "niceness" had been disrupted, and many of us did not know what to do.

Here we were again, exactly where we had been stymied before. The subject of race had been broached and panic had ensued. Indeed, it seemed we

couldn't talk about this. This time, though, people refused to let it go back underground. At the end of this case conference, a small group of individuals asked if others at the CVC would like to change the dynamics of the conversation, and talk about race, privilege, and power. Instead of just a few interested staff, one third of the staff showed up—including supervisors, program directors, and managers. As we discussed our purpose, one of the African American women said, "Let's not be a committee . . . committees don't do anything. Let's form a task force." With this distinction, she called us to come together for action, not just to conduct academic-like analysis (an occupational hazard for many of us trained as therapists!). She empowered us to become the Task Force for Cultural Responsiveness and Accountability. Momentum had shifted, and there was agreement from the start that departmental change had to happen.

THE TASK FORCE IN ACTION

One of the first decisions of the task force, supported by the CVC clinical director, was that we devote our existing monthly "brown-bag" clinical meetings to focusing on the effects of our own culture and privilege and its impact on our work with children and families. The meetings were open to all staff, including administrative staff. We noticed that there was rich conversation when we broke into smaller groups, but the silence and awkwardness reappeared when the group gathered as a whole. It seemed that there was mistrust between programs. We attempted to have programs introduce themselves and make explicit their thoughts about working with people from cultures with varying levels of culture, power, and privilege. The vocabularies and philosophies were so different that it was often hard to hear each other. There were undercurrents of grumblings about superficial political correctness, objections that conversations about culture threatened to eclipse clinical case conferences, and a repeated and well-justified refrain that "we want to talk about race, class, power, and privilege, but we don't know each other well enough to have these conversations."

From its inception, the task force has seen its purpose as guiding the CVC and its staff to reflect on how our own positions of power and privilege—as individuals and as an agency—affect the families with whom we work. Participation from all "levels" of staff was crucial: the fact that

management, office staff, supervisors, therapists, and case managers were present with the intention of learning together was hugely significant. Since culture and racism were our initial focus, it also was significant that participants were Latina, Jewish, African American, and dominant culture white, and of course, within these categories, we had ranges of experience and identifications in terms of class, gender, sexual and affectional orientation, and generation. We agreed that though diversity was a shared value, it was no longer sufficient as even a minimum standard of care. If we were to work together toward providing ethical, high-quality care to the communities we hoped to serve, we would have to go deeper and wider in our anti-oppression work in order to build accountable relationships. We had to expose and understand the effects of historical and current injustices and power differentials among CVC staff, and between our agency and the families and communities we serve.

The road was not easy. Even within the task force, we differed in our experiences of thinking about these issues. We tried to operate by consensus and often disagreed and floundered. We met weekly at first and eventually settled into a bimonthly schedule, learning and adapting as we went. In an initial attempt to define our vision, we introduced Crossroads Ministry's "Continuum on Becoming an Anti-Racist, Multicultural Institution" (Crossroads Ministry, 2006). We thought it would provide us with an assessment tool and a map, a great way to name the limitations of white liberal racism, but there were snags. Not surprisingly, some of us with white-skin privilege thought we were further along than the people of color thought we were, and we stalled for weeks on this.

At about this time, many of us attended the first "ISMS" Conference sponsored by the University of California at Berkeley School of Public Health: "Privilege, Bias, and Oppression: Addressing Barriers to Eliminating Health Disparities Within Health Organizations." At the conference, we were heartened by presentations by other agencies on this journey, and we met two consultants, Laurin Mayeno and Jacqueline Elena Featherstone, who had helped them along the way (Mayeno & Featherstone, 2010). We had come to realize that we couldn't do therapy on our own family, and so we asked for their help (Bradley et al., 2008). They understood right away that we needed help not only with interpersonal communication but with institutional change. They held a long-term vision for us and said, "You can't let the hesitation of the few hold up the whole group."

Our managers, who were now actively prioritizing this work, secured funding and committed institutional time to mandatory staff training by the consultants. We were all ready to start afresh—and then it happened: we hit another patch of ice. In an exercise on "checking out assumptions," a clinician chose to practice in front of the entire staff by checking out with a program director the assumption that her program didn't talk about culture. There was a moment of breathlessness. Some staff became defensive. Most felt helpless, as chasms of old distrust reopened. The facilitators, in an effort to accommodate multiple voices, changed their format and original presentation to a conversation about hierarchy and honoring different personalities. Once again, we veered from the topic of racism. This was painful for some, hopeful for others, and confusing for many.

But once again, what could have been a breakdown became a breakthrough. At our next task force meeting we did not know how to proceed. Some blamed the facilitators, and we asked them to join us. One of the facilitators arrived at our department within 15 minutes. She heard the task force's fears, complaints, and confusion. She took responsibility for some of the day going off course and committed to helping us out of the tangle.

Instead of ignoring what had happened, in the next staff training the trainers and the managers modeled accountability, stating clearly what they had done and not done that had contributed to minimizing the effects of racism and power differentials, and the actions they would take to rectify this. These statements had a profound effect on all of us. The managers enacted humility and accountable leadership and demonstrated a commitment from those in power to keep the agency growing toward culturally responsive and ethical treatment of families and of each other. This made institutional change an agency priority, and conveyed the intention to take a piece of the burden off the women of color who had been working so hard to raise the standards of cultural accountability and responsiveness in our practice.

The facilitators led discussions that helped us to identify our priorities, and helped lead us to find common ground. This was the success we had needed, and along with the commitment of management, it sent the clear message that discussions of culture and power were now part of the expected standard of practice. Cultural responsiveness and accountability were now part of "the CVC way."

The consultants then met with the task force and proposed that we move forward in an intentional way toward developing a cultural strategic plan. If we continued just to talk, it would lead to our demise, they said. We needed to take action and create small successes (Mayeno, 2007). On the basis of the priorities identified by the staff at one of the trainings, they proposed that the cultural strategic plan be based on five work groups, focusing on the positive work environment of the department, community outreach, bigger systems (i.e., outside the department), department policies and procedures, and clinical practice (Mayeno, 2007). Every staff member would become a member of one of the work groups, which would be facilitated by task force members. A strategic planning group with staff members from different positions within the department was enlisted to coordinate efforts. The consultants suggested that each work group create a vision, define an issue in need of attention, and devise a sequence of recommended actions to address the issue. These were compiled in a Handbook for Cultural Responsiveness and Accountability. Although the original intent was to meet one or two times, the groups themselves decided to continue, and have done so for the intervening three years.

The groups did profound work, partly because their membership cut across programs, so people knew each other in new ways. There was from the start a "no repercussions agreement," which addressed the fact that work groups included but were not run by managers and supervisors. Management set aside time each month for meetings, and participation was mandatory. The creative initiatives of the groups made inroads into real institutional change (Bradley et al., 2008). There are impressive examples of what was accomplished.

For example, the positive work environment group attended to our frayed morale and addressed the "we don't know each other well enough" problem by replacing some meetings with potluck gatherings, organizing a staff barbecue with games, initiating a newsletter, and incorporating icebreakers and appreciations in meetings. They also created a culture of acknowledgment, a "goodie basket" of nurturing teas and snacks in the front offices, and a "birthday fairy" who acknowledged birthdays by sending good wishes and online cake and balloons. They made a real departmental change by developing polices governing greetings and good-byes, and clarifying program supervisory responsibility in acknowledging staff accomplishments and milestones.

The clinical practice work group, consisting of office staff along with clinicians, worked diligently to hear and respect one another across theoretical and experiential differences. They developed a set of "essential questions" to be included at clinical meetings so that when clinicians described the children and families with whom they worked, they also had to describe their own power and privilege and the impact of it on the relationship with the family. A laminated copy of these questions is in every conference room at the CVC. The group also developed a statement of commitment that the strategic planning group adopted as the foundation statement of our work. It reads:

> Our Promise, Our Commitment: we commit to cultural accountability to each other and our clients in every interaction. We are guided by our awareness of the impact of oppression and marginalization, membership in target and non-target groups, and the central impact of historical and institutional racism. We will be sensitive to our role in institutional oppression and we will seek consultation from the communities with whom we work. We will strive to be transparent and explicit in our process.

The policy and personnel group reviewed forms, hiring policies, and competencies. They altered performance evaluations to include cultural responsiveness and instituted policies to address continuity of care when trainees leave. They created a new orientation procedure to welcome new employees and trainees. Throughout this process they used surveys to make sure staff voices were included in the changes.

BACK TO THE PRESENT

The Task Force for Cultural Responsiveness and Accountability has been an important part of CVC culture since 2006, operating in an advisory capacity with management. Using Tatum's analogy of institutional racism as a moving sidewalk, we try to keep walking in the other direction (Tatum, 2003). We operate as a process group, challenging and supporting each other, and as a leadership group, ensuring that issues of culture and power stay central to the CVC's work with families and with other institutions. We are often stuck between action and reflection. And we have to keep asking ourselves: What might we be missing as we become mainstream? In what ways are we participating in oppression?

We at the CVC are still not all in agreement about the meaning of cultural responsiveness and accountability, and we do not all equally prioritize these issues or see their relevance. "Dead zones" of silence still happen in meetings sometimes, and inadvertent injuries, frustrations, assumptions, and personality conflicts occur. We try to reflect on where we've come from, and acknowledge the changes made in "the CVC way." We need to be reminded that hurts and awkwardnesses are inevitable as we try to expose things that have thrived for centuries in silence and obfuscation. And it is our hope that as people raise these issues—and the issues of which we are not yet aware—they will not have to do it alone anymore.

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