

The Citizen Professional: Working with Families and Communities on Problems People Care About¹

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Abstract. This paper gives an overview of the idea of the citizen professional and the author's development in this way of working with communities. Citizen professionals engage deeply and democratically with fellow community members in co-creating solutions to public problems. They see the traditional professional expert and provider/consumer models as inadequate for the complex problems we face in health care, human services, government, and education. Citizen professionals aim to restore the civic nature of the professions and revive the ethic of "we the people" tackling the problems of our time. The paper also describes the principles and main strategies of the Families and Democracy Model, and illustrates the model with several community projects. The central tenet of this approach is that the greatest untapped resources for improving the health and wellbeing of families and communities is the energy and experience of people who have faced challenging issues in their own lives.

Keywords: Community, Families, Professionals, Citizenship.

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Introduction

I began my journey to becoming a citizen professional in the mid-1990s with a growing sense that my professional services as a marriage and family therapist, my collaborative work with physicians in health care settings, and my academic teaching and research were not addressing important problems in the larger community and culture. I recalled the title of a book by Ventura and Hillman (1993), *We've Had a Hundred Years of Psychotherapy—and the World's Getting Worse*. I had flirted with community psychology during graduate school in the 1970s but found its methods not clear enough at that time and its proponents too dismissive of direct services to individuals and families.

Then in 1995 I came across the work of Harry Boyte and his colleagues at the Center for Democracy and Citizenship at the University of Minnesota (Boyte, 2005; Boyte and Kari, 1996). They helped me see the limitations of the traditional professional role of expert provider to consumers or clients who would benefit from our knowledge and skills. And not just the limitations of the therapeutic model but also two other models of professional help at the community level which often involve professional experts intervening at neighborhood instead of the individual level, and the advocacy model, which often involves professional experts working on behalf of communities but not with them. What I learned was a critique of the heart of the traditional model of being a professional, and a new way of thinking about being a citizen professional, or what some writers call democratic professionalism (Dzur, 2007).

Here's a three sentence description of what I mean by citizen professionalism. Citizen professionals engage deeply and democratically with fellow community members in co-creating solutions to public problems. They see the traditional professional expert and provider/consumer models as inadequate for the complex problems we face in health care, human services, government, and education. Citizen professionals aim to restore the civic nature of the

professions and revive the ethic of “we the people” tackling the problems of our time (see www.citizenprofession.org).

Here is a longer description. The term “citizen professional” comes from recent scholarship reexamining the role of the professions in society. It emphasizes the role of professionals in rebuilding the civic life of communities in addition to their traditional role in providing specialized services to individuals. It moves beyond the late 20th century notion of the professional as a detached expert who informs other citizens but is not informed by them, who critiques social systems but does not act to change these systems, and who sees patients, clients and communities in terms of their needs but not their capacities for individual and collective action. Traditional professional ethics codes emphasize the expertise and benevolence of the professional and the importance of promoting the autonomy and wellbeing of the individual patient or client. These are essential values, but taken alone they render invisible the roles of professionals and their clients as citizens of a broader community.

Citizen professionalism is first an *identity*: seeing oneself first as a citizen with special expertise working alongside other citizens with their own special expertise in order to solve community problems that require everyone’s effort. This not just an idealistic self-image but comes from a grounded realization that the really big problems in health care, education, and social welfare—sometimes known as “wicked problems”—cannot be solved by professionals working alone, nor by government action alone. We will not make headway against the tide unless we all row together.

Citizen professionals have a *body of knowledge* about the connections between the personal and the public dimensions of their professional practice. Citizen physicians and nurses, for example, understand the connection between diabetes, the fast food industry, and cultural practices of diet and exercise.

Citizen professionals have a set of craft skills for facilitating public conversations and catalyzing public action. In the context of their regular service delivery, they are able to interweave the personal and public dimensions of the issues they and their patients or clients face. And when the

time is ripe, they are able to bring together other citizens for public conversations and local action projects to address community concerns.

When it comes to *research*, citizen professionals have access to the rich tradition of community based participatory research. This approach involves close collaboration between the researcher and a community at every stage of the project, from identifying the problem to designing interventions and evaluating the outcomes. It features a democratic process in which everyone's expertise is brought to bear to generate useful knowledge to solve community problems.

It took a few years for me to start translating these new ideas into practice. My first foray emerged from my concern that we're turning middle-class childhood into a rat race of overscheduling and overachievement, and that parents have come to see themselves as service providers to their children. I saw this disturbing development in my clinical practice and in my local community. The desire to get involved came when I began to see this problem as not just an individual family issue, but as organically connected to larger social forces (the invasion of competitive, market-driven individualism) and to community institutions (the sports leagues and ballet schools that have increasingly taken over children's lives) (Anderson and Doherty, 2005).

An opportunity for community engagement soon emerged. I was invited to give a talk to a group of parents in Wayzata, Minnesota, an upper-middle-class suburb of Minneapolis, Minnesota on reclaiming family time. Following my talk, many parents spoke up about feeling out of control regarding their kids' schedules and feeling helpless to restore a semblance of family life. Afterward, a middle-school principal confided in me, "We school leaders are part of this problem: we offer so many activities to kids that if parents agree to even half of them, they're not going to have much family life left." This brief exchange both startled and energized me. It drove home the reality that overscheduling wasn't just an individual family issue. In a hypercompetitive world, where parenting has become a form of product development, family time is a public issue.

With my newfound insight into the public dimensions of this problem, I moved to the next essential task of the citizen professional: talking with people in the community about the issue. Whenever I expressed curiosity about hockey schedules and missed family dinners and traveling leagues and cutthroat competitive dance, I was flooded with stories from exhausted, discouraged parents. When I asked my therapy clients about their daily schedules (a topic I'd previously avoided as "too superficial"), they told me at length about their harried lives.

I learned to start conversations with parents in my community by passing on stories from previous conversations, which elicited vigorous nods and even more outrageous stories to pass on--like the 4-year-olds who practiced hockey at 5:00 a.m. on nursery school days (true story). Whenever I got myself invited to speak to parent groups and church forums, I asked for more stories and invited attendees to reflect together on what's happened in our culture to bring this craziness upon us. Virtually every parent I talked to was eager to engage with this as a public issue.

It's relatively easy to get people talking about problems that bedevil their own families; it's a bigger challenge to help them connect their own stories to the community's story and to the work that lies ahead. At a town meeting in Wayzata for the launching of the Putting Family First project, I decided to address this challenge head-on. I put four questions to the 80-some parents, school board members, and community officials present: "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 group was charged up, shouting out answers to the first three questions: "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 noise level grew intense as people discussed the final question in small groups. When they all reassembled, hands flew in the air as people vied to

speaking. Parents said they were fed up with the rat race, and they were thrilled that we were going to do something about it. One mother stood up and said: “I could use something like a Good Housekeeping Magazine 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.”

The Putting Family First leadership group came into being that night. A dozen parents, representing a wide swath of the community, went on to develop a Putting Family First Seal of Approval for local organizations that offer activities for kids, and a Consumer’s Guide to Kids’ Activities, a handbook that rates all the community and school sports programs on the family friendliness of their schedules. The key to launching this initiative was the public event that captured the energy of the community and got them working together creatively. In the initial phase I facilitated the planning meetings, and then a parent leader did. That parent group put the issue of overscheduled kids on the national radar in the United States starting in the year 2000 with a big New York Times article, followed by several years of intense media publicity. In fact, the group coined the term “overscheduled kids,” which is now a widely used expression and translated all over the world (Doherty, 2003).

A short time later, I started a Citizen Professional group with students and colleagues. This led to the Citizen Professional Center at the University of Minnesota, which was founded in 2009 to train citizen professionals and do community based participatory research (Berge, Doherty, & Mendenhall, 2009). We initiated a number of projects in health care, coining terms like “citizen patient” and “citizen parent” to describe people who work for the health of the community as well as self and family. These are individuals who understand an aphorism attributed to Nobel Peace Prize winner Jane Addams in the early 20th century: “To be a good parent is to have one foot in the home and one foot in the community, because the community is also raising our children.”

The Families and Democracy Model

Through a series of journal articles and book chapters, my colleagues and I, especially Tai Mendenhall and Jerica Berge, developed the Families and Democracy Model (which we call Citizen Health Care when we work on health issues). I'd like to briefly describe the model (Doherty and Carroll, 2007; Doherty *et al.*, 2010.)

The starting point: A pressure point for families and communities. Pressure points are serious health or social challenges that are important to a community but cannot be solved by traditional programs or professional service approaches. Pressure points are usually "wicked problems" with many causes and no clear, simple solutions.

The central premise of this work is that the greatest untapped resource for improving health and social well-being is the knowledge, wisdom, and energy of individuals, families, and communities who face challenging issues in their everyday lives. The ten core principles are as follows:

1. See all personal problems as public ones too: the I and the We.
2. Look to family and community resources first.
3. See families and communities as producers, not just clients or consumers.
4. See professionals as partners, not just providers.
5. Let community members drive programs rather than programs service communities.
6. Make sure every initiative reflects the local culture.
7. Grow leaders, then more leaders.
8. Make all decisions democratically.
9. Go deep before taking action.
10. Think big, act practically, and let your light shine.

Finally, we have five key implementation strategies:

1. Identify a pressure point for professionals and for an identifiable local community.

2. Get buy-in from key institutional and community leaders.
3. For a short term consultation group: identify and meet 3-4 times with a few people who are connected to the community and have experience with the issue. If they buy into the pressure point and this democratic model of working on it, invite them to help recruit a citizen action group.
4. Form a Citizen Action Group of 8-12 people who plan the project.
5. The planning phase generally takes at least 15 meetings before taking action, and involves an organized, democratic process of going deep into the challenge, exploring community resources to address it, and developing an action initiative that is consistent with the model and is feasible within existing or readily accessible resources.

The resulting projects often involve sustained community action over years. These are usually connected to a community institution that embraces the philosophy. Some other projects are designed as short term “cultural organizing” initiatives aimed to naming a problem, activating new voices, and starting a cultural conversation locally or nationally. The citizen professional’s role is to facilitate the meetings, coach on the democratic model, and participate in the planning. This generally requires 6-8 hours per month of the citizen professional’s time.

An American Indian Diabetes Project

I’d like to tell you about one of our projects in the health care area³. American Indian community leaders and tribal elders in the Minneapolis/St. Paul area were worried about the ever-increasing prevalence of diabetes and its impact on their people. Its pervasiveness was made even more alarming by the sense of defeat that many among many American Indian people: that diabetes is expected, it will disable you, and it’s not preventable. Providers working with

³ The Appendix contains brief descriptions of several projects not described in the text of this article.

American Indian community were frustrated with the failure of conventional care and educational programs.

My colleague Tai Mendenhall and leaders in the St. Paul Area Council of Churches' Department of Indian Work approached this challenge with a community-based participatory research approach, using the Citizen Healthcare Model as a guide. Considerable effort was spent in designing a partnership with providers that was very different than conventional top-down models of care. American Indian community members succeeded in sensitizing clinical researchers regarding the process, pace, and importance of building trust within American Indian circles. As the team engaged in a series of meetings, discussions, and American Indian community events, this trust evolved. Researchers learned about AI culture, the diversity of tribes within this larger frame, spiritual and belief systems regarding health and "living in balance," and interpersonal propriety and manners. In turn, community members gained more understanding regarding how Western medicine is oriented, and thereby gained insights into providers' habit and perspectives in care delivery (Mendenhall *et al.*, 2010).

The Family Education Diabetes Series (FEDS) was designed and implemented as a supplement to standard care for members of the AI community touched by diabetes. Patients, their families (spouses, parents, children), and providers (physicians, nurses, dieticians, mental health personnel) come together every other week for an evening of fellowship, education, and support. Generally 6-7 providers, 4-5 tribal elders, and 40-50 community members attend. Meetings begin with members checking and recording each other's blood sugars, weight, body mass index (BMI), blood pressure, and conducting foot checks. Participants cook meals together that are consistent with AI cultures and traditions, and a great deal of discussion is put forth regarding the meal's ingredients, portion sizes, and relevance to diabetes. Educational programs follow (which are designed according to participants' interests and wants), and take place in talking circles and a variety of lively activities (e.g., traditional and modern music, chair dancing and aerobics, drumming and singing, impromptu theater/role-plays). Instructional topics are similarly diverse, e.g.,

basic diabetes education, obesity, foot care, stress management, exercise, family relationships, retinopathy, dental care, and resources to facilitate access to medical services and supplies. FEDS evenings conclude with devoted time for informal sharing and support. These bi-weekly series are scheduled to last for three hours, but most participants arrive early and stay late.

Quantitative evaluations of the FEDS have found significant improvement across key objective diabetes-related measures (e.g., weight, metabolic control). Qualitative evaluations (conducted within the culturally-consistent contexts of talking circles) have found that the community-owned nature of the program—and the social support and interpersonal accountability that this encompasses—is perceived as the principal driver of said improvements and change (Mendenhall *et al.*, 2010).

It is clear that clinical and lay participants in FEDS worked collaboratively throughout every stage of the initiative's development—from early efforts in relationship-building and establishing mutual respect and trust, to brainstorming the program's design, educational foci and format, public visibility, implementation, and ongoing modifications. The DIW and its clinical collaborators are now considering extending their efforts to create new programs in other areas of the community that are not readily reached by state- or reservation- sponsored care systems (e.g., inner-city, low-income American Indians). They also working to partner with local elementary and secondary magnet schools to create and implement culturally-engaging and developmentally-appropriate co-education and community/interpersonal support for youth, alongside new programs designed in partnership with and for adult American Indian men and fathers (who have historically not been well reached by conventional health care initiatives).

The Citizen Father Project

One question asked of us when we started was whether our approach could work with people on the margins of society, especially low income people

without the kind of tribal connections that many American Indians have. I got involved with the Father Project when its staff leaders heard about my community work. It's a program that helps low-income, mostly minority, single fathers reconnect with their children, land jobs, and get right with child support. Like most human services agencies, the Father Project had no role for successful "graduates," the people who were doing well now and no longer needed services.

The executive director, Andrew Freeberg, asked me to coach him and his colleague Guy Bowling in how to involve the successful men as citizens with a larger mission. I met several times with them to develop criteria for which men we'd invite to deliberate with us about whether this was an attractive and feasible project. This small group then generated a larger list, and we began to meet as the Citizen Father Project (Doherty, 2008).

These men, mostly low-income and African American, a number of whom have fathered children by several children and some of whom have committed crimes, are the kind of people that Reagan-era conservatives in the United States scapegoated as the purveyors of social breakdown and that '60s liberals viewed as victims of forces beyond their control, but these men see themselves as neither scapegoats nor victims. They know they once weren't good fathers, but now are committed to their children and invested in improving their community through a mission "to support, educate, and develop healthy, active fathers and to rebuild family and community values." I've documented the group's work and the powerful ideas and language that come up in our conversations: "We have no 'father backbone' from our own fathers." "I am tired of being a statistic; I want to be part of the solution." "We are citizen fathers, and what we do will live after us in our community."

These men are no strangers to the enduring legacy of racism in America, but they see no margin in being angry victims. They hold themselves morally responsible for lapses with their children and for getting right by them and the children's mothers. Our meetings were intense, sometimes rambling, often warm and funny, and always proud. Coached by citizen-professionals, these men are now doing community outreach to make a difference in a problem that

they see as holding their community back. They have done over 100 public presentations, and have taken on another generation of Citizen Fathers. In fact, there is now a leadership pathway in the program that goes from success as a client receiving services to helping as a co-facilitator of support groups, to mentoring other men one to one and then becoming a Citizen Father who works to change the community. Andrew and Guy, the process leaders, are learning the craft of citizen-professional work: how to guide the men as they go deeply into a personal and public issue and then develop strategic actions. Some of the men in the group have given presentations at national conferences on this work.

Conclusion

We have learned some important lessons along the way, and I want to end with them.

1. This work is about identity transformation as a citizen professional, not just about learning a new set of skills.
2. It is about identifying and developing leaders in the community as much as about a specific issue or action. This leadership development dimension of the model distinguishes it from other forms of community based participatory research and community engagement models.
3. It is about sustained initiatives, not one-time events.
4. Citizen initiatives are often slow and messy during in the gestation period.
5. You need a champion with influence in the institution.
6. Until grounded in an institution's culture and practices, these initiatives are quite vulnerable to shifts in the organizational context.
7. A professional who is putting too much time into a project is over-functioning and not using the model. We have found the average time commitment to be on the order of 6-8 hours per month, but over a number of years.

8. Substantial external funding at the outset can be a trap because of timelines and deliverables, but funding can be useful for capacity building to learn the model, and for expanding the scope of citizen projects once they are developed.
9. The pull of the traditional provider/consumer model is very strong on all sides; democratic decision making requires eternal vigilance.
10. You cannot learn this approach without mentoring, and it takes two years to get good at it.

As I finish, I'd like to share one additional learning. I've had to give myself permission to be deliberately inspirational at times, to get past the academic, professional, rational language we are trained in. As I mentioned, every project has a big bold vision while working on local, specific issues. Every project is about "we the people" tackling big problems in our communities and nation. We don't talk about "prevention," or "risk reduction." We talk about unleashing the power of democratic action, of seeing people for their gifts and capacities and not just their deficits, not just as clients or consumers but as builders of their world. As citizen parent Jael Weere from Ghana said in a citizen action meeting, "Back in Africa, we knew about pseudodemocracy; what I am seeing here is real, empowered democracy." And as American Indian healer Sam Gurnoe told me once in the early stages of my journey as a citizen professional, "Outside of a culture, a community, and spirituality, you can treat but you cannot heal." We aim for genuine healing through activating the energetic soul of the community.

References

- Anderson, J. A., & Doherty, W. J. (2005). Democratic community initiatives: The case of overscheduled children. *Family Relations*, *54*, 654-665.
- Berge, J., M., Doherty, W. J., & Mendenhall, T. J. (2009). Using community-based participatory research (CBPR) to target health disparities. *Family Relations*, *58*, 475-488.
- Boyte, H. (2005). *Everyday politics*. Philadelphia: University of Pennsylvania Press.
- Boyte, H., & Kari, N. (1996). *Building America: The democratic promise of public work*. Philadelphia, PA: Temple University Press.
- Doherty, W. J. (2003). See how they run: When did childhood turn into a rat race? *Psychotherapy Networker*, September/October, 38-46.
- Doherty, W. J. (2008). Beyond the consulting room: Therapists as catalysts for social change. *Psychotherapy Networker*, November/December, 28-35.
- Doherty, W. J. & Carroll, J. S. (2007). *Families and Therapists as Citizens: The Families and Democracy Project*. In E. Aldarondo (ed.), *Advancing Social Justice Through Clinical Practice*. (p. 225-244). Mahwah, NJ: Lawrence Erlbaum Associates
- Doherty, W. J., Mendenhall, T. J. & Berge, J. M. (2010). The Families and Democracy and Citizen Health Care Project, *Journal of Marital and Family Therapy*, *36*, 389-402.
- Dzur, A. (2007). *Democratic professionalism*. State Park, PA: Pennsylvania State University.
- Hillman, J. & Ventura, M. (1993). *We've had a hundred years of psychotherapy—and the world's getting worse*. New York: Harper Collins.
- Mendenhall, T., Harper, P., Whipple, H. & Haas, S. (2010). The SANTA Project (Students Against Nicotine and Tobacco Addiction): Using community-based participatory research to improve health in a high-risk young adult population. *Action Research*, *9*, 199-213.
- Mendenhall, T. J., Berge, J. M., Harper, P., GreenCrow, B., LittleWalker, N., WhiteEagle, S. & BrownOwl, S. (2010). The Family Education Diabetes Series (FEDS): Community-based participatory research with a Midwestern American Indian community. *Nursing Inquiry*, *17*, 359-372.
- Mendenhall, T., Whipple, H., Harper, P. & Haas, S. (2008). Students Against Nicotine and Tobacco Addiction (S.A.N.T.A.): Community-based participatory research in a high-risk young adult population. *Families, Systems & Health*, *26*, 225-231.
- Mendenhall, T. J. & Doherty, W. J. (2007). Partners in Diabetes: Action research in a primary care setting. *Action Research* *5*, 378-406.

Appendix

A. Other Families And Democracy/Citizen Health Care Projects

Students Against Nicotine and Tobacco Abuse (S.A.N.T.A.). This initiative, started in 2006 and funded by ClearWay-Minnesota, engages local providers in partnership with students, teachers, and administrators in the HHH St. Paul Job Corps community to address on-campus smoking (and the concomitant reduction of students' stressors and the adoption of healthier lifestyles). Its mission is to improve the health and well-being of students at Job Corps through smoking cessation, education, stress reduction, and support. Recently the leadership group decided to tackle another "A": alcohol problems. To develop the County's capacity to engage deeply and democratically with citizens as solvers of problems and not just clients or consumers of services (Mendenhall, Harper, Stephenson, & Haas, 2010).

Play It Forward—Paha Sapa. Emerging from concerns about childhood obesity, this project in Burnsville, MN involves parents in one neighborhood (Paha Sapa) joining together to plan joint ways for families to be active and healthy. They have held 11 informal community play events and a large event on the theme of having an active winter. All events feature parents and children playing together. Evaluation is underway.

Citizen Teen Pregnancy Prevention Project (S.M.A.R.T.: Sexually Mature and Responsible Teens). Based at South High in Minneapolis, this group has developed messages and peer outreach strategies to address teen pregnancy as a community problem. Starting with a boys group and girls group separately, the two groups combined to develop their action steps which involved teen to teen conversations at lunch tables and in one to one conversations during the school day. Supported by the Minneapolis Department of Health.

Citizen Health Care Home. Based in HealthPartners' Como Clinic, this project has developed a framework for deeper engagement of patients in a local health care community. This citizenship has three levels: personal and family responsibility for one's own health care, a vehicle to do health care together via peer Health Goal Groups, and opportunities for patient leadership development and co-responsibility for

the health mission of the clinic. The leadership group has created an Active Member Project to engage citizen patients in the mission of the clinic, and is developing an Experienced Patient Project to tap the knowledge and wisdom of patients who have something to offer those facing similar challenges.

African Family Health, Child Success. This project emerged from concerns of African immigrant community leaders in northwest Hennepin County about their children's mental health. The citizen action group identified the goal of breaking the silence in the community about the ongoing impact of war and trauma on children and families. The group developed a public performance with youth acting out their stories and those they had heard about, with big picture commentary from an elder. This is followed by a community conversation about challenges and resilience in the face of war and trauma. First performance has been held, evaluation underway.

B. Citizen Professional Training Project

Hennepin County Citizen Professional Project. The goal of this initiative is develop the County's capacity to engage deeply and democratically with citizens as solvers of problems and not just clients or consumers of services. Initiated in 2010 through the efforts of the Hennepin/University Partnership, we have worked with a group of six Hennepin professionals to learn the core principles and craft of Citizen Professional work. This group is now generating projects that engage communities in the following areas: improving the health of African American women, school readiness in the Latino community, and neighborhood improvement in a challenged area of Minneapolis. As current and new professionals engage in this work, the goal is that they will serve as resources to other Hennepin County professionals in this new way of working with communities.