

This book is a valuable resource for therapists working in communities and with communities to address a variety of urgent psychosocial challenges, such as improving race relations, reducing political polarization, and promoting peer support in health care. At a time when citizen participation is so needed to strengthen our democracy, therapists will find this book helpful as a guide to expanding their role to include education, advocacy, and organizing for community-based problem solving.

—**Jack Saul, PhD**, author of *Collective Trauma, Collective Healing: Promoting Community Resilience in the Aftermath of Disaster*

Doherty and Mendenhall bring therapy and democracy together in an inspiring handbook that encourages all of us to become “citizen therapists.” They vividly describe real-life partnerships and collaborations between therapists and community members in which *each person* has expertise and energy to bring to community problems. The chapters include collective efforts focused on serious problems of our time, such as chronic illness, political polarization, and relations between police and young Black men. Are you feeling helpless in our current fragmented world? Has the COVID experience and political polarization rendered you pessimistic and passive? I strongly encourage you to *read this book!* Doherty and Mendenhall’s concept of “citizen therapist” is an inspiring recipe for reengaging our collective sense of agency, communion, and hope.

—**Susan H. McDaniel, PhD**, Dr. Laurie Sands Distinguished Professor of Families & Health, Academic Chief, Division of Collaborative Care and Wellness, and Director of the Institute for the Family in the Department of Psychiatry, University of Rochester, Rochester, NY

# Contents

<b>I. OVERVIEW OF CITIZEN THERAPIST WORK</b>	<b>1</b>
Introduction: What Can Therapists Offer the Larger World?	3
1. Foundations of Citizen Therapist Work	19
<b>II. HEALTH CARE PROJECTS</b>	<b>31</b>
2. The Family Education Diabetes Series: Tackling the Diabetes Epidemic in an American Indian Community	33
3. Students Against Nicotine and Tobacco Addiction	41
4. The Como Clinic Health Club: Activating Citizen Patient Leaders	49
<b>III. FAMILY AND CULTURAL CHANGE PROJECTS</b>	<b>63</b>
5. Putting Family First: Resisting the Pull of Overscheduling Kids	65
6. The Citizen Father Project	77
7. Braver Angels: Counteracting Political Polarization	93
<b>IV. PROJECTS DEALING WITH RACE</b>	<b>113</b>
8. The Relationships Project With Young Black Men	115
9. The Police and Black Men Project	131

<b>V. BECOMING AND SUCCEEDING AS A CITIZEN THERAPIST</b>	<b>149</b>
<b>10. Case Studies in Other Citizen Therapist Work</b>	<b>151</b>
<i>With Mark Meier, Marisol L. Meyer, Alexis R. Franklin, Ceewin N. Louder, Joelle Dorsett, Marie Boursiquot White, Guerda Nicolas, and Brooke Miller</i>	
<b>11. Maintaining Citizen Health Care Projects Over Time</b>	<b>175</b>
<b>12. Funding and Evaluation in Citizen Health Care</b>	<b>183</b>
<b>13. Getting Started as a Citizen Therapist</b>	<b>191</b>
<b>14. The Citizen Therapist as a Person and as a Professional</b>	<b>201</b>
<b>Afterword</b>	<b>209</b>
<i>References</i>	<i>211</i>
<i>Index</i>	<i>221</i>
<i>About the Authors</i>	<i>231</i>

# INTRODUCTION

## *What Can Therapists Offer the Larger World?*

As someone who came of age in the 1960s, I (Bill) viewed therapists as potential change agents in society. If we got enough political leaders into personal growth groups, would social justice not be far away? Fast forward to the mid-1990s when I had become deeply dissatisfied with the constricted role of therapists in an increasingly troubled world. I was haunted by Hillman and Ventura's (1993) classic book, *We've Had a Hundred Years of Psychotherapy—and the World's Getting Worse*. Looking back, I realized that my training in the humanistic psychology era of the 1970s had left me with the naïve notion that widespread uptake of therapy and related self-help offerings would bubble up to change the larger society. Likewise, my deep dive into family systems theory had left me with unrealistic expectations of how family therapy principles could apply to the broader systems of society.

My training took place in a long-gone era of optimism when the world seemed to be newly discovering psychology and the fruits of therapy. But by the end of the 1970s, the Equal Rights Amendment had stalled, the divorce rate had doubled, violent crime was escalating, indicators of social trust had begun their decline, and the economy was mired in something called *stagflation* (Bailey & Farber, 2004). The Reagan era of the 1980s would dash

---

<https://doi.org/10.1037/0000378-001>

*Becoming a Citizen Therapist: Integrating Community Problem-Solving Into Your Work as a Healer*, by W. J. Doherty and T. J. Mendenhall

Copyright © 2024 by the American Psychological Association. All rights reserved.

hopes that national leaders would welcome the application of therapy and the social sciences for solving our social problems.

As I looked around for models of how to work as a therapist on social change and community well-being, I was not comforted. The prevailing community psychology models seemed to disparage therapy practitioners as offering Band-Aids for problems that were structural, not personal (Albee, 1998). The real answers, we therapists were told, would come from public policy experts, legislative advocates, and community specialists with expertise in public, large-scale projects. Meaningful action was upstream—to prevent mental health problems—and therapists worked downstream via the medical model of treating people after they developed diagnosable problems.

Would I have to abandon my clinical work and identity as a therapist if I wanted to make a difference in the broader community? It seemed too late in my career for that kind of transition; I was an experienced, enthusiastic therapist and midcareer academic. The community-change projects I knew about involved large grants or public funds to hire community psychologists or community social workers, with no role for therapists. Our contributions were relegated to offering pro bono services or practicing in economically disadvantaged communities. Or maybe write a book for the lay public. (Nowadays, it would be to write a popular blog or have a social media account with lots of followers.)

Then, as now, the most accessible way to become involved in the public sphere was via advocacy for the profession: protecting licensure, gaining access to the insurance panels, and obtaining favorable reimbursement rates. All legitimate endeavors but not exactly world changing. Success in the policy arena generally depends on raising funds and hiring good lobbyists. Although important for the profession, this kind of advocacy comes with an unspoken assumption that if therapists thrive in the clinical practice of psychotherapy, the world will do better. We now have more than 100 years of data that only partially support this assumption. We do help many people, but we don't seem to be counteracting a toxic environment, let alone forging new pathways for people to connect to their communities and solve social problems.

## **BREAKING THROUGH TO A WIDER VIEW**

Staying with Bill's story for now (Tai's story comes later): By the mid-1990s, I had finished writing a book on the ethical and moral dimensions of psychotherapy (Doherty, 1995), in which I challenged the field to move beyond a

nearly exclusive emphasis on the individual self-interest of the client. (Doherty, 2022, is an updated version of that book.) I called for considering additional stakeholders in clients' actions and decisions, including family members and others closely connected to the client. The book included a chapter on community because I did not want to limit the ethical dimension of life to personal relationships. But my ideas there were underdeveloped. I had defined the aspiration that therapists might promote community well-being, but I did not yet have a guiding map.

That map came from outside of our field via mentoring by political theorists and social activists Harry Boyte and Nancy Kari, who were connected to the University of Minnesota's Center for Democracy and Citizenship. (See Chapter 1 of this book for an explanation of their public work model.) As I turned the pages of the typed, prepublication version of their new book (Boyte & Kari, 1996), I told myself, "This is where I want to take my career now." They gave me a critique of traditional professionalism as it emerged in the early 20th century and a way of thinking about how a professional can be an agent of community capacity building and grassroots democracy. I felt the same kind of thrill as when I first engaged with the world of psychology and family therapy.

This thrill came with discomfort because it meant a reevaluation of my identity as a therapist and academic. I realized that I had always seen my work as apart from community, even above it, as something delivered to community and not done alongside community. My fellow citizens were the population I served, taught, and studied, not my partners in solving problems. As a therapist I helped clients access their personal capacities, but I never considered how I might help groups of citizens access their collective capacities for promoting mutual well-being and solving public problems. (Note: In this book we use the term *citizens* not in its legal sense but to refer to joint stakeholders in building and maintaining communities and the larger commonwealth.)

But where to start? Along with colleague Patrick Dougherty, I launched a local group of therapists to explore the possibilities of deeper engagement with our community. Although launched with a big goal and the lofty name "The Psychotherapy and Public Work Project," it was a bust. We couldn't agree on what kind of project to work on, and nobody but Patrick and I was interested in reading Boyte and Kari's book. In retrospect, the most problematic part was that we seemed to think of public engagement as engaging with low-income, ethnic minority communities. And we were all White professionals in either private practice or big institutions such as hospitals or universities, with little access to the communities we assumed we should be working with. After that group dissolved, I realized that I would have to

set out on my own to learn to be what I would later come to call a “citizen therapist” and to start with communities I did have access to.

Because I had a background in codeveloping the area of medical family therapy (McDaniel et al., 2014), I decided to start my citizen therapist journey around a health care problem that was taxing the care system and the communities it served. Through the influence of physician colleague Mac Baird, I approached the health promotion leaders of HealthPartners, a large health care organization. The idea was to engage patients as leaders to codevelop a project that would draw on their capacities to make a difference for fellow patients. Furthermore, I offered to work pro bono on the project. The HealthPartners leaders were intrigued. I asked them what problem they would like to start with, and they chose diabetes for a variety of reasons (chronic, difficult to manage, many complications, and expensive to the health care system). They put out the word to the clinics they thought might be interested, and a clinic leader, physician Jim Hart, stepped up.

Around this time, I met my coauthor, Tai, a graduate student who was exploring medical family therapy as a potential career specialty. Within a couple of months, Tai and I were meeting with a group of clinic patients who were experienced with diabetes and eager to share their expertise. The year was 1999, and this was my internship with citizen therapist work. More than 2 decades later, I haven’t stopped engaging with fellow citizens across a variety of other settings to cocreate and carry out the projects described in this book. Next Tai will tell his origin story in this work.

## **TAI’S STORY**

I was in graduate school when I began to be disillusioned with traditional models in academia and therapy. I had finished my master of science degree in marriage and family therapy, during which time I had fallen in love with systems theory. My dissatisfaction stemmed from three observations about the models I was learning to practice. First, the therapist was positioned as the unquestioned expert, delivering care in a top-down, provider–consumer manner and functioning in isolation from other professions. Second, clients were portrayed as having straightforward mental health or relational troubles, and medical and larger community issues were rarely mentioned or attended to. Third, we never connected clients with one another for mutual learning and support; instead, they waited their turn to get treated by a professional. As much as I loved seeing clients, therapy as a profession seemed too hierarchical and too limited in scope.

In 1999, I began my doctoral studies and declared medical family therapy as a specialization in my journey. I sought out Bill, one of the founders of this specialization, as my advisor. He helped me get an early clinical placement in a primary care residency, which sealed the deal for me that choosing this path was a good idea. Far from the isolated, structured, 1-hour-at-a-time models of private practice with a relatively narrow range of clients and clinical presentations I had started with in my graduate training, this work was interdisciplinary, collaborative, often unpredictable, diverse, and clinically intense. I engaged with teams that included physicians, mental health providers, social service experts, patient advocates, interpreters, and cultural brokers such as community Elders and shamans.

I recall during the early days of my doctoral program feeling as if I had “arrived.” I had finally figured out what I was going to do. My plan: to never leave this messy world of on-the-ground, in-the-trenches, systemic, integrated health care and to continue to advance its mission and scope as a clinician, teacher, trainer, supervisor, and scholar.

But something started to nag at me as I worked harder and harder, especially in cases that involved those who were living with chronic illnesses. I wished that, while offering care, I could consult with some patients and their families who’d dealt with similar issues, to find out what worked best for them. I found myself bumping up against conventional practice patterns where care had to go one way—from me to patients in a provider–consumer direction. But I did not usually have the lived experience and wisdom that other patients had, a wisdom gained by actually having an illness or living with someone with that illness. Instead of sitting in the waiting room looking at outdated magazines or their cellphones, wouldn’t it be great if a “veteran patient” could talk with a newly diagnosed one? Or if a spouse who had figured out how to be supportive without being a nag about diet, exercise, and medications could talk with somebody who wanted to be helpful but was not sure how?

I didn’t know it then, but Bill was struggling with some of these same challenges related to scope and reach, tapping both professional knowledge and lived-experience knowledge. As mentioned above, he was talking with HealthPartners leaders about ways to engage patients living with diabetes as coleaders to codevelop a project that would draw on their capacities to make a difference for fellow patients, and he invited me into the emerging project. What followed was our first citizen therapist initiative. Its evolution and key learnings were the principal focus of my doctoral dissertation, and it set into motion the career that I have pursued in integrated health care and citizen therapist work ever since.

## THE PARTNERS IN DIABETES PROJECT: TAI'S STORY CONTINUES

Bill and I have told the long-version story of our first project—Partners in Diabetes—through a couple of publications (Mendenhall & Doherty, 2003, 2007b). The short version is this: Our early meetings with physicians, clinic administrators, and providers and then with patients and their families served to confirm that diabetes was a pressure point for everybody. Put simply, this meant that nobody was happy with how things were going. Although their reasons were different (administrators were worried about how much diabetes care was costing; providers were wrestling with feelings of futility and being “maxed out”; patients felt demoralized by characterizations of them as noncompliant vis-à-vis commonplace inabilities to afford healthy foods, not feeling safe to exercise in their neighborhoods), everybody agreed that something new was needed.

Providers nominated and invited 14 patients and spouses of patients to coconstruct a project in which they would be paired as support partners with other patients and families who were struggling with diabetes. These paired patients and family members were generally in one of two situations: (a) they were struggling with managing the disease well (e.g., three consecutive A1C tests of > 9%) or (b) they had recently been diagnosed and were thereby navigating initial and often overwhelming phases of adjusting to it. The support partners' efforts involved a variety of diabetes management strategies and educational content. In some cases they met with members once for an encouraging pep talk, and in other cases they met for several months in person or over the telephone.

As a supplement to standard care, patients' engagement with Partners in Diabetes was not billed, and the content of meetings between support partners and members was not formally documented in medical records or related charting. And though the project was not formally evaluated, anecdotally patients and providers communicated high satisfaction with the program. Patients described learning strategies for effective disease management (e.g., administering insulin injections, where and when to purchase healthy foods affordably, chair aerobics at home). Providers described patients whom they had long since given up on to manage diabetes well to be improving across metabolic control, weight, and blood pressure measures. Alongside this, administrators described feeling more hopeful about diabetes not bankrupting their clinic.

For my dissertation, I conducted a thematic analysis of process notes and in-depth, key-informant interviews (Mendenhall & Doherty, 2003, 2007b). In retrospect, this was somewhat risky because the project's planning took

many turns and nearly did not come to fruition. The risk was made vividly clear to me when, about halfway through, Bill asked the leadership group of patients and providers if we “still have a project here,” given that energy and meeting attendance seemed to be flagging. (The group rose to the challenge and recommitted to the work.) I’m still a bit traumatized by that—this was to be my dissertation!—and have forever since recommended that my own graduate students not do dissertations on startup projects.

In *Partners in Diabetes*, Bill and I learned how to work with leadership groups that included patients, family members, and providers in a flattened hierarchy. The patients developed confidence in their own wisdom as “life experts.” The providers learned a new form of collaboration in which their knowledge and expertise were “on tap,” not “on top.” Once this democratic process was in place, every decision was made collaboratively: designing support partners’ training curriculum, marketing the program, coordinating referral processes, and performing ongoing program troubleshooting and problem solving. And it never took more than 2 to 4 hours per week of anybody’s time.

After several years of local implementation across two clinics, *Partners in Diabetes* concluded when one clinic closed and the other changed its clinical focus. But the project’s DNA had already begun to inform other like-minded projects. One, called the ANGELS (A Neighbor Giving Encouragement, Love, and Support), was taking root through my internship placement in a partnership between providers in a children’s hospital, adolescent patients, and their parents in North Carolina (Mendenhall & Doherty, 2007a). Another, called the FEDS (Family Education Diabetes Series), was gaining momentum in Saint Paul, Minnesota, through a partnership between an American Indian<sup>1</sup> community organization and the University of Minnesota (Mendenhall et al., 2010). This project, originally proposed by two local Elders who were also support partners in *Partners in Diabetes*, would go on to be the longest-standing citizen health care project to date (see Chapter 2).

## ANOTHER STARTUP PROJECT: PUTTING FAMILY FIRST

Back to Bill now. A second project belongs in the origin story of our citizen therapist work because it began at the same time as *Partners in Diabetes* and because its very different focus illustrates the breadth of issues that can be tackled through this way of working.

---

<sup>1</sup>We use the terms *American Indian*, *Indigenous*, and *Native* interchangeably. This is consistent with preferences of Elders in the FEDS.

In April 1998, I gave a keynote talk to a large conference for parents in Wayzata, Minnesota—an upper-middle-class suburb of Minneapolis—on the topic of family time and family rituals. I addressed a concern I had been hearing about the loss of family time to outside activities for children and the rat race that parents were experiencing in keeping up with sports practices and traveling teams. The parents responded to the message but were befuddled about how they could buck the trend of overbusyness, given the pressures they felt to have their children succeed. Several school leaders who attended told me privately that their schools were contributing to the problem by offering an ever-increasing array of activities without alerting parents to the side effect: the loss of family time and downtime for kids. The upshot for me was a deeper awareness of the connection between the personal and public dimensions of disappearing family time.

Later that year, the conference organizer invited me to give a similar talk during a new lecture series on parenting. I saw an opportunity to try out my wings as a publicly engaged therapist. I declined to just give a presentation on the same topic but proposed that we organize parents to take action on the problem. She readily agreed. So, we decided to combine a talk and a town meeting at a school. About 300 parents showed up for the talk, and about 70 of them stayed for the town meeting.

Parents are used to talking about personal parenting challenges. The challenge was to help them connect their personal experience to a larger community story and to encourage them to take collective action. At the town meeting, I asked four questions in sequence: “Is this problem we’re talking about here—overscheduled kids and underconnected families—only an individual family problem, or is it also a community problem? Are the solutions only individual family solutions, or are they also community solutions? Do you think this community is ready to take action? What actions should we take?”

The first three questions lit the fire: “Yes, it’s a community problem! Yes, the solutions must come at the community level as well as the family level! Yes, we’re ready to take action!” The meeting became intense as parents worked on the “What shall we do?” question in breakout groups. Afterward, a lot of parents wanted to speak. They were sick of the rat race and eager to do something about it together. One mother stood and said, “I could use something like a Good Housekeeping Seal of Approval for organizations I’m signing my kids up with—something that would show me that this organization will work with me in my efforts to have a balanced family life.” That became the seed of an idea eventually adopted by a parent project called Putting Family First (see Chapter 5). On my end, this was my first experience with the power of a public launch event for a citizen therapist project.

There were a couple of moments during the meeting where my clinical skills proved useful. When the discussion started to turn into bashing coaches and community leaders, I intervened like a couples therapist preventing a mutual blame meltdown. “I don’t think anybody is setting out to hurt kids,” I said, “and I know that there are a lot of competitive pressures on coaches and school leaders. In my view, we’re all part of this problem, and we can all be part of the solution.” This seemed to connect with most of the parents and later became part of a core theme of the initiative: no villains, no scapegoats.

I did another quick intervention when a woman sitting in the front took a shot at other parents: “This is all well and good, but we’re preaching to the choir. It’s the parents who aren’t here who are the problem.” Then somebody added, “There should have been three times as many parents here tonight.” As heads nodded, my heart started to sink. But as a family therapist, I know how to intervene when an anxious family member starts pulling the plug on a moment of family courage or connection. I responded, “I think it was Margaret Mead who said that it only takes a small group of committed people to change the world, and indeed that it’s never been changed in any other way.” After this sank in, I picked up on the choir metaphor: “Every social movement begins with a choir,” I said. “And we have a lot of people already in this choir.” People sat up in their chairs, and I could sense energy flowing back into the space. Then I brought it home: “If only 12 people with the passion and energy I see in this room had shown up here, I’d have been happy.”

More on this project and the FEDS later. For now, we just wanted to give you a sense of how energizing it was for both of us to begin our citizen therapist journeys. Many successes and stumbles later, we wrote this book in hopes of passing on this energy, along with the skills and tools we’ve learned along the way. Next we define some key terms and then walk you through what this book covers.

## **WHAT IS A CITIZEN THERAPIST?**

Most contemporary therapists understand the connection between personal and public issues. No one could avoid seeing the spillover of public issues during the COVID pandemic of the early 2020s and the political polarization all around us. And of course we are not the first to conceptualize how therapists can contribute at the population level. For example, many therapists work outside of the clinical hour to educate the public about mental health and relational issues. Historically this has taken the form of public speaking, books and magazine articles, and media interviews. In recent years, blogging and developing membership portals have been prominent. A therapist with

a clinical specialty in, say, infertility counseling, can reach a large population of people experiencing this challenge. We call such a person a “community educator therapist”—they bring therapeutic knowledge and skills to the wider public, not just clients. It’s a valuable way to work upstream from the problems we see in our offices and one that we have engaged in ourselves.

As mentioned earlier, advocacy in the arena of public policy is another way that therapists work to influence the world outside of clinical practice. Much of this is done through professional organizations that prepare therapists with skills in communicating with elected officials and policymakers. For example, many state-level professional associations hold legislative action days when their members lobby state legislators on issues of importance to the profession. Although the focus is generally on the advancement of the profession, therapist advocates can also focus on public policies that directly influence communities in need. In addition to organizational efforts, some therapists are active as individuals in advocating for social-change policies on issues they care deeply about. We call this the “therapist advocate”—a therapist who bring their perspectives and expertise to policymakers. Along with the work of the community educator therapists, advocacy is an important contribution of therapists to the public good. Again, it’s an arena in which we have practiced during our careers.

In recent years there has been a renewed interest in *public psychology*; this term originated in the 1960s and received systematic attention culminating in a special issue of the journal *American Psychologist* (Eaton et al., 2021). Most relevant for our purposes is an article by Miles and Fassinger (2021), who called for a scientist–practitioner–advocate model that transcends the traditional two-part scientist–practitioner model by stressing the need to prepare graduate students to become advocates for social justice, particularly in the domain of public policy. Outside the realm of graduate education, our colleague Rob Pasick (2018) has identified for his whole career as a public psychologist, with a remarkable number of projects in which he has promoted institutional change to make psychological services available to new community groups. Thus, there is a term for a public psychologist who advocates for social justice and for expanding clinical services to communities in need.

In light of these existing social-change roles of therapists, why introduce the new term “citizen therapist”? Because the approach described in this book focuses on a kind of activity that has been less common among therapists and other professionals: engaging community members in projects of collective action on health and social problems. The term *citizen therapist* connotes an “alongside of” relationship rather than a service delivery or an “advocating on behalf of” relationship. The citizen therapist’s role is that of

a catalyst for other citizens (again, defined as people who take responsibility for their communities) to activate their joint capacity for social change. To repeat the key distinction: Citizen therapists (as we conceptualize the role) work with—rather than for—other community members. The short-term outcome of citizen therapist work is a group of everyday people who develop a sense that “we can do important work together for our community.” The long-term outcomes of successful projects are visible changes in a specific community and sometimes beyond. The community might be local and geographic, or it might be international via a Web-based group who share the same challenges—or anything in between.

Exhibit 1 offers our way of thinking about three roles of citizen therapists: educator, advocate, and organizer. Although our own work has focused on the organizer role (convening community members to engage in joint projects), we also encourage readers to consider the citizen therapist roles of educator and advocate. Note in Exhibit 1 that we distinguish between the traditional public educator role for therapists, which emphasizes how we bring knowledge to communities, and the citizen therapist educator role, which emphasizes synergy between professional knowledge and knowledge already present in communities. Likewise, we distinguish between traditional advocacy that focuses on either guild interests or influencing public policy on behalf of marginalized communities (both of which are important) and citizen therapist advocacy that collaborates closely with communities working toward policy changes.

Citizen therapists as organizers (again, the focus of this book) are conveners, facilitators, and process leaders for projects that are pressure points for a community. They are catalysts and partners, not managers. They bring interpersonal and group skills to the joint table, along with areas of professional knowledge, and add these to the mix of knowledge and skills that community members bring. At a larger level, citizen therapist work of all kinds is about the role of therapists in reviving democracy defined as the collective agency of “we the diverse people” taking responsibility for solving our collective problems. It’s impossible to do citizen therapist work without thinking about democracy all the time.

A final distinction between the citizen therapist role and some other forms of public engagement is that the therapist can engage with any community struggling with a pressing concern, including but not confined to communities that have been disenfranchised. The “we the people” in a citizen therapist project can be a largely upper-middle-class White community struggling with the social pathologies of contemporary family life (see Chapter 5) or a largely low-income urban-dwelling American Indian community struggling with the impact of diabetes (see Chapter 2). With no political or ideological litmus tests for who comes to the table to create a project, it can involve police

**EXHIBIT I.1. Three Roles for Citizen Therapists**

---

**1. Educator**

- Mission: Capacity building for a democratic way of life. Equipping people with the knowledge and tools for decision making, self-care, close relationships, participation in community—and less dependence on professionals
- Practice: Democratic knowledge sharing. Blending professional expertise and community expertise, with special emphasis on sharing the knowledge and wisdom of community members
- Difference from traditional educator role: Not hierarchical and expert-oriented, two-way learning (everyone a teacher and learner), valuing local knowledge and not just universal, academic knowledge
- Examples: Community education that accesses parents' knowledge and energy; a public health education campaign on lead risk to children carried out by a group of professionals and community members; using Web 2.0 in a way that engages public reflection and deliberation

**2. Advocate**

- Mission: Open up public resources and influence public policy. An emphasis on policies and resources that develop capacity for personal and community agency instead of consumer dependence
- Practice: Joint education, persuasion, and pressure. Working closely with other community members to influence public leaders to provide more equitable distribution of resources and to adopt policies that engage citizens in personal and public problem solving
- Difference from traditional advocate role: Not professional guild oriented, always teamed with other citizens, emphasizes the role of government as partner and capacity builder, not parent
- Example: Neighborhood advocates persuading the City of Seattle to create a collaborative neighborhood design within its comprehensive city planning

**3. Organizer**

- Mission: Community-based problem solving. Activating and partnering with grassroots groups of citizens to tackle community pressure points
  - Practice: Community organizing. Democratic planning, leadership development, outreach, and action initiatives that call upon the talents and passions of a specific community
  - Difference from traditional community organizer: Involves an important role for professionals, willing to use academic knowledge “on tap,” not “on top”
  - Examples: Citizen health care projects described in this book
- 

officers and Black community members who feel oppressed by the police (see Chapter 9). Political conservatives can engage with liberals without the citizen therapist asking anyone to embrace contemporary social justice perspectives (see Chapter 10). We deal with diversity and social justice by creating containers within which people who differ along the lines of power and race come together in flattened hierarchies to solve problems that they cannot without each other.

We know that the citizen therapist concept can be hard to grasp at first. That's why this book is full of project examples of our work and that of other therapists. As you read the stories, we encourage you to identify your clinical passions or personal or family challenges and then imagine the communities of people who face a similar health or social challenge. In other words, place problems you care about in the context of a large number of people sharing the same concern. Then connect their concerns to a larger picture that might include issues such as social isolation or lack of public understanding. In other words, identify the bigger landscape that these clients navigate and then conceive some initial ideas about how they could do two things: better navigate that landscape together and eventually change features of that landscape. Mutual support and social change: This combination is the sweet spot for citizen therapist activities as we think of them. And as we emphasize repeatedly in this book, citizen therapists continue in their day jobs of providing therapeutic services to clients. Just as the citizen legislator serves in a state legislature in addition to their regular paid work in their home communities, citizen therapists approach this work as their contributions to the public good in addition to their everyday work as healers.

A note about realistic expectations: There are times in life when active engagement in community work is feasible and energizing and other times when it would cause overload. In this book we are more interested in planting a way of thinking in the minds of readers so that when the time is right, they have some guideposts to become active in their communities. Sometimes it's enough to just incubate an idea and talk to others about it, with no expectation of near-term action. We know a therapist living with chronic illness who is inspired by the ideas we present in this book and is waiting for a time when her energy level permits her to start a project that would be different from anything she sees going on in disability communities. For everything there is a season. Having said that, we believe that therapists who can take the plunge into this kind of civic work will reap personal and professional rewards. We certainly have.

## **OVERVIEW OF THE BOOK**

We've written this book with three main audiences in mind. First is graduate students and new professionals in the therapy field who are interested in making a difference in the world beyond their clinical work. Building in time and space for citizen therapist work at the outset of one's career may be easier than doing so after making commitments that might have to be curtailed to do this kind of work. The second audience is retired therapists

who have the time and energy for engaging in civic work. The third set of readers is experienced therapists who are itching to get involved in public work and might consider shuffling their current priorities to make room for it. Although one of the projects described in Chapter 10 is in Africa, this book focuses primarily on the U.S. context, including its democracy, which, although currently under strain, allows for citizen engagement in civic and institutional systems.

Chapter 1 completes Part I, our overview of citizen therapist work, by presenting its theoretical framework. Therein we describe the origins of our framework in Boyte and colleagues' public work model as we've adapted it to our citizen health care model.

Part II (Chapters 2–4) describes citizen therapist projects in health care: around diabetes (Chapter 2 on the Family Education Diabetes Series, our longest-standing project), on smoking cessation in a Job Corps setting (Chapter 3), and in a clinic-wide community building (Chapter 4).

Part III (Chapters 5–7) describes our work in cultural change. Two projects involve parents: Chapter 5 (Putting Family First) addresses challenges particularly pertinent to parents in middle-class families in hypercompetitive communities and Chapter 6 (Citizen Father Project) involves low-income, unmarried single fathers giving back to their community. Chapter 7 (Braver Angels) tells the story of a project on political polarization—couples therapy on a national scale.

Part IV has two chapters on projects dealing with race: the Relationships Project with young Black men in a public high school (Chapter 8) and the Police and Black Men Project (Chapter 9). The focus of both projects is on agency and building empowered relationships across differences, rather than an us-versus-them approach.

Part V includes chapters addressing how to become a citizen therapist and how to succeed in this work. Chapter 10 profiles several projects of other citizen therapists and discusses core elements of their work. Chapter 11 describes how to maintain collaborative projects over a long period. Chapter 12 offers ideas on how to get projects funded and how to evaluate them. Chapter 13 drills down on how to get started in citizen therapist work, including how to find an issue and a community and how to exercise process leadership. We also discuss lessons we learned from projects that failed to get traction. Chapter 14 addresses the citizen therapist as a person and professional, including the self of the therapist and different roles such as graduate student, community therapist, academic, and retired therapist. The afterword is a call to action and offers an important resource for readers who want to go further with this kind of work.

We have some advice for how to read this book. Start with Chapter 1 on foundations of our model, sample the chapters in Parts II through IV depending on your interest in the various issues addressed in the projects, and then focus on the Part V chapters to integrate your understanding of citizen therapist work and learn how to get started.

Here is how we envision what therapists can contribute to a troubled world. The cornerstone is that therapists believe in human agency and the capacity for constructive change. The world needs this belief and related skills to renew our civic life. This renewal of our commonwealth won't come just from clinical work in the personal sphere or from supporting the right candidates in the public sphere. We can create a new breed of public actor with exceptional interpersonal skills: citizen therapists for a troubled world.