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ABSTRACT

The purpose of this research is to understand the meanings and perceptions that families, teachers, and school-based service providers on the Westside in Syracuse, New York ascribe to school-based mental health services. The Westside is an economically disadvantaged and under-resourced neighborhood where children experience a great deal of stress in everyday life. Many children in need of mental health care are referred to school-based mental health service providers by their teachers. The primary motivation of this research is to understand how parents and school staff give meaning to the school-based mental health services and how these meanings affect whether they decide to access such services for their children. This research will explore what it means to the families when a child is identified as requiring mental health care and how the identification affects families. The methods I will use include in-depth interviews and focus groups with parents and guardians with children who have been identified in school as in need of mental health services. Interviews with school-based teachers, health providers and case coordinators will also be utilized. In addition to the interviews, I will conduct participant observation in the school classrooms and health offices in the four elementary and two middle schools located on the Westside. By understanding how individuals in each of these groups perceive school-based mental health services and observing the coordination and delivery of services, it may be possible to find discrepancies between perceptions. These differences may provide insight into recommendations for more effective services that meet the needs of youth on the Westside.

MEETING OF THE MINDS: PERCEPTIONS OF AND EXPERIENCES WITH
SCHOOL-BASED HEALTH SERVICES

By

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DISSERTATION

Submitted in partial fulfillment of the requirements for the
Degree of Doctor of Philosophy in Anthropology
in the Graduate School of Syracuse University

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CHAPTER I: INTRODUCTION

In 2005 Roberta Rodriguez began to see behavioral changes in her son Paul. According to Roberta, when Paul was in 5th grade he began being disrespectful to his parents and teachers, disappearing at all hours of the night, and getting into fights at school and in the neighborhood. In less than a year, he had been suspended at least a half dozen times and forced to permanently leave two different schools. As a young child he had done well in school and was always respectful. Roberta was concerned about her son and was at a loss about what to do. She was thinking about getting some sort of treatment for her son but was not sure where to turn for support.

When a teacher at her son's middle school recommended that Paul see a school counselor, Roberta welcomed the offer for help with her son. She knew little about school counseling services and was not exactly sure what to expect from them, but she was hopeful they might be able to help her son. After having such bad experiences with the schools for almost two years, she was pleased that someone in the school seemed to care about Paul. She accepted counseling services for her son and encouraged him to attend them. At first he participated in the school counseling sessions regularly, but after a few weeks he began skipping them. The school counselor referred Paul to a psychiatrist at St. Joseph's Hospital. Roberta was glad for the referral and felt that she could enforce her son's attendance at the hospital because she would be responsible for taking him and picking him up from his sessions. A year and a half later, Paul still sees his psychiatrist at St. Joseph's once a month but has chosen not to see his school counselor even though the school has repeatedly requested that he attend sessions

during school. Roberta says Paul's behavior has improved greatly and he went an entire school year without being suspended or getting into any fights.

Roberta said that she was happy that the school offered counseling services to her son and provided a referral for an external psychiatrist. She expressed that she thought it was important for schools to take on the role of offering mental and behavioral health services and referrals because it gives families an introduction into the mental health system with which they may be unfamiliar. Because there is such a great need for such services for children, public schools in America have taken on multiple roles in the community, providing not only academic services to children, but also social, physical and mental health services for entire families. Such services may be provided directly by the school district or schools can provide referrals to external agencies, and the teachers, counselors, social workers and administrators all play a role in the them. The goal of my research is to understand how school staff and parents perceive and experience schools as providers of these services, particularly as providers of child mental health care.

Due to a dearth of child mental health professionals and poor access to primary care physicians, many children and their caregivers have their first point of contact with child mental health services through the public school system (GIH 2010). I began my research wondering how families felt about schools taking responsibility for their children's mental health. I wanted to know whether families felt that schools were indeed responsible for providing child mental health services and how they perceived and experienced such services. My research evolved, however, once I began interviewing school and affiliated staff. In addition to understanding parents'

experiences and perceptions of these services, I also realized it was important to understand how those directly involved felt about their roles in delivery of the services. School staff are responsible for identifying, labeling and treating children. I wanted to understand how they felt about these responsibilities and being part of the child mental health care process.

The research presented here is based on ethnographic data collected in six public schools on the Westside neighborhood in Syracuse, NY, four elementary and two middle schools. This dissertation explores the way public school faculty and parents of children who attend public school experience and perceive school-based mental health services. First, I examine the multiple roles that public school teachers, counselors, nurses, social workers and other public school staff take on as both educational and mental health service providers. I explore how school staff feel about their role in identifying, labeling and treating children.

Second, I examine how parents experience and perceive school-based mental health services.¹ I look at how parents feel about their children receiving these services and the cultural factors that influence families' decisions about whether to use and how to engage with school-based mental health service. At the moment a child is labeled as in need of mental health services, the institution categorizes the child, and new expectations for the child are created. The act of labeling gives the child a new identity within the school that suggests that the child needs treatment to be "normalized" (Rhodes 1991). I examine this process of labeling a child as needing mental health services and the cultural factors that affect how families react to and interact with the label and service options. I use the term cultural factors to mean those factors that

¹ I provide an indepth description of school-based mental health services and labels in Chapter XXX

shape an individual's beliefs, values, perceptions and behaviors through interactions with other people. Cultural factors may include language (Helman 1990; Fabrega 1997; Hunt et al 2003), conceptual metaphors (Lakoff and Johnson 1980), religion (Ruiz and Langrod 1976; Fabrego 1997), lifestyle choices (Fabrego 1997; Hunt et al 2003), educational interests (Susser 2001; Budrys 2003), health seeking behaviors (Hunt et al 2003), community narratives (Gergan 1991; Young 1993; Harter et al 2005) and social support (Helman 1990; Barrio 2000; Korbin 2003). Cultural factors influence the perceptions of and interactions with school-based mental health services and the decisions of parents living in an economically and socially marginalized community to access or engage in these services. While school-based service providers and the local community share some cultural factors, there are also many factors that differ between the two groups that influence their experiences and perceptions of schools and school-based services.

From my preliminary research, I learned from service providers that many families do not engage with the mental health services offered to their children through the schools. I wanted to understand how the use of services is categorized by service providers and parents. I explore what it means to both groups to "use" or "not use" services. While some parents verbally accept the services, they frequently do not follow through with the long-term mental health treatments offered to their children. For example, in my preliminary research I was told by several case coordinators that parents and guardians often miss appointments or do not complete the home-based activities suggested by a counselor. My research explores the ways in which families'

beliefs and experiences with school-based mental health services align or do not align with school-based providers' beliefs about school-based services.

CHAPTER II: BACKGROUND

History of Syracuse

Syracuse, New York is the largest city in Onondaga County and often affectionately referred to as the heart of Central New York.² It has seen much change in its two centuries, including social, cultural and economic shifts. Syracuse, with a current population of approximately 140,600 people (U.S. Census Bureau 2006), began not as the heart of Central New York, but rather as a small settlement that was created due to the state's need for some extra money. In 1804, New York State sold 250 acres of salt reservation for revenue for improving the state's major road Seneca Turnpike. The purchaser of the land, Abraham Walton, developed a grist mill nearby and sold a small lot to Henry Bogardus who opened a tavern. From there, people moved, houses were built, and a town was created under the name of Cossitt's Corner (Baker 1941; Conners 2006).

When the War of 1812 broke out, military supplies needed to reach soldiers located in all parts of New York. Cossitt's Corner was well located for supply distribution, and an arsenal was erected. Although peace was declared three years later, soldiers remained in the area, bringing their families to live with them. The land was fertile for farming and the salt was plentiful, making the area a fine place for new families to settle.

The 1820s were a prosperous time for Cossitt's Corner. Because of its extensive salt reserves, good transportation was needed to haul this highly valued natural resource. A local resident, So Foreman saw the economic potential of being able to transport the salt and began work on creating a canal in 1817 (Baker 1941; Conners

² See Appendix 1 and 2 for a map of New York State and the location of Syracuse.

2006). By 1825 the canal was complete, and new businesses began popping up all along the waterway. Also during this time, a post office was developed, and Cossitt's Corner became Syracuse. In search for a more formal name, a local lawyer suggested that the town be renamed Syracuse after an Italian city that was also located near a lake and had salt reserves. The suggestion was well-received, and the current name became official.

The canal was a successful method in bringing growth and prosperity to Syracuse for the next century. By 1840, Syracuse's population rose to over 25,000 from 1,000 just 30 years earlier (Baker 1941). In addition to the canal, railroad tracks were extended to connect Syracuse with neighboring cities. The first main commercial district was located just north of the first railroad depot, an area known as Hanover Square. South of Hanover Square became residential, houses stretching south on Salina Street and east on James Street. Streetcar rails were built and provided fast transportation within the city. Syracuse grew out from these streets as the population and economy exploded. The salt industry was booming, and soon other industries developed "... to produce a staggering variety of products from caskets to agricultural plows and from lanterns to automobiles" (Connors 2006:44).

Most of the early settlers in Syracuse as a defined city were from other parts of New York and the surrounding states. But within a few decades, immigrants from Europe came to the region to work on the salt flats, the canal, the railway and the other industries that developed in Syracuse during the nineteenth century. Immigrants included Germans, Irish, French, Polish, Dutch, English, Greeks and Ukrainians. The immigrants built social networks connecting fellow immigrants from their home

countries with religious institutions, taverns and social clubs helping newcomers become integrated into their new communities in Syracuse. With good job opportunities and extended families and friends, immigrants were a lynchpin to the prosperity of Syracuse during the nineteenth and early twentieth century.

In addition to a thriving economy and booming population in the mid to late nineteenth century, Syracuse was a hotbed for anti-slavery and women's rights activism. The Underground Railroad was located nearby, and families risked imprisonment to help fugitive slaves reach Canada or find safety in Syracuse and surrounding areas (Stamps and Stamps 2008). Conventions were held in Syracuse, hosting prominent anti-slavery activists such as Frederick Douglass, John Brown and Susan B. Anthony. The third National Woman's Rights Convention was held in Syracuse in 1852. The decades that followed brought the women's suffrage movement into full swing in Central New York. Just a county away in Seneca Falls, women rights activists Elizabeth Cady Stanton and Susan B. Anthony among others started the National Woman Suffrage Association.

Although Syracuse had many features as a city, it was not impervious against the affects of industry and economy. Syracuse, like the rest of the country, was hit by the Great Depression. Many businesses were unable to remain open, and individuals lost their jobs during the 1930s. Almost 50 percent of industrial jobs in Syracuse were lost by 1933, affecting 13,000 employees and their families (Connors 2006).

During the Depression, America's first public housing was constructed, including Pioneer Homes apartments near downtown Syracuse. The apartments offered 730 families housing and a promise of escape from slum neighborhoods with fair

housing conditions (Department of Community Development 2004). Today, Pioneer Homes remains occupied, but rather than an escape from the slums, the apartments represent last resort housing for families that is not so different than the slums that the initial residents were escaping.

While the early 1930s brought some downfalls for Syracuse, the following decade brought the city prosperity once again. In the late 1930s, Willis Carrier brought his air conditioning operations to Syracuse from Newark, New Jersey bringing thousands of manufacturing jobs to the city (Carrier Corporation 2009). During World War II factories reopened to provide supplies and machinery to the military (Connors 2006). After the War and men returned home, new industry opened up in Syracuse, including electronics and pharmaceutical manufacturing. New suburban neighborhoods also began sprouting up as families sought their own housing and land.

With the influx of residents moving to Syracuse because of new manufacturing jobs and education opportunities, new roads and highways were needed. Retail was expanded out of the city and into the suburbs. At the same time, urban renewal was occurring. Municipal squares such as Clinton and Hanover Squares were renovated as a way to bring people to the city.

The opportunity for prosperity brought many families to Syracuse from around the country. Many African-Americans moved north to find jobs and better treatment than they experienced in the south (Davis 1980; Stamps and Stamps 2008). However, their arrival to Syracuse led them to live primarily in one enclave in the city, the 15th Ward, where Pioneer Homes was located. In 1950, almost 90% of African American Syracuse residents lived here (Connors 2006), and by 1987 over 96% of Pioneer Homes

residents were black (Stamps and Stamps 2008). In the early 1960s, Interstate 81 was constructed, displacing 75% of the African American population living in the 15th Ward (Stamps and Stamps 2008; Conners 2006). Unfortunately, these individuals found much of the city inhospitable for African Americans, and many were forced to turn to older and run-down neighborhoods (Davis 1980; Stamps and Stamps 2008).³ Some were able to move to other parts of the city, but they did not find much of a community in their new homes. In addition to the physical separation of African Americans, the loss of the 15th Ward also was a loss of cohesiveness and identity for those who lived there.

As African Americans moved into new neighborhoods, white families who could afford to move relocated to the suburbs. This led to even greater segregation in the city than had existed just a few years earlier. The individuals with low incomes and limited labor market skills, particularly black individuals, remained in the city in unhealthy environmental and housing conditions. Many of the poor black families lived, and continue to live, in poorly kept rental apartments. Urban rental units are often fraught with health hazards, including exposure to urban pollution and lead poisoning. Lead poisoning is associated with lowered cognitive capacity and diminished abilities to "... plan, learn from prior experience, and control impulsive behavior, impairments that are collectively termed deficits in 'executive function'" (Lane 2008:136). The environmental exposures and long-term consequences of those

³ It is interesting to note that while Syracuse was a center of human rights activism, including slavery abolition, it eventually became such a segregated city. Research on Syracuse provides little insight into this phenomenon. There may have been a change of attitude when jobs became scarce and there was more competition for employment, or it may reflect the attitudes of the newer settlers to the area.

exposures that are associated with living in poor urban areas are experienced by many families in Syracuse (Lane 2008; Stamps and Stamps 2008).

The white flight to the suburbs not only exacerbated segregation and health inequities, it also removed a significant amount of the tax base for the city of Syracuse which led to educational inequalities. When white families moved out of the cities into the suburbs, property was left vacant, and property values diminished. The decrease in city property values led to reduced property tax revenue for Syracuse. The decrease in property tax revenues affects the schools in particular as schools are primarily financially supported by property taxes. With less property tax revenue came less money for the public schools. As less money was pumped into the schools, wealthier families, particularly white families, continued to move out to the suburbs in order for their children to attend the richer and, thus, perceived better schools.

Additionally, the city and suburbs experienced political polarity. While the individuals in the city primarily vote Democrat, those living in the suburbs tend to vote Republican. Such political differences made, and continue to make, decision-making in Onondaga County difficult (Connors 2006). With loss of its tax base and difficulties in finding solidarity with surrounding political figures, Syracuse suffered, and continues to suffer, from limited resources and cohesive decision-making. Further, the manufacturing jobs slowly moved out of Syracuse to places where labor was cheaper. These shortcomings have historically made Syracuse a difficult place to prosper as a city as well as for many of the individuals living there. However, many recent efforts have been made to improve the city. A variety of initiatives and organizations have

been developed to enhance the city and the living environment for the city residents, such as the Northside Initiative and Near West Side Initiative.

Schools in Syracuse:

The earliest schools in Syracuse were housed in churches and synagogues. The cultural diversity of people in Syracuse led to the need for an array of facilities for religious services. Buildings were erected to provide spaces for services for a variety of Christian denominations and Jewish practices. These same buildings acted as the first school buildings. Later, small structures were built, and a minister or another single male would teach the children. Because many of the families were farmers, they needed their children's assistance planting and harvesting. Thus, school was in session for less than 5 months a year, from November to March (Conners 2006). Basic reading, writing and math were taught in these public schoolhouses. For families who did not need their children's help on the farm and could afford a more in-depth education, private schools were developed. Although girls were not allowed in the early public schools, many of the private institutions offered a female division where girls could learn appropriate female behavior, needlework and music (Conners 2006).

In 1826, the first formal school in Syracuse was erected. Two decades later in 1848, a public school board was formed. Jefferson School, located at the corner of Park and Court Streets, was the first official school building under the board. With 24 staff, nine men and fifteen women, the building was the first to offer high school classes in Syracuse (Conners 2006). Soon, schools were sprinkled across the city. In 1868, a high school building was constructed on West Genesee. The next year, 6,000 books were

relocated from the public library to a library in the high school, providing the school with resources for advanced and more specialized education than elementary school (Connors 2006). This high school was the only building that provided high school classes in Syracuse for over 30 years until 1902 when Central High School opened its doors.

Since the beginning of the twentieth century, Jefferson School has closed and almost 50 public schools have opened their doors to students in Syracuse. Currently, there are 39 functioning public schools in the city of Syracuse. There are four high schools, two technical schools, six middle schools, seven combined elementary and middle schools, seventeen elementary schools and three alternative schools (SCSD 2008).

The Last Twenty Years:

The last two decades brought a great deal of change to Syracuse. New industry and new people have entered the city. The early European settlers continue to have a large presence in the city, with regular festivals and events celebrating their respective cultures and religions. African-Americans make up one-fourth of the population in the city (Census Bureau 2006) and fifty-four percent of Syracuse City School District students (SCSD 2011). New immigrants have also added to the city diversity. Individuals from a variety of Asian countries have come to Syracuse, making up approximately 3.5 percent of the city population (Census Bureau 2006). Additionally, people of Latino origin have moved to Syracuse, with over 5 percent of the city population claiming Latino descent (Census Bureau 2006). Evidence of the national

and cultural diversity of the city can be seen in the variety of festivals and events celebrating their cultures and communities.

In addition to the immigrants who have moved to Syracuse for employment and family connections, the city is also home for hundreds of refugees. The Center for New Americans is a non-profit organization that works to help refugees find housing, work and community in Syracuse. The Center for New Americans offers infrastructure for refugees in the United States, and has led to an influx of refugees in the city.

While the city boasts of many cultures and festivals celebrating the diverse population, Syracuse remains heavily segregated. Due to economic shifts away from manufacturing and general poor economic conditions across the country, the people in Syracuse continue to experience job losses. Such losses hit minority groups particularly hard. Minority groups continue to suffer from the displacement that occurred when Interstate 81 was built. African and Latino Americans disproportionately live in neighborhoods with debilitated housing, limited grocery store options, poor schools and the highest rates of lead poisoning in the city (Lane 2008). Approximately 27% of individuals living in Syracuse live below the poverty line (Census Bureau 2006). An estimated 40% of individuals living in poverty in Syracuse are African Americans, despite making up only 25% of the entire city population (U.S. Census Bureau 2006).

While there is indeed crime and violence, the perception of the danger is magnified by the media and the scary stories associated with the city. Local people often refer to the city as a place of "... drive-by shootings three blocks away, drug deals out in the open, arrests, and unsupervised youth behavior" (Morrissey 2006:64). Syracuse, the Westside in particular, is associated with danger, a place to be avoided by

individuals in the city and suburbs. Such tales propagate racial and economic stereotypes and perpetuate segregation in Syracuse and the surrounding areas.

Although Syracuse remains segregated, efforts have been made to unite the city and to provide minority individuals the opportunity to find leadership roles within the city. Some neighborhoods have a much more integrated mix of people than they had just a few decades ago. For example, the Northside is a highly diverse neighborhood with over twenty nationalities represented (Robinson 2009). In 2001, the first Latina/o, Beathaida Gonzalez, was elected as President of Syracuse Common Council. The current mayoral race is comprised of two African American men. There is, of course, a long way to go before people of color have equal opportunity to hold leadership roles, but many are paving the way.

Economic development has a stronghold in Syracuse. Organizations such as the Metropolitan Development Agency and Greater Syracuse Economic Growth Council are working to provide economic viability in the city, including providing enticements for individuals to start new businesses as well as helping the current businesses prosper. Efforts are being made to revitalize the downtown area. Areas such as Clinton, Hanover and Armory Squares offer residents and visitors an array of restaurants, bars, shops, museums and historical structures.

Syracuse is also undergoing a transition to become a “green” city. This means that efforts are being made to make businesses and homes more environmentally safe. One of the biggest projects in Syracuse is Destiny, a large complex of shops, restaurants, spas, and hotels. Destiny was set to open in fall 2009, but due to a number of setbacks the opening has been delayed indefinitely. It’s development was predicated

on bringing tourists to Syracuse. There is much debate as to how successful Destiny will be in bringing people to the city, but it is currently the largest endeavor on the horizon for Syracuse economic growth.

The efforts made to help Syracuse vary in their degrees of success. However, the sentiments behind them suggest that Syracuse residents are proud of the city and willing to work to make it prosper. There remains, however, a great amount of work left to provide equal opportunities and resources to all Syracuse residents.

Westside Neighborhood

The Westside is broken into four neighborhoods: Westside, Near Westside, Far Westside and Skunk City. As the name implies, the Westside is located west of downtown Syracuse.⁴ The Far Westside is located north of West Genesee and extends west to Emerson Avenue (City of Syracuse 2009). Tipperary Hill and Burnet Park are both located in the Far West Side. The Westside is the area located between West Erie Boulevard and West Genesee Street near the North Geddes Street arterial (City of Syracuse 2009). The Near Westside is situated south of West Fayette Street between West and South Geddes Streets. Skunk City is bounded by Burnet Park on the south and Grand Avenue on the north. While the Westside encompasses a wide area, for the purposes of this paper, the term Westside will be used to refer to primarily the Near Westside and Westside neighborhoods.

The early European immigrants who inhabited the Westside were Irish and Ukrainian immigrants who came to Syracuse to work in the factories (Near West Side Initiative 2009). While many families of the early inhabitants remain on the Westside, a

⁴ See Appendix 2 for a map of the Westside.

large number of them moved west to Tipperary Hill, to the suburbs or out of the Syracuse area. Today, the Westside is comprised of an ethnically diverse population of African, Hispanic and Native Americans. Forty-one percent of Westside residents identify as African American, 30% as Hispanic or Latino, 26% as white and 2% as Native American (Near West Side Initiative 2009).

As discussed earlier, many families were displaced from their homes near downtown under the urban renewal process that occurred across the country. Urban renewal brought the destruction of homes and displaced families in cities throughout the United States (Fullilove 2004). Syracuse was no exception. The individuals who were hit hardest were those with limited resources and labor market skills, primarily African Americans who moved north at the prospect of a better life. At the same time urban renewal was taking place, many factory jobs were being moved out of Syracuse for cheaper land and labor in the south (Connors 2006). With the economic shifts in Syracuse and across the country, many businesses and factories were forced to move or close, leaving local residents with limited job opportunities. So, while poor urban families were being displaced, they were also losing their jobs.

With limited options, poor urban families began to take up residence in the older homes located west of downtown. The housing to which they were relocated was old, debilitated housing that had been abandoned for decades by the original residents for more modern homes on Tipperary Hill and the suburbs. Further, the poor were concentrated in undesirable neighborhoods with limited access to community resources such as grocery stores or good schools (Fullilove 2004; Lane 2008). When families are uprooted to new neighborhoods, there are negative consequences. Mindy Thompson

Fullilove (2004) uses the term “root shock” to describe the experiences of individuals who are displaced from their homes and community. Root shock, at the level of the community, be it neighborhood or something else, ruptures bonds, dispersing people to all directions of the compass. Even if they manage to regroup, they are not sure what to do with one another... The elegance of the neighborhood-each person in his social and geographic slot-is destroyed, and even if the neighborhood is rebuilt exactly as it was, it won't work (Fullilove 2004:14).

In Syracuse, the individuals who were displaced and relocated to the Westside no doubt experienced this type of root shock. Individuals were sent to neighborhoods based on where cheap housing was available, which was rarely where they would have moved by choice (Kreisberg 1970). Families experienced both traumatic loss of their familiar everyday lives and their mechanisms of community functioning (Fullilove 2004).

As a result of urban renewal and economic shifts, the Westside neighborhood remains an extremely disadvantaged and under-resourced community with high poverty rates. Over 50% of the people living on the Westside are estimated to live below the poverty line (Near Westside Initiative 2009), and 81% of students in Syracuse public schools receive free or reduced lunches (SCSD 2011). With poor economic opportunities comes a great deal of barriers to safety, education, healthcare and other resources.

In her dissertation on the WIC program in Syracuse, Suzanne Morrissey argues that “... a history of racism and segregation in Syracuse affects the services available to residents, contributes to violence and the perception of danger in certain neighborhoods,

and in turn, impacts the movement, activities, and health of residents” (2006:47).

Families living in impoverished urban communities experience harmful affects on their physical and mental health (Budrys 2003; Cockerham 2007). High pollution, diabetes, heart disease, lead poisoning, theft, rape, drug abuse, homicide and other health and safety problems are disproportionately found in poor urban areas (Susser 2001; Cockerham 2007).

Children are vulnerable to the health hazards of living in a poor urban environment. The health problems associated with poverty can begin in the womb if a mother is exposed to environmental risk factors such as smoke, alcohol, and pathogens or unable to get adequate food (Wadsworth and Butterworth 2006:32). Poverty is associated with malnutrition (Frerer and Vu 2007). As children grow up and develop physically and mentally, they require a certain amount of nutrition. Without proper nutrition children may experience problems in their physical and mental development. Many parents on the Westside are not able to afford adequate amounts of nutritious food, and there are limited options for places to purchase fresh fruits and vegetables on the Westside (Lane 2008).

The houses on the Westside are old and have not been well-maintained. Families often rent their homes, and landlords frequently do not make appropriate repairs to their rental properties. Many old houses were painted with lead paint that has not been removed or contained. Children who live in houses with lead paint are exposed to paint chips that can be eaten or inhaled, leading to lead poisoning. As discussed earlier, lead poisoning can have negative consequences on children’s cognitive abilities (Lane 2008). Additionally, the housing units are often crowded with

years of dust and dirt built up in them. Such conditions can lead to asthma and the spread of pathogens, affecting the health of the adults and children who live there (Frerer and Vu 2007).

Although the Westside is an economically disadvantaged area and has the issues associated with being a poor urban community, there are also a variety of positive aspects of the Westside community. There is a rich history and strong community for many who live on the Westside. Some of the oldest and most historical homes in Syracuse are located there. St. Lucy's Church acts as a community center for many local residents, including holding Latina/o "town hall" meetings. Members of the Latina/o community congregate at St. Lucy's for community meetings, religious services and cultural festivals. Churches on the Westside also play an important role in the African American community, offering support and escape from some of their everyday problems (Stamps and Stamps 2008:178).

The Westside is home to the Burnet Park and Zoo as well as an array of ethnic restaurants and grocery stores. Local residents can dine at Mexican, Dominican, Puerto Rican, Cuban and Afro-Caribbean restaurants. Festivals and events are held regularly to celebrate the cultures and religions of the people who live on the Westside. Throughout the year, community facilities, such as local schools and churches, hold carnivals and barbeques for local residents.

There are also a variety of organizations and initiatives working to provide services and neighborhood improvement projects on the Westside. The Near West Side Initiative was created to "... combine the power of art, technology, and innovation – with neighborhood values and culture – to revitalize Syracuse's Near West Side

neighborhood” working “... with the people and assets that already exist in the community to help create grassroots growth” (Near West Side Initiative 2009). The Spanish Action League and Syracuse Area Latinos United against Disparities are both located on the Westside and work to provide services for the local Latina/o community. Additionally, the West Side Learning Center and Partners in Learning offer educational services, focused particularly on immigrant populations.

The community resources and initiatives may have positive impacts on the neighborhood, but poverty and inequities remain. For many families living on the Westside, everyday life can be difficult. In addition to the exposures to health hazards, parents must also live with the reality that their children will likely be exposed to other children who use illegal drugs, own a gun, and have dropped out of school. Such exposures will likely have an impact on their children’s behaviors. Behaviors are influenced by neighborhood conditions, including population density, arrangement of housing, behaviors of neighbors and local institutions (Kreisberg 1970:43). For example, in a neighborhood where housing is small and crowded, children and teenagers may be more likely to congregate outside the home on street corners away from parental supervision. Additionally, parents who work to be able to support their families may not be able to afford child care, and many children are left at home alone. Such circumstances may lead to behaviors that are less likely to occur if the children were able to be comfortable at home with supervision of a parent (Kreisberg 1970).

Louis Kreisberg (1970) argues that individuals living in poverty are less likely to have stable employment or housing, and children who live in poverty often live in an environment of instability and learn behaviors that are an “accommodation of their

circumstances” (1970:2). This means that children may behave in ways that are not congruent with norms of those who do not live in poverty, including the expected behavioral norms in schools. For example, in a home where a child has a single mother who works two jobs with daily concerns whether she will lose her job or be evicted from her apartment because she is unable to pay rent, a child may learn to get attention from his distracted mother by yelling loudly or running around the house. When a child learns such behaviors at home, they may transfer to their behaviors at school. School staff may see these behaviors as indicative of a mental health problem and the child may be labeled as needing mental health services. My research examines the way in which parents perceive and experience being introduced to the mental health system via the perception that school staff have of children’s behavioral responses to their everyday experiences on the Westside.

History of Mental Health Services in Syracuse

In 1869 St. Joseph’s Hospital, the first general hospital in Syracuse, was founded by Franciscan Sisters (Luft, Potash and Schneiderman 2008). It provided medical care as well as clinical teaching facilities for medical students at the Syracuse University College of Medicine. The building, located on Prospect Avenue, remains an active hospital with a slight name change to St. Joseph’s Hospital Health Center. Three years after St. Joseph’s Hospital opened, Good Shepherd was founded by the Episcopal Diocese of Central New York (Luft, Potash and Schneiderman 2008). Like St. Joseph’s Hospital, Good Shepherd provided training facilities for medical students. Good

Shepherd was originally located on East Fayette Street. After several moves, it was moved to its final home on East Adams Street.

Syracuse Women's Hospital and Training School for Nurses opened its doors in 1887 as the primary health care facility for women and children (Luft, Potash and Schneiderman 2008). In 1908, it began admitting men, and ten years later the name was changed to Syracuse Memorial Hospital. In 1902 Crouse Irving Hospital was founded across the street from Syracuse Memorial. They operated independently for over sixty years until they merged in 1968, taking the name of Crouse Irving Hospital and later becoming just Crouse Hospital. The Syracuse Veterans Administration Medical Center opened its doors in 1953. When Syracuse University College of Medicine was sold to SUNY in 1950, SUNY merged several medical facilities to create SUNY Upstate Medical Center, including University Hospital, Good Shepherd, Syracuse Memorial Hospital, Syracuse VA and St. Joseph's Hospital (Luft, Potash and Schneiderman 2008).

While medical facilities were being established in Syracuse, across town a different type of facility was being developed. In the nineteenth century, mental health care was not considered the responsibility of hospitals. Rather, separate institutions were created to deal with individuals suffering from mental illnesses and disabilities. In 1846 the New York State Asylum for Lunatics issued a report recommending that an asylum be established (Luft, Potash and Schneiderman 2008). The New York State Asylum for Idiots was originally located in Albany but was moved to Syracuse in 1855 to provide a more central location. After a succession of name changes, it finally became known as the Syracuse State School and took on the primary responsibility to

care and educate New York children who had a mental illness or disability. In the 1970s students were slowly moved into the community as part of the deinstitutionalization movement in the United States. The institution was eventually closed in 1998 (Luft, Potach and Schneiderman 2008).

When the State Asylum became the State School for children, a need arose for mental health care for adults. In 1930 the Syracuse Psychopathic Hospital was founded by the Dean of Syracuse University College of Medicine. A year later the name changed to Syracuse Psychiatric Hospital (Luft, Potash and Schneiderman 2008). In 1972 the Psychiatric Hospital moved under the auspices of the New York State Office of Mental Health and became known as Hutchings Psychiatric Hospital (University Hill Cooperation 2009).

In 1964 the Syracuse Regional Advisory Committee on Mental Health was established to work together with other New York State Regional Committees to develop a comprehensive mental health program for the State (Gosline et al. 1964). At the time of establishment, the Syracuse Mental Health Region had over 20 clinics, hospital, and schools providing public and private mental health services. The goal of the Committee was to assess and evaluate the current facilities and resources, identify and assess the deficiencies of the local agencies and professionals providing mental health services, and collect and analyze data about the mental health patterns and trend in the population (Gosline et al. 1964). Nine subcommittees were established to accomplish these goals in different areas of mental health care. Two of these subcommittees were the Subcommittees on Mental Health Services in Schools and Mental Health Services for Children. At the request of the Department of Mental

Hygiene and the State Department of Education, questionnaires were not circulated through the schools. Therefore, information about the school-based mental health services remained limited and no recommendations were made (Gosline et al. 1964).

A year later, the Subcommittee of Mental Health Services for Children worked in conjunction with the Child Welfare Study to administer questionnaires to facilities that provided mental health care to children. The two-page questionnaires asked for information about the children needing mental health services, the types of services that were requested for children, the current available services and the path for those children who were unable to access appropriate services (Gosline et al. 1964). The results of the study led the researchers to recommend that services be consolidated for all children with mental illnesses, mental disabilities and other handicaps in order for the state to provide more efficient services at the most affordable cost (Gosline et al. 1964). All administration and record keeping would occur at a centralized location while the actual services would continue to be provided by the current institutions that were providing mental health services for children.

This report was a contributing factor to the role the state played in the development and delivery of child mental health services in Syracuse. Once all public institutions became part of a single unit, the State believed that there would cease to be a duplication of services (Gosline et al. 1964). Unfortunately, there were no published reports of subsequent studies that evaluated or discussed how effective consolidation was in terms of saving the State money or reducing the duplication of services.

However, this report set the stage for public and community mental health services for

children across New York State. Since the 1960s child mental health care has been integrated into public and nonprofit health facilities and social service agencies.

Current Child Mental Health Services

Today, the primary medical facilities that provide mental health services in Syracuse are St. Joseph's Hospital, Hutchings Psychiatric Center and the Comprehensive Psychiatric Emergency Program (CPEP) housed out of St. Joseph's Hospital Health Center. Hutchings offers 105 adult inpatient beds and 30 child/adolescent inpatient beds. There is no separate inpatient facility for children or adolescents in Onondaga County or the surrounding areas who need inpatient mental health services. Hutchings offers children and adolescents out patient day treatment and clinic programs.

CPEP provides psychiatric evaluation and stabilization for adults and children suffering with an acute mental health crisis. There are no long-term inpatient beds at CPEP. There are four emergency observation beds in which an individual is observed and stabilized for no longer than 72 hours. Upon release, a patient is referred to community resources. If a patient does not have housing in which s/he can return, CPEP will refer the patient to crisis residence at Hutchings Psychiatric Center. If a patient is not safe to return home, s/he can be admitted into Hutchings as an inpatient resident. CPEP acts as an entry point to the mental health system for many adults and children.

Part of CPEP is the Children's Health Innovation Project (CHIP). CHIP provides the following services: 1) training for pediatricians, primary care physicians,

nurse practitioners and other health professionals who may encounter children with mental health service needs, 2) an annual conference on planning, organizing and administering mental health services to children, 3) referral resource for families seeking child mental health services, 4) resource directory of child mental health services in Onondaga County.

Although there are efforts being made to train pediatricians and primary care physicians to screen and diagnose child mental health problems, schools remain one of the primary methods by which children are identified as having physical and mental health problems. Schools have taken on a primary role in helping families identify when they think a child needs mental health services, locate mental health care options and coordinate the services.

CHAPTER III: METHODOLOGY

I conducted two years of ethnographic research in the Westside neighborhood of Syracuse, New York. In order to conduct my research, I applied for and received Institutional Review Board consent from both Syracuse University and the Syracuse Public School District. I observed and conducted interviews at community events and in two middle schools, four elementary schools and one K-8th grade school on the Westside.

My observations and interviews were conducted with both school district and affiliated staff as well as community families with children who attended public schools on the Westside. Perspectives are structured and historically rooted and will vary not only by the individual's role in the institution, but also their role and position in society as a whole (Campbell 1998). Because a person's position in a community or institution greatly influences how that person perceives the world, it is necessary to explore "... not only vertical relations but also upon horizontal and diagonal relations, both within the organizations and among organizations" (Whyte 1978:142). This means that in order to fully understand the workings of an institution, I needed to interview individuals at all levels of the institution, from individuals at the top bureaucratic level to individuals on the "front line" to people served by the institution, as well as look at the relationships between individuals at each level. My observations and interviews were conducted at all these levels.

School Ethnography

I conducted a year of ethnographic research in six schools in the Westside neighborhood of Syracuse, New York. I volunteered in one elementary school for two years, working in different classrooms and with students one-on-one. Volunteering allowed me to observe while being an active participant in the schools to get a first-hand look at the behaviors and interactions of school staff and students. As a volunteer I worked with a variety of students from ages 5 to 13 years of age. Sometimes I worked as an extra support person for an entire class, engaging students who needed help on an assignment. For example, one young boy in Kindergarten was unable to correctly identify or write all the letters in the alphabet. During writing practices time, I would assist him in writing his letters and practice saying them. At times I would work with a student individually outside of the classroom who needed extra help in specific areas that were not necessarily being addressed in the classroom. I worked with one second grade boy once a week on time and money. We had a variety of activities where we would practice telling time with a paper clock or play “store” where he could purchase items by providing the correct change. Such activities gave me an opportunity to work closely with both teachers and students.

My time in the schools also gave me the chance to observe different aspects of the school. I took every opportunity I had to come watch school programs, take a sick student to the nurse’s office, walk a student to the office or just hang out in the communal areas such as the library or cafeteria. I was able to observe classrooms, administrative offices, the teacher’s lounge, and the nurse’s office. I kept detailed field notes about my experiences and observations.

While observing and participating is helpful in gaining insight into the physical structure, patterns of behavior, and interactions of a cultural phenomenon, our ability to truly understand these observed aspects is limited without understanding what they mean to those who participate in them (Tierney and Dilley 2002). Interviews are the most common qualitative method used in institutional research (Tierney and Dilley 2002). Conducting interviews offers the researcher the opportunity to learn the way in which meaning is assigned cultural phenomenon, structures and interactions. Interviews provide social researchers with “biographical meanings of observed interactions” (Warren 2002:85). In other words, the individuals who are interviewed about their experiences and perception are “native speakers” in which they have inside knowledge about a culture and interactions within that culture that a researcher observes (Spradley 1979). Interviewing is the primary method used to understand how participants give meaning to the institution, institutional goals and activities, and their own roles in the context of the institution.

I interviewed 24 individuals who work in the public schools. Fifteen participants were public school employees who worked in two different schools, an elementary and middle school. They included teachers, social workers, school counselors. All of these interviews were audio recorded. Unfortunately, no school nurse was willing to engage in a formal interview, so I was not able to conduct a recorded, semi-structured interview with a nurse. However, I did engage in informal discussions with two school nurses while I was in the schools. Nine participants I interviewed were affiliate service providers who worked in six different school

buildings but are employed by an outside agency.⁵ Nineteen interviews took place in the schools, either in the classroom or an adjacent room. The remaining interviews took place at a local coffee shop. I also had informal discussions with two school principals and over a dozen mental health service providers who work with children outside the public schools in either hospitals or community agencies.

Each interview I conducted was a semi-structured interview. Semi-structured interviews involve a general guide of open-ended questions and cover a list of topics (Bernard 2002). The reason I chose semi-structured interviews is because they allow for flexibility in the order that questions are asked and in the answers provided. Semi-structured interviews allow anthropologists to focus on the specific cultural phenomena, but trade generalizability and comparability for internal validity and contextual understanding (Maxwell 2005). They are a good method of getting information from individuals about specific topics while allowing the participants to incorporate relevant information that may not have been included in the original questionnaire. They offer some degree of control over people’s responses so that an anthropologist can obtain relevant information from the participant while at the same time offering the participant the opportunity to provide information that may not be specifically asked for in the interview (Spradley 1979).

Table I: Interviewee Characteristics

	Male	Female	Total
SCSD Employees	2	13	15
Teachers	2	10	12

⁵ When I began my research, six of the external staff I interviewed held positions with the Westside School Strategy. However, when the Strategy merged with Say Yes to Education, their positions changed. In general, I refer to them as case coordinators because that was the position they held when I first interviewed them. However, they currently hold a variety of new positions within Say Yes, including site directors and program coordinators.

Social Workers	0	1	1
School Counselors	0	2	2
External service providers housed in SCSD schools	2	6	9
Case Coordinators	3	4	7
Mental Health Counselors	0	2	2

Community Ethnography

In addition to interviewing school and affiliated staff, I also interviewed parents of children who attended public schools on the Westside. I conducted unstructured interviews with ten parents, nine mothers and one father. Unstructured interviews are interviews where there is no predetermined script, and guided primarily by the responses of the person being interviewed. The unstructured interviews I conducted took place in public settings, such as neighborhood gatherings and city celebrations. I met the parents at these events and discussed their experiences with the public schools. Many parents explained that they would be happy to talk to me about their experiences at the events, but they were not prepared to meet me elsewhere or at another time for a formal, structured interview. However, the unstructured interviews had their benefits. They allow individuals to open up on their own terms, about topics that are most salient to them and at their own pace (Bernard 2002). Most anthropologists will conduct at least a few unstructured interviews. While in the field, anthropologists will at some point have the opportunity to just sit and talk with a community member or other relevant person to the research topic without a scripted questionnaire. When this happens it is important to let the individual guide the interview. As Bernard explains,

the goal of an unstructured interview is to “... get people onto a topic of interest and get out of the way” (2002:209).

I also conducted semi-structured interviews with four mothers in their own homes. I was able to gain access to these four parents by sending out a request for participants through local community service agencies. Initially, I began my research intending to access the community through snowball sampling. Snowball sampling is accomplished through social networks of the participants. It involves a researcher acquiring from one participant the name or names of other individuals who meet the criteria of potential participants and might be interested in being interviewed as part of the research project (Arksey and Knight 1999; Warren 2002).

I intended on meeting a couple of parents and having them introduce me to other parents who might be interested in participating. However, when I requested names and contacts of other parents who might be interested in talking about their experiences with the public schools, I was given no names. I was told by each parent that he or she did not know any other parent who might be interested in participating. I talk more about this in Chapter five, but it is important to note that I was not successful at snowball sampling. My access to parents was dependent on my participating in community events and through community service agencies gracious enough to let me advertise my quest for research participants.

Narrative Collection

Part of studying human perceptions and experiences in a given community or institution involves describing and interpreting how people behave, “... the functions

they perform, and the interrelations among the hierarchal structures” (Britan and Cohen 1980:3). In order to understand people’s behaviors, it is necessary to understand how they interpret their own behaviors. By gathering narratives of individuals in both the community and within the institution, it is possible to understand how people make sense of their own experiences and behaviors. Narratives are accounts people provide about beliefs and experiences as a way to provide meaning and knowledge of self and others (Harter et al 2005; Gergan 1991). They express the “... lived sociocultural and political contexts in which agents construct, share and revise stories” (Harter et al 2005:8) about individual lived experiences.

Narratives are the primary way individuals can make sense of and give meaning to their experiences, mediating “... between an inner world of thought-feeling and an outer world of observable actions and states of affairs” (Garro and Mattingly 2000:1). In Myrna Sayles’ (1978) research on counselors in prisons, she was struck by the amount of emotion that the counselors put into their work. Individuals who work in large institutions, such as schools, are not just unemotional puppets of the organization; they are “... highly emotional and increasingly meld their personal lives and feelings into their jobs” (Sayles 1978:215). Sayles (1978) exhibits the importance of anthropologists’ acknowledgement of the significance of the emotional involvement of the staff members in the school and not perceive them as robots in the institution. To understand individuals’ emotions and how they perceive their role and the role of those they serve, it is necessary to listen to their narratives about their personal feeling about their work and the institution in which they work. By asking individuals to give their

own story about their experiences, I was able to uncover the emotions of the participants of the study.

Personal narratives rely on personal experiences “... to illustrate problems, shape arguments and engage emotions, as well as to persuade, evaluate, reward and punish” (Japp 2005:55). They are particularly useful in understanding individual and group experiences with an institution. Narratives connect personal and institutional experiences (Japp 2005). They helped me understand the meanings given to behaviors in the context of the institution. The way I began each of my narrative collections was by asking participants to tell me about their experiences with the public schools. For example, when I spoke with school staff members for the first time I often began by asking them to describe their experiences as a person in their professional position in the schools. Such a question opened up the chance for school staff participants to discuss their experiences in their own way without constraints of specific prompts. Some school staff began by describing their roles and duties within the school. Others started their response by explaining the difficulties of their job.⁶ And other staff members began by describing specific examples of experiences they had with parents or other staff members. While initial approaches to this probe differed, all staff participants discussed their experiences and feelings about their schools, school-based services, students and parents.

When I first interviewed parents, I began by asking them about their experiences with their child’s school. Like the school staff, parents began in different ways. Some began by talking about their general feelings about the school while others began with a

⁶ Difficulties of the job included lack of resources and feelings of limited support networks. I will discuss these topics more in Chapter 4.

narrative about a specific interaction they had with a school staff member. But the stories that emerged from all the interviews were based on interactions with individuals in the school, including school staff members, other parents, and other students.

Behaviors and interactions have different meanings for institutional employees and community members (Ryen 2002). For example, a student in the classroom who frequently spoke in a very loud voice was viewed by a teacher I interviewed as too excited or in need of too much attention. The teacher gave a narrative about how this student had emotional problems that needed to be addressed by his mother and possibly through school-based services. However, the child's mother explained that they lived in a small space with a lot of people, so her son just learned to yell to be heard. Her narrative included an anecdote about how her son was treated as a disciplinary problem in the classroom, but she did not think that it was a problem that her son spoke loudly. She did not perceive his loud voice as indicative of any behavioral health issue that needed to be addressed. Through listening to the two narratives it is possible to understand the difference in meanings that school staff and parents give to behaviors. Such a discrepancy in meanings given to a raised voice can create miscommunication and cause a child to be labeled as having a mental or behavioral health problem when in fact the child was acting in an everyday behavior that is acceptable in his own home.

Narratives are also an important avenue to understanding health care experiences because they "... wrestle with complexities that face contemporary health care participants: identity construction, order and disorder, autonomy and community, fixed and fluid experiences" (Harter 2005:8). Narratives reveal the way in which individuals construct their illness and represent personal experiences with attempts to

obtain moral, medical and public legitimacy of their illness (Japp and Japp 2005).

Through narratives, individual perceptions of an illness as well as their experiences are expressed.

When I asked for parents to tell me about their experiences with school-based behavioral or mental health services, one of the main themes that emerged was their construction of their child's behavioral or mental health problem. I talk more about this in chapter eight, but I will note here that I did find that the narratives parents gave did address the way in which they understood their child's label as in need of mental or behavioral health services, how the label affected their child and their family, and how they felt about their involvement in their child's treatment. Parents' narratives provided insight into the meaning that they and their children gave to the labels, services, and service providers.

While collecting narratives, I found that many of the participants appreciated having someone to whom they could tell their story. I was told on several occasions that they liked having an opportunity to tell their story. I say this not to pat myself on the back but rather to acknowledge that narratives are not only an anthropological method for data collection, but also a cathartic medium for those giving the interviews. In a way, it is an opportunity for anthropologists to provide something in return to participants while those participants are providing a service (i.e. participation) for the anthropologist. I did make sure I was clear that while my goal was to provide an avenue for both parents and school staff to express their thoughts and experiences, I could not guarantee any outcomes.

Data Analysis

The primary method for analysis for an anthropologist is field work which involves interviews and participant observation. The mechanics of fieldwork include establishing rapport, gathering field data through interviews and observation, organizing relationships and strategies for leaving the field (Gubrium 1988:10). My data analysis involved the interpretation of these mechanics. Data collected from fieldwork tells you how to "... convey the field's everyday realities and its member's common philosophical engagement" (Gubrium 1988:10). Analysis involves the interpretation of meaning. Individual's interpretations of events and perceptions are based on their lived experiences as well as the structure within which the experiences occur (Gubrium 1988).

Ethnographic research involves the interpretation of the meanings of the terms and concepts of the participants. For a researcher to understand a participant's meanings, she must be able to interpret the applications of the meanings to specific situations (Holstein and Gubrium 1994). This means that I not only needed to outline specific meanings given to events and structures, but also understand the context in which those meanings exist. Interpretation involves conceiving a cultural phenomenon "... in terms of its own poetics – its metaphors, tropes and other forms of representation" (Atkinson and Hammersley 1994:258). I discuss cultural metaphors of schools and school-based services in chapter seven. The interpretations that an anthropologist derives from the data should be based on the cultural framework of the participants, using their categories and descriptions to give meaning to a cultural phenomenon (Holstein and Gubrium 1994).

Interpretation of observations and interviews is often a descriptive analysis that explains the lived experiences of those who are studied (Denzin and Lincoln 1994). To interpret ethnographic data means to situate cultural phenomenon in a local context that defines and constitutes the phenomenon being studied. My goal was to stay as true to the cultural framework of my participants as possible. I did this by double-checking with participants my own interpretations of what I saw and heard to help ensure that I understood their perceptions and meanings.

I began each semi-structured interview with a general guide of questions and followed up with probing questions (See Appendices A and B for questionnaires). The semi-structured interviews with school staff and parents were recorded. After each interview, I transcribed the audio recordings. For the semi-structured interviews with the six affiliated staff and unstructured interviews with parents where I was unable to audio record, I took in-depth notes.

Comparisons between what individuals said and did are critical to analyzing data. Comparisons can be developed through coding. An anthropologist can code both field notes and interviews. Both involve pulling common themes from the data. Coding can be very precise, involving exact tabulation of the number of times a response is given and expressed in numbers (Bernard 2002). More frequently, however, anthropologists will pull out themes in order to uncover patterns in interview responses and observations. This is how I conducted coding for my interviews. I extracted themes in order to uncover patterns in interview responses and observations. Immediately following each of these interviews I formalized my notes. From the formal transcripts and outlines, I coded each interview using Nvivo 2.0. I transcribed

each interview and imported them into Nvivo. I developed nodes, or themes, using a “bottom-up” approach by creating nodes based on themes that arose from the data.

Coding requires an anthropologist to make judgments about what are the same concepts in different words (Weller and Romney 1988). This means that while participants may use different words an anthropologist will make decisions about how those words compare to what other participants say. To help to ensure the accuracy of these judgments about what people mean, I asked for clarification in the interviews. I asked follow-up questions during the interviews with school staff and parents and repeated what I believed I understood to ensure that I was understanding them correctly. For school staff, I was able to have follow up discussions to help make clarifications. This was a particularly useful method in later interviews after I began to develop an idea about the types of themes that frequently arose in the interviews. Unfortunately, I did not have repeat access to parents, so I was unable to engage in follow-up interviews.

With the coded interviews with school staff and parents, text analysis, observations and collection of narratives, I triangulated my data. Triangulation involves using multiple methods of data collection in order to understand a cultural phenomenon. By using multiple sources of data I was able to make comparisons and cross-check information between the data sources. Triangulation enhances the “scope, density and clarity” of the structures and behaviors that are being studied (LeCompte and Preissle 1993:48). Multiple data sources gave me several perspectives of school-based mental health services.

One elementary school teacher gave me access to her employee handbook. To analyze the school handbook, I examined what information was included and absent

regarding school-based mental health services. I looked at the handbook to see if there were official protocols to help staff make decisions about students who may benefit from mental health services and guidelines on how to find services for their students. Many teachers and other staff members developed their own protocols on how to interact with students they believed could benefit from mental health services without any official guidelines. Many staff members said they developed procedures on how to interact with students based on their personal experiences with students and the experiences of other staff. My examination of the handbook and observations and interviews with staff suggested there was a lack of official procedures provided by the school administration on how to decide when a student needed mental health services or how to help them find such services. The absence of official guidelines led staff to work with each other to develop their own procedures. The handbook played only a small role in the decision-making process of staff on their treatment of students they felt needed additional services for mental or behavioral health problems.

While the core methods of anthropological research are ethnographic interviews and participant observation, the other data collection techniques are used to compliment the ethnographic approach (Rubinstein 2008:57). Triangulation is a method for testing preconceived notions as well as validating what I observed (LeCompte and Preissle 1993). Triangulation of my interviews, observations and text analysis helped validate my interpretations of what people said and what I observed and other assumptions I made before and throughout my research. Through these methods, I conducted my research on experiences with and perceptions of school-based mental health services. I was able understand the relationship between school policies, staff and parents'

behaviors and interactions, and their perceptions of school and school-based mental health services.

CHAPTER IV: SCHOOL-BASED MENTAL HEALTH SERVICES

Since the beginning of the twentieth century, schools have played a large role in providing health care for children. In 1924, the nine school physicians working in the Syracuse Public Schools reported making 14,981 physical examinations of children in schools during the academic year (Palmer 1925). These examinations were part of the Syracuse Health Demonstration, a program established to promote hygiene among school-aged children. Under the Syracuse Health Demonstration, children were inspected once a week by a school nurse. Children who exhibited signs of having a contagious illness were sent to have physical examinations, which often led them to be excluded from school activities if they were found to have what was believed to be a contagious disease. The Demonstration also introduced nutrition classes, open air schools, and personal and oral hygiene programs to the Syracuse Public Schools. Joseph Palmer (1925), the Director of the Division of Health Supervision of School Children during the 1920s, maintained that the Syracuse School Demonstration was a successful program that reduced illness caused by poor personal hygiene as well as the spread of contagious diseases in the public schools.

The Syracuse School Demonstration has long since disappeared from the Syracuse Public Schools, but the idea of health care being integrated in the schools remains. There are 11 health attendants and over 45 Registered Nurses working within the Syracuse School District's 39 schools, with at least one nurse in every school (SCSD 2008). School-based health services are an important component to the education system in Syracuse. Because many students live in poor communities, they are exposed to a high rate of physical and emotional stressors that can lead to health

problems. Poor physical and mental health can lead to poor academic performance. High school completion is associated with better health outcomes in the future, and there are a number of poor health outcomes for individuals who do not complete high school. Lacking a high school education is correlated with fewer job opportunities, lower incomes, and lack of health insurance. Individuals who graduate from high school live longer on average, are less likely to experience an infant death, and be healthier throughout their lives (Lane 2008). The importance of good health on academic performance and positive health outcomes in the future has led to schools taking on the responsibility for screening and providing health services for students who may have limited other health care options.

At the beginning of the twentieth century schools had one of their earliest interventions to deal with health issues in schools. Specifically, nurses were in charge of helping prevent the spread of communicable diseases. By the end of the twentieth century, the role of school nurses expanded to facilitate "... normal development; promote health and safety; intervene with actual and potential health problems; provide case management services; and actively collaborate with others to build student and family capacity for adaptation, self-management, self-advocacy, and learning" (NASN 2002). And in the last decade the role of school nurses has evolved to include screening and referring students for a wide variety of health issues, caring for school staff members, promoting a healthy school environment and acting as a liaison between schools, parents and the local community (NASN 2002).

School health care has expanded to include not only addressing physical health care needs, but also mental and behavioral health care. As school nurses have taken on

more extensive roles, additional positions have opened in schools to assist in health-related needs for staff, students and their families. Such positions include school psychologists, counselors, social workers, program coordinators and case managers, all of whom may be responsible for identifying or treating a child who they believe needs mental health care services. Mental health services refer to treatment that addresses mental and emotional health problems that are collectively referred to as mental disorders. The Surgeon General defines mental disorders as "... health conditions that are characterized by alterations in thinking, mood or behavior (or some combination thereof) associated with distress and/or impaired functioning" (USDHHS 1999). Mental health services refer to any services that address these conditions, regardless of whether an individual has been officially diagnosed with a mental illness. Many mental disorders may meet the above description but are not sufficient enough to meet DSM-IV criteria for a diagnosable mental illness.

Mental health problems are connected with living in poverty.⁷ Long-term exposure to financial strains, poor housing, limited social support networks and the fear of an unsafe living environment all contribute to stress in daily life, especially when opportunities to escape these conditions are perceived as limited or impossible (Brunner and Marmot 2006:13). Many of the residents on the Westside were driven there because of urban renewal projects and not by choice. Community connections that were severed may not have redeveloped for many families, exacerbating stress levels with limited social support (Fullilove 2004). Further, many parents on the Westside have to work long hours that leave them with limited time and energy when they are

⁷ I address the medicalization of poverty in chapter five in my discussion on the medicalization of deviance.

home. Some parents are unemployed or underemployed and have to deal with the daily stress of providing food and other resources for their families.

One mother I spoke with said her husband worked two jobs and was seldom home. She suffered from a disability causing her to sleep during the day and rarely leave the house. She said their circumstances made it very difficult to keep track of her teenage son.

He often skips schools because neither me or my husband can make sure he goes. My husband is gone, and I am usually asleep when he gets up. And sometimes he doesn't come home until after we've gone to bed. It is hard to know where he is. And it can be bad out there. He is always out there getting in trouble. When he is in school, he is talking back to the teachers. And when he is out with his friends he is getting in trouble with the law. It causes a lot of stress on me and his dad. I know he is a smart boy, but he can't seem to act straight.

Children who grow up in an environment where these are common concerns experience stress (Wadsworth and Butterworth 2006). The stresses that children experience may be exhibited in their everyday behaviors and interactions, such as school. According to the case coordinators I interviewed, the inability to concentrate, anxiety and depressive symptoms are some of the common ways that stress may be exhibited by children in school. When a teacher or other staff member at the school observes behaviors associated with hyperactivity, anxiety or depression, the child will

be labeled as possibly needing mental health services. A teacher is usually the first school staff member to suggest that a child could benefit from mental or behavioral health services, but there is often consultation with other staff such as social workers or counselors. Once a child is identified as needing services, the parents are contacted. The parents may choose to accept or refuse services. If the parents accept services, the school may provide the specific care in the form of counseling or special in-house activities, or the school may help coordinate services with community mental health organizations.

Several community mental health programs are affiliated with the Syracuse schools to provide services for students and their families who are unable to access services through other avenues. The Brownell Center for Behavioral Health, ARISE and Contact Community Services and Syracuse Community Health Center all work with the city schools to provide mental health services to children who experience behavioral or emotional health problems. All of these organizations are associated with schools on the Westside where there are children who experience high stress environments and have limited coping or treatment options outside the school.

There are a variety of organizations and initiatives outside of the school working to provide educational, social and health services for families living on the Westside, such as the West Side Learning Center, Spanish Action League, and Syracuse Community Health Center. And while these community resources and initiatives may have positive influences on the neighborhood, schools remain a primary resource for families to obtain these services. For example, Karen, a mother of a child in middle school said she had been concerned about her son for about a year when a teacher

referred him to the school counselor. After a car accident, he began being rude and disrespectful to her and his teachers. Eventually, he was suspended from school. Karen was concerned but she was not sure where to turn for help with her son. After his expulsion, a teacher suggested that he start seeing the school counselor. Karen was glad for the intervention and told me that the school had been really helpful in finding her son service to deal with his anger issues.

One of the main reasons schools continue to serve as key community service and service referral providers in Syracuse, and elsewhere, is that schools address many of the barriers to service, including lack of transportation, awareness of services, insurance and financial resources (Committee on School Health 2004). Services provided in a hospital or clinic can be difficult for parents to reach if they do not have their own transportation. School buses provide children with free transportation to school-based services. The schools have contact information for parents and guardians, so they can contact parents about service options. For services provided outside the school, outreach to the parents can be expensive and difficult. Additionally, many school-based mental health services do not require direct fees from the parents. And for those services that do require fees, staff members are available to assist families for signing up for Medicaid or other insurance plans for their children. Schools are also important providers of child mental health services because they are frequently the first point of contact for children entering the mental health care system, especially for children who live in poor urban environments (Grantmakers in Health 2010).

School-based Health Services on the Westside

According to the state report card on city school districts in 2003, the Syracuse City School District (SCSD) ranked below average for New York State (NYSED 2003). About one-half of adults in Syracuse are estimated to read at or below a middle school level (Lane 2008). High school graduation rates in Syracuse are among some of the lowest in New York State according to the 2001 Urban Institute Report on New York schools (Lane 2008). Approximately 28% of individuals who started high school in 1998 received a high school diploma in 2002 (Lane 2008). The remaining students dropped out, transferred to schools outside the district, enrolled in GRE classes or spent an additional year in high school (NYSED 2003; Lane 2008). Current statistics for graduation rates in Syracuse vary depending on the source. According to the Syracuse City Schools website (2009), the average graduation rate for all high schools is 66%. However, according to the New York Schools website (2009), the graduation rate for Syracuse public schools is 59.8%. The discrepancies in data are due to the way in which graduation rates are determined. For example, some reports determine graduation rates based on the number of students who started at the school as Freshman, while other reports determine graduation rates strictly based on the number of students enrolled in twelfth grade.

High school incompleteness disproportionately occurs in minority populations. Nationally, the graduation rate for African American students was 51% and 52% for Hispanic students, compared to 72% for white students in 2003 (Greene and Forster 2003). New York State ranked slightly below national average for African American and Hispanic students, with the state rate of African American students at 47% and 42% for Hispanic students (Greene and Forster 2003). In contrast, New York ranked slightly

higher than average for white students, with 77% of white students completing high school (Greene and Forster 2003). Such disparities lead to the under-representation of African American and Hispanic students in college admission pools, and therefore they are underrepresented in college graduates and professional job pools. The disparities in education attainment for minority students mean that there are a disproportionate number who will have throughout their lives limited access to resources such as safe housing, good nutrition, and health care.

At George Fowler High School, located on the Westside of Syracuse and in one of the poorest neighborhoods in the city, the graduation rate was 41%, based on the number of students enrolled in the 12th grade class, with 132 students out of 337 senior students graduating (City Data 2006). In 2005, Fowler High School on the Westside of Syracuse was identified as “persistently dangerous” by the New York State Education Department (SCSD 2009). It was also identified as a School Under Registration Review (SURR) due to the poor student performance (SCSD 2009). The SURR required an internal and external review of Fowler High School. As a result of the review, a number of recommendations were made to improve school structure and academic achievement of the students.

Many of the issues revealed in the SURR were addressed by the Westside Community School Strategy. The Westside Community School Strategy was modeled after a full-service community school model that was piloted at Shea Middle School, now called Bellevue Middle School, in 2002. The full-service community school model involves a partnership between the school and community resources as a way to integrate education, health and social services and support systems in order to improve

student academic achievement and healthier families and communities (Fletcher 2008). The pilot program was considered successful because of the positive feedback from the community, and in 2006, planning for the Westside Community School Strategy began. The Strategy expanded to integrate the full-service community school model to five other schools on the Westside.

The overarching goal of the Strategy is to increase graduation rates for students on the Westside so that they may be prepared for higher education, the work force, and to be “thoughtful, productive and contributing citizens” (Fletcher 2008:3). The students who attend the Strategy schools are among the poorest in the city. According to the 2006 Community Survey administered by the U.S. Census Bureau, the following table shows the estimated poverty levels from the census tracts where the families live who attend Strategy schools:

Table 1: Zip Codes and poverty rates for schools served by WSCSS

Onondaga County Census tract number	School(s) located within Census tract	% of families below poverty level	% of students eligible for free or reduced priced lunch
30	Blodgett Elementary & Middle Schools	48.8%	94%
38	Delaware Elementary School	26.2%	96%
40	Seymour Elementary School	26.2%	95%
50	Bellevue Elementary & Middle Schools	26.9%	88% and 89% (respectively)

(Fletcher 2008; SCSD 2008)

These numbers are high when compared to the overall poverty rate of Ononadaga County, which is 10.3% of families living below the poverty level. The Strategy worked to help students overcome barriers associated with living in an impoverished and under-resourced neighborhood.

Unfortunately, due to financial constraints, Westside Community School Strategy dissolved in 2009. However, much of the Strategy staff was integrated into Say Yes to Education, which shared the Strategy's mission to increase high school graduation rates of Syracuse City public school students. Although Say Yes to Education has primarily an academic focus, program directors and social workers are housed in 12 elementary and middle schools across the city to help identify and manage additional services for students and their families. They work closely with family specialists at Huntington Family Centers to help families apply to government assistance programs, find health care, and get the support they need to help remove educational, health or any other type of barriers they may face.

Once a child is identified as facing a significant academic, health or social barrier, the family is contacted. The way that the family is contacted varies depending on the school and the prior experiences the family may have had with the school. One case coordinator stated that she preferred to be the primary contact person for the family (personal communication August 2008). Another case coordinator said that if the families were Hispanic, then the social worker, who is Hispanic, would be the contact person (personal communication August 2008). The same case coordinator also stated that the contact person may also be the teacher if the teacher has developed a rapport with a parent.

Parents developed different types of relationships with school staff. Isabella, a mother of a teenaged daughter, said when her daughter began getting in trouble at school, she was contacted by the school social worker. Isabella was told that her daughter had been disrespectful to her teacher by yelling, cussing and walking out of

the classroom when being addressed. This first contact helped Isabella develop a relationship with the social worker. As her daughter was referred to the school counselor and received subsequent disciplinary actions, the social worker was the primary person to contact Isabella. Isabella said she liked talking to the social worker because she felt like she really cared about her daughter. She said she was less comfortable talking to her daughter's teacher because the teacher seemed angrier, like she blamed Isabella for the trouble her daughter got in. Although I was not able to talk to the social worker about Isabella and her daughter, I do know that the social worker liked being the contact point for parents. She said her distance from the classroom interactions was helpful for the development of a relationship with families. Isabella was a good example of how this distance helped the social worker act as social support for parents.

David, a father of a daughter in elementary school, said he was more comfortable talking to his daughter's teacher. He said he had such little interaction with other staff members that he preferred to talk to the teacher because she knew him and his daughter. When his daughter was unable to concentrate or failed to complete assignments, David liked it when he was contacted by the teacher. When the school counselor called him on one occasion, he said he felt less comfortable talking to her about his daughter. In contrast to Isabella who liked talking to someone who had distance from her daughter's interactions, David preferred to talk to the person most involved with his daughter.

There are at least two factors that influence this difference. First, Isabella and David's daughters were identified with different behavioral problems. While Isabella's

daughter often had disciplinary problems due to aggressive behaviors, David's daughter exhibited her emotional problems by failing to complete assignments or daydreaming in class. Because Isabella's daughter was seen as aggressive, she was less comfortable talking to the person who most frequently witnessed her daughter's anger. David, however, was more comfortable talking to his daughter's teacher because his daughter really liked her, and he felt like she understood her more since she was with her everyday in the classroom.

Second, Isabella and her daughter's social worker were both Hispanic. They were able to speak Spanish with each other, while her teacher was not able to speak Spanish. Having a common language and cultural background was helpful in the two developing a rapport. In contrast, David was an African-American man. Both his daughter's teacher and counselor were white women, so there was less of camaraderie due to a common cultural background. Rather, he told me during our interview that his comfort level was based on his daughter's strong affection for her teacher.

Once a parent is notified that his or her child has exhibited some sort of problem in the classroom, the parent can choose to engage in services. Services will vary depending on the child's and family's needs. For example, a child may be recommended for weekly counseling if s/he has shown signs of depression. Another child may be recommended for health care at a local clinic if s/he has shown signs of a health problem. If the families choose to engage in services, they will be assigned a Strategy Family Specialist. The Family Specialist helps coordinate services for the family that extend beyond the school building. They may provide transportation to a health clinic or help a parent apply for Medicaid.

The following table shows the student enrollment for school-based services for each school in 2008:

Table 2: Services by Type Provided to Students in Each School in 2008

	Health/ Dental	Mental Health	Youth Development	Academic Intervention	Family Support	Total # of Students
Bellevue El.	N/A	10	39	49	30	381
Bellevue Mid.	184	40	85	92	48	277
Blodgett	N/A	210	336	444	73	608
Delaware El.	332	42	64	163	74	481
Seymour El..	N/A	27	79	76	49	380
Fowler High	335	78	244	189	30	1182
Total	871	407	847	1013	304	3309

(Fletcher 2008:9)

Although a substantial number of students are listed as receiving services, there are many students who do not receive services. When Suzanne Morrissey (2006:241-242) conducted fieldwork in Syracuse on the WIC program, she found that many low-income women chose not to use WIC or to only use it as a last resort because of the stigma associated with it. Similarly, many parents choose not to access or engage in school-based mental health services for their children because it may imply similar sentiments. While some parents may become actively involved in their child's mental health services, many parents choose to refuse services while others verbally accept services but do not engage in them the way the school would like them to be involved. I will discuss this further in chapter seven. When the parent is notified that a child is identified as having a mental health problem and offered the school's recommendation for mental health services, the parent or guardian must decide how to deal with the label and recommendations. My research explores what factors influence how parents react to and interact with school-based mental health services.

Kreisberg (1970) argues that individuals living in poverty are less likely to have stable employment or housing, and thus, children living in poverty often experience

unstable environments and learn behaviors that are an “accommodation of their circumstances” (1970:2). This means that children may behave in ways that are not congruent with norms of those who do not live in poverty, including the expected behavioral norms in schools. These behaviors can often be interpreted as a child having a behavioral or mental health problem. For example, in a home where a child has a single mother who works two jobs with daily worries whether she will lose her job or be evicted from her apartment because she is unable to pay rent, a child may learn to get attention from his distracted mother by yelling loudly or running around the house.

Dangers of Essentializing Poverty

Although there are real social and structural constraints associated with living in poverty, it is important to keep in mind that living in poverty is not a homogenous experience. Living in poor environments is not necessarily indicative of an individual’s values and behaviors. Suggesting otherwise essentializes poverty. By assuming that lacking access to resources is inherently equivalent to a single cultural experience perpetuates Oscar Lewis’ (1966) notion of the culture of poverty. Such sweeping generalizations about people living in poverty are not only fallacious; they also perpetuate stereotypes about poor individuals (Goode and Eames 1996; Bourgois 1996).

Rather than examining people’s experiences and behaviors from a culture of poverty framework, it is more accurate and productive to recognize that there are social constraints that influence the complexity of people’s lives. For example, one mother, Karen, said that she had three children and lived with her brother who had two of his own children, and their nephew from another sibling also lived with them. With so

many children in the house it was difficult to keep track of them all. She was the only adult in the household who had a steady paying job and received regular paychecks. Her brother did not have a consistent job but occasionally helped out some people he knew who had a moving business. When he wasn't working, he usually could be found at his friends' houses drinking and playing video games. Her mother also lived with them, but she had a disability and was unable to do much around the house, including watching the children. Therefore, Karen said she was the primary caretaker of all six children as well as the primary wage earner. She said she just didn't have the time or energy to watch all the kids all the time.

Sometimes they get away. I can't control them, especially when they get older. Sometimes they start talking back, and I just can't deal with them.

That is how they start. Then they learn that is how to get out of the house.

When I can't deal with them, they know I just want them to leave so they do.

Karen is like many mothers who spend so much time and effort working and managing the household that there is little energy left to interact with the children on a regular basis. Her vignette suggests not that there is something specifically cultural about her experiences. Rather, it demonstrates that she experiences daily challenges and develops strategic approaches to dealing with them. School staff may be unfamiliar with such experiences and tactics. They may view such behaviors not as products of active decision-making or strategizing but as a cultural phenomenon.⁸ Because of a lack of understanding, not a lack of cultural congruency, the behaviors that the children learn at

⁸ I discuss the use of culture by school staff to explain differences more in chapter ten.

home become problematized in schools and treated as symptomatic of a behavioral or mental health problem. Such an approach can lead a child to be labeled as needing mental health services. This is a sort of “medicalization” of deviant behaviors. The following section addresses the problems associated with medicalizing behaviors.

CHAPTER V: MEDICALIZATION OF DEVIANCE

The term medicalization was first coined by Irving Zola in 1972 in *Medicine as an Institution for Social Control* (Lock 2001). Zola (1972) explained medicalization as the phenomenon in which everyday domains of life, including non-medical ones, are brought into medical authority as a form of social control. The term medicalization has been revised and altered by scholars since Zola. For example, medicalization has been defined as the tendency in biomedicine to miss identify "... between the individual and the social bodies and a tendency to transform the social into the biological" (Scheper-Hughes & Lock 1987:23).

The social discourse about health suggests that it is important to be healthy and dangerous to be unhealthy, with unhealthy as defined as behaving in ways that are not congruent with the norms (in my case, school norms). Social discourse refers to the "... coherent way of describing and categorizing the social and physical world" (Lupton 2004:20). Health is referred to as a right, an obligation and a fundamental good that should be sought through self-regulation. If your body is unable to self-regulate, you become subject to medical labeling and treatment (Lupton 2004). Parsons (1951) argues that any illness is viewed as deviance of the body that does not allow a person to perform social roles, and medicine is the mechanism by which society uses to control the deviant body. When an individual is unable to perform functions and obligations in society, there is a need for social control of that body. Medicine acts as a way to control the body to make it fold back into its social roles.

Behavior and emotions are now under the rubric of medicine, defining "... the limits of normality and the proper functioning and deportment of the human body"

(Lupton 2004:1). Deviant behavior is often medicalized, meaning it is viewed not as a social issue but rather as a medical problem that warrants a medical label (Conrad and Schneider 1980; Conrad 1976). The medical label given to deviant behavior is mental illness. Mental illness is a social construct based on the cultural definitions and perceptions of certain behaviors and the beliefs about their etiologies, treatments and influences on society as a whole (Becker and Arnold 1986; Ablon 1981). Social stereotypes inherently influence medical professional's perceptions and decisions about labeling and treating an individual (Townsend 1995; Loring and Powell 1988; Fernando 1988).

Self-control and self-discipline over the body are valued in the medicalized Western world (Lupton 2004; Foucault 1977). The types of behaviors that are considered deviant and a medical problem are both socially and politically influenced. Medicine is inherently influenced by social, historical and political understandings of the world because people embody medical categories based on social, historical and political knowledge and experiences (Lock 2001:483). As science became based on supposed "empirical knowledge" in the late 19th century, the field of medicine entered the jurisdiction of this empirical science. This shift was less about pure knowledge of the body and more about structuring how modern medicine examined and labeled the body (Foucault 1973).

According to Foucault (1967) the social construction of psychiatric labels began in the 17th century. Behaviors were labeled as either good (normal) or bad (abnormal). A person who behaves incongruent with societal norms can either become a medical problem (if he accepts the psychiatric label) or "immoral" if he refuses it (Foucault

1977; Szasz 2007). Medicine of the mind, or psychiatry, became a system of power of bodies and minds whereby the body and mind became under surveillance. Psychiatric professionals make the arbitrary distinctions between behaviors we attribute to reason (choices) and behavior we attribute to causes (diseases) (Szasz 2007). Foucault (1977) calls this medical social control as the “medical gaze” that gives medical staff legitimate claim over deviant behavior as a way to control such behavior. Psychiatry began not by individuals’ need to have cures, rather the discipline began because family members wanted relief from troublesome kin (Foucault 1977). Most early psychiatric patients were not patients voluntarily; thus, from the beginning psychiatry was a discipline of control (Szasz 2007).

The authoritative knowledge of medicine plays an important role in the social control of psychiatry. Authoritative knowledge refers to the knowledge that acts as the basis for our motivations and decisions (Jordan 1993). According to Jordan (1993) there are a variety of systems of knowledge on which we can base our decisions, but one of those systems of knowledge gains authority by devaluing and de-legitimizing the other systems. This process of authoritative knowledge has occurred in the biomedical and psychiatric system of knowledge, giving biomedical psychiatry authority in the realm of mental health and mental illness. Individuals working in the field of psychiatry have the power to diagnose, label and treat people according to the biomedical system of knowledge. Due to the authority of the biomedical system, individuals both working in and being treated by the system base and accept decisions established on the biomedical system of knowledge. In the last few decades many people have shifted away from basing health care decisions on the authority of

biomedicine, preferring alternative forms of health care systems to either replace or complement biomedical diagnosis and treatment. Although there are individuals who question the authoritative knowledge of biomedicine and integrate other systems of knowledge, it remains an authority due to a larger social consensus (Jordan 1993).

The power of psychiatrists and other biomedical professions is not as strong as it was in the 18th and 19th century (Singer 1987). With deinstitutionalization and advocates for more humane treatment of people with mental health problems, individuals are able to have greater control on how they engage with the medical world. However, such changes have also led mental illnesses to take on a life of their own. For example, people no longer just feel depressed, they now have depression. Depression kills people rather than people feeling depressed commit suicide (Szasz 2007). Rather than giving control to medical professionals, medicalization has taken a turn to give the diagnosis primary control. Power is given not to the patients or doctors, but rather the medical label.

Social Norms and Deviance in Children

Social norms determine how a person is expected to behave in given situations, and individuals in positions of authority, such as teachers, are able to influence social norms, decide what are considered appropriate behaviors and punish those behaviors that they consider deviant from the social expectations. What is viewed as deviant behavior is based on the "... social process of collective rule making and definition, identification and social response" (Conrad 1976:2).

When a student acts outside those prescribed social norms, he is considered deviant and in need of some sort of treatment. The treatment may be a sanction, such as having recess withheld, but the treatment is frequently in the form of mental or behavioral health treatment, such as individual or group counseling. Thus, the deviant behaviors of the child are medicalized and treated as a mental health problem that can be improved through mental health treatments.

Conrad (1976) identifies two trends during the mid-twentieth century which have been identified as strong influences on the medicalization of deviant behaviors in children. First, the government became very interested in child mental hygiene. There was a surge of research in the schools that suggested that children across the country were behaving erratically and needed medical attention to address their behavioral problems. The government's interest in child mental hygiene is discussed further in the following section on the history of school-based mental health services, but it is important to note here that it was a prevailing movement that was occurring in the public schools during the early to mid 1900s. The second trend was the pharmaceutical revolution in the 1950s and 1960s. During this time there was an increase in the production and medical use of psychotropic medications. These medications became particularly popular after deinstitutionalization of mental health patients.

Both trends were a result of the social and political need to control people who engaged in behaviors that fit outside of social expectations.⁹ When individuals, specifically children and deinstitutionalized mental health patients, behaved in ways that were not congruent with social norms, a need arose to control those individuals.

⁹ I discuss the problems associated with the control of medicalization in the following section on the consequences of medicalization.

This need occurred from individuals who subscribed to the dominant culture and was legitimated to individuals in positions of authority. The dominant culture was integrated with fear, dislike and annoyance of certain behaviors and traits, and individuals who do not fit the mold were viewed as needing to be controlled (Foucault 1977). This need for social control came first and was followed by a medical label because medicine was perceived as scientific and objective, thus legitimizing the label and giving of medication (Szasz 2007).

The medical label also served two additional purposes. First, by calling a child's unsavory behavior a medical problem, parents' guilt was alleviated. Rather than it being a failing in their parenting skills, they could blame a medical condition when their child did not behave in ways they considered appropriate. The medical diagnosis became naturalized. Second, the medications often were successful at controlling both children's and mental health patients' behaviors. The medical label was not just a smokescreen for parents and other family members to hide behind; it justified the use of effective medications. And the effective use of medication further justified the medical label. Thus, the medical diagnosis, labels and medications reinforced each other. Of course these medications also frequently had very negative side effects, but that was a small price to pay for a well-behaved child or mentally ill family member. In general, medications became viewed as a simple way to control the uncontrollable.

Today, the medical model is still frequently used to explain a child's deviant behavior, and efforts to manage his behavior often involve medical attention. At the moment a behavior is regarded as a medical problem, that behavior has been

medicalized. This point usually comes when managing behaviors, or control, becomes the central issue in a child's life (Conrad 1976).

Medications play a significant role in the medicalization of child deviance. They help legitimize a child as having a medical problem and alleviates a child and parent from blame for the behavior. If she responds (i.e. is controlled) with medication, then it is seen as evidence to support the medical label. Medication also is seen as a decent way to control behaviors, as opposed to other forms of control such as institutionalization. Medications are often given not only as a treatment to manage behaviors, but also as a diagnostic tool (Conrad 1976). By trying different medications and seeing which one is most effective in managing the child's behaviors, medical professionals are able to decide in what medical category the child best fits.

Consequences of Medicalization

Medicalization perpetuates social inequalities. People who live in poverty have been particularly vulnerable to medicalization. Disadvantaged groups are more likely to have negative labels attached to them and encounter marginalization (Scheff 1966). Those with social power (doctors, teachers, etc) frequently come from the upper, often white, class (MacLeod 2009). The upper class values dominate in medicine. People with limited access to social, political and economic resources often act in ways that are not congruent with social norms and are therefore targeted by medicine as those who need to be controlled (Lupton 2004). Their behaviors are often considered abnormal and in need of being controlled. And as discussed above, medicalizing the behaviors is a legitimized way for people in authority to help gain control.

While working in the schools on the Westside I heard several staff members talk about how many of their students acted in ways that suggested they needed some type of mental or behavioral health care. They described students based on certain behaviors, such as talking back, not completing assignments and arguing and fighting with other students, using terms such as “rambunctious,” “unable to concentrate,” “disruptive” and “troublesome.” Such behaviors were often attributed to the fact that the students lived in an impoverished neighborhood, connecting poverty with their perception that the students needed mental or behavioral health care services. The staff medicalized their students’ behaviors, linking behaviors they associated with poverty to the need for medical attention.

Stigma associated to medical labels is influenced by the access to social and political power of the labeled individual. Groups with such powers are able to determine what is “normal” and “abnormal,” or what behaviors are to be sanctioned and those to be feared (Link and Phelan 2001). When behaviors are viewed as normal ups and downs for a child, there are lower levels of rejection than when behaviors are considered socially abnormal (Martin et al. 2007). The appropriateness of behaviors is culturally defined, yet when an individual engages in behaviors that are considered abnormal, the consequences are more than just cultural. Individuals who have been medically labeled as abnormal must deal with social control of medicalization, loss of autonomy, and social stigma.

Stigma is a cultural process that occurs through the creation and perpetuation of certain beliefs and behaviors that are embedded in social norms (Becker and Arnold 1986: 41). Labeling a condition an illness or disease is a form of communication “...

through which nature, society and culture speak” (Scheper-Hughes and Lock 1979:31). Through medical labels, social inequalities are medicalized and result in social stigma. Inequalities based on income, skin color or education level result in stigma associated based on having the “wrong” kind of these characteristics. The more certain groups do not have the “right” or “favored” traits, the more they will be stigmatized (Becker and Arnold 1986: 46). The stigma associated with unfavorable traits is exacerbated when given a label of having a mental health problem. In addition to cultural traits, the underlying cause of a behavior also influences how behaviors are perceived and a child is labeled. For example, depressive symptoms from a specific incident are considered less “problematic” than erratic behavior associated with uncontrollability (Martin et al. 2007:52). A child exhibiting the former is likely to be labeled with a stigmatizing medical label than a child exhibiting the latter.

Medical labels provide information about how an individual is perceived and treated in the context of the institution and often in the community as well (Estroff 1981). For example, a person may be labeled as mentally ill within a medical institution. Such a label determines how that individual is served by the institution and how others in the institution interact with that person. The effects of the label act as a form of control by prescribing certain treatment for that individual (Estroff 1981; Rhodes 1991). If the label becomes known within the community, it can also affect how family, friends and neighbors perceive and interact with the labeled person.

While the effects of an institutionally defined label in the community may not be intentional by the institution, the labeled individual still may feel the influence of the mentally ill label outside the institution. The person must adapt to new perceptions and

learn to interact in the context of that label both in and out of the institution which provided the label (Estroff 1981; Stein 1990). The meanings of labels that are given to an individual are learned and understood by that individual through interactions with the institution from which the label is given (Estroff 1981; Barrett 1996) as well as interactions in the community (Stein 1990). Individual reactions to those labels are the product of not only the interactions with the institution, but also the understandings that are acquired through the neighborhood and community culture (Stein 1990).

Medical labels are not unique to biomedical institutions. Research suggests that “... all types of societies show a natural inclination to medicalize deviant behavior” (Fabrega 1993:186). However, the types of behavior that are considered ‘deviant’ and how those who exhibit such behavior are treated varies greatly. Many personality disorders in the biomedical psychiatry discipline “... may not be recognized or handled as sickness in other societies” (Fabrega 1997:5). Additionally, the categories and terms used to label a mental health problem may seem inappropriate for some individuals who do not have a shared understanding of terms used by service providers in an institution.

The meaning that individuals give to the label they receive is derived from two main aspects of that person’s life. First, the community in which they live is a primary way in which individuals derive meaning to labels (Fabrega 1995; Barrio 2000). Second, the interactions with the institution, including service providers, classifications and institutional discourse are also a key way in which individuals understand and interact with a given label (Barrett 1996; Lovell 2007). This is not to say that they are separate understandings, rather they both interact to give the label meaning (Stein 1990).

According to Fabrega (1993:167), intrinsic to labeling an individual as needing mental health care is its derision of an individual with a mental disorder and the need to correct the behaviors associated with the mental disorder; psychiatric treatment is thus "...controlling if not actually coercive and potentially stigmatizing," especially among socially marginalized groups.

Medical labels, social inequality and stigma have a strong relationship. Perceptions of behaviors are influenced by expectations for a child. The background of a child, including his or her family's access to resources and living environment, influence what authority figures expect from that child. For children with families that appear to support upper class values, there is less expectation that the child will be deviant. Conversely, a child who comes from socially and economically disadvantaged backgrounds is more closely watched for deviant behaviors (Tucker 2009). Thus, the stigma associated with living in poverty frequently leads to a child being labeled with a behavioral or mental health problem. The medical label then creates further stigma for that child.

According to the labeling theory, the act of labeling a person with a mental health problem will create stigma against that person making other people less willing to interact with that person (Scheff 1966). Supporting this view, Martin et al. (2007) found that one in five parents reported not wanting their child in a classroom with a child labeled as having ADHD or depression. This is due to perceptions that the child is dangerous and should be avoided. The stigma associated with a mental health problem is more severe the more the label is perceived as threatening, dangerous or associated with behaviors that are outside "conventional norms" (Martin et al. 2007:52).

Individuals who view a child as having a mental illness have greater preference for distance from that child than if he is labeled as having a physical illness or no illness.

The social metaphors associated with health problems can also be stigmatizing. For example, Sontag (2001) uses Acquired Immunodeficiency Syndrome as an example. AIDS is associated with immorality, pollution of the body and self-indulgence. Similarly, the images associated with someone labeled with a mental illness also have a stigmatizing effect. A mental illness label is associated with pollution of the mind, inability to follow social convention, dangerous behaviors, and something to be avoided. Such discourse expresses a lack of value and morality in a person and perpetuates social stigma (Sontag 2001).

Lupton (2004) also argues that there is a morality issue often associated with illness, particularly mental illness. However, I argue this is less of an issue for kids. Rather than blaming children, social discourse lays blame on the parents and environment. In most of my interviews with school staff, parents and social structures were often used to explain behaviors of students. At the same time, the fact that many of the children live in poverty was also mentioned in most of my interviews. The conditions of poverty, including limited parental supervision, poor housing conditions, exposure to an unsafe environment, and easy access to illegal and unsafe activities, all were given as reasons why children had mental and behavioral health problems. I found that it is not only the medicalization of behaviors that students and their families are subjected to, but also the medicalization of poverty. Deviant behaviors of children were perceived by school staff as a result of living without access to social and

economic resources, and the way to deal with these poverty-provoked behaviors was through medical treatment.

Previous research (Weissman 1997) suggests that student misbehavior is also criminalized as well as medicalized. The labels attached to disruptive behaviors by students are often described in legal terms that suggest the need for judicial intervention. For example, Weissman (1997) found that public schools will use the term “assault” rather than “fight” when describing altercations between students. Such a shift in terms brings in a legal connotation and opens up the door for legal action against the students. The criminal justice system was mentioned in conjunction to mental health services in several of my interviews with school staff and parents. Many of the school staff I spoke with said they felt that by giving a medical label to disruptive or disassociated students and getting them into mental or behavioral health services in early elementary school, they were actually helping divert them from entering the criminal justice system later in life. Parents also said that they felt that getting their children into mental health services was a way to help them “succeed in school” as well as “keeping them off the streets and out of jail.” To both parents and school staff, medicalizing a child was preferred to criminalizing him or her.

Medicalization of deviant behaviors has at least three consequences on children’s bodies. First, medicalization of behaviors is a form social control of the body (Foucault 1977; Zola 1972). By placing children under the medical gaze, they are controlled by social norms that are channeled through the medical professionals. This means that medical professionals can place sanctions on children’s behaviors based on social expectations. These sanctions can be in the form of counseling or medications.

Second, health care professionals are considered legitimate experts that have the power to control individuals under the guise of neutrality (Conrad 1976; Parsons 1951). Because medicine is considered an objective science, health care professionals are considered objective observers and diagnostic instruments for medical problems exhibited through certain behaviors. Medical personnel use this belief that medicine is unbiased to legitimize medical treatment for behaviors that are not congruent with social norms.

Third, medicalization of behaviors ignores the social and political structures that influence behaviors (Foucault 1977; Conrad 1976). Social problems are individualized. For example, the medicalization of domestic violence explains battering as a mental health problem and neglects issues associated with patriarchal values and gender inequality (Tierney 1982). When a behavior becomes medicalized, the subjective and symptomatic reports of the body are examined not in terms of social and political institutions/power but rather "... subsumed into medical pathologies and standard deviations from medical norms, and the focus of attention is on the bodies of individuals, who are essentially made responsible for their own condition" (Lock 2001: 481). Rather than understanding a child's behaviors being affected by social structures, his behaviors are seen as an individual problem that can be remedied through medical attention. Changes are not made to help improve social problems, rather they are made at an individual level.

The social power of medicalization starts with the initial screening and diagnosis for a behavioral or mental health problem. In the medical world, screening and diagnosis is frequently determined by which mental illness is covered by insurance

(Szasz 2007; personal communication 2010). Once screened, the power continues through a label and then subsequently treatment (Lupton 2004). For children, this is particularly problematic because of the methods used to medically label a child. Rather than self-reporting, children are subject to observations and interpretations of adults. Questionnaires are distributed to parents and teachers to identify a child as having a mental or behavioral health problem. For example, diagnosis of ADHD is done through questionnaires to parents about child's behaviors and observations in search for "soft" neurological signs through behaviors (Tuchman 1996). I argue that diagnosis and treatment for mental illness differ from most physical illnesses because the diagnosis and treatment are determined rarely by a physical exam or even the patient's account. Rather, mental illness is frequently identified and diagnosed based on other people's accounts. In the case of the school, it may be a teacher or school counselor.

This labeling process is inherently political because it claims to be scientific and neutral, yet it is based on social understandings of what is appropriate behavior for a child. Further, teacher's and school staff's reports of children's behaviors are considered more legitimate than parents' reports because teachers are seen to be more neutral and trained to understand behaviors (Tuchman 1996; Conrad 1976). However, the training these professionals have received is based on social norms, not necessarily on objective truths about what are "right" behaviors. For example, one counselor I spoke with said she based her assessment of students on a rubric designed by the school district in conjunction with the state to evaluate students in a variety of areas, including mental health status. This rubric looked at behaviors in the classroom and interactions with teachers and other students, using the school norms as the benchmark for the

appropriate behaviors and interactions. However, as discussed in previous chapters, many students learn to behave and interact with others in ways that are not congruent with the school norms. These students frequently receive labels in schools that identify them not just from their social backgrounds but rather as in need of mental or behavioral health services.

Sociodemographic characteristics, such as race, education and income, also affect a teacher's assessment of that person's behavior (MacLeod 2009). Such traits influence whether a child is labeled with a mental disorder, based on what the evaluator expects to see based on these characteristics (Martin et al. 2007). An interview with an elementary school teacher illustrates this point. When asked about her expectations for her students, she said that she is happy if some of them just show up for school. She said that parents of many of the students are so busy with other things that they often don't bother to get the children ready for school on time. She added that when parents are so poor, they not only have limited personal 'tools' to get their kids off to school in a timely manner, they also don't know how to be good parents. This limited access to the "tools" for being a good parent was given as a reason that kids missed school and misbehaved when they did attend. Poverty was given as a reason for children not coming to school and related to the children having behavioral problems.

While the absences alone were not given as the reason to give medical treatment, excessive absences were associated with children who were in need of mental health services. When children missed numerous days of school, behave in ways that are considered disruptive in the classroom, or show signs of being depressed, they are more likely to be recommended for counseling. The reason given for this

correlation was that when parents were occupied with other life events besides childcare, a phenomenon frequently associated with poor parents on the Westside, the children suffer and can benefit from group or individual counseling sessions to help them deal with the neglect they are experiencing. This is a form of the medicalization of poverty. Conditions associated with poverty for children, such as parent neglect, are believed to be best dealt with through mental health treatment.

Medicalization and Stigma

When a child is labeled as in need of mental health care, the parents may have some shared understandings with the individuals in the institution who labeled the child, including the loss of a valued capability. Labeling children as in need of mental health services "... can overlook the individual's needs... and stigmatize them or otherwise label them in ways that undermine their social credibility as citizens" (Fabrega 1993:169). Labeling affects individuals' and their families' experiences in the psychiatric institution and in society as a whole (Waxler 1986). Mental and physical "... functionality is one of our most positively valued cultural symptoms and any hint of dysfunction , and the dreaded dependency associated with it, is one of our most negatively valued cultural symptoms" (Stein 1990:57). These notions of dysfunction and loss of control that are associated with mental health problems may be shared by both individuals in the institution and community because of a larger cultural bias towards being mentally healthy.

When an individual has a trait that has negative connotations in a given cultural context, attempts are made to "normalize" the individual (Bluebond-Langer 1996: Ablon 1988; Goffman 1963). Ablon (1988) further argues that the more a trait is valued

by a society and is absent or different in a person, the more that individual is stigmatized for the lack of that characteristic. Because mental functionality is a highly valued characteristic in the United States (Fabrega 1993; Stein 1990), the absence, or perceived absence, of strong mental functioning is highly stigmatized (Edgerton 1967; Estroff 1981). The value of mental functionality is expressed in everyday vernacular. As Ablon (1988:9) points out that daily expressions such as “falls short of” and “pint size” indicate the negative value that is associated with being short, I argue that everyday expressions also suggest that loss of mental function has a negative connotation in our culture. For example, when someone behaves in a way that another person does not understand, the confused person might respond by saying “Are you crazy” or “Don’t be mental.” Such common expressions penetrate daily life and can cause individuals to internalize the value of having sound mental capabilities, or the denunciation of lacking such functionality.

Tara, a mother of a son in middle school, said he was teased by his peers when he began seeing the school counselor. Other students often asked him if he was “crazy” or “suicidal” because he went to the counselor’s office once a week. Such teasing suggested that her son was not stable or “normal.” It made him very uncomfortable, and he ceased seeing the school counselor, opting for a counselor outside of the school building so that no one saw him going to his sessions.

The negative connotation associated with mental health problems is a form of stigmatizing those who are labeled as having a mental health problem. Stigma involves a “discrediting” characteristic (Goffman 1963) that conveys a specific negative identity in a given social context (Crocker et al. 1998). A mental health problem is discrediting

(Goffman 1963) and is associated with negative self and social identities (Estroff 1981; Rhodes 1991).

The stigma associated with mental health problems is further exacerbated for individuals who have other characteristics that also are stigmatized or marginalized in society (Goffman 1967). For example, if a person is poor and exhibiting mental health problems and would like to receive services to help them with these conditions, it is often those very conditions that prevent them from accessing and using services. When individuals experience multiple forms of stigma, they often experience multiple barriers to services that address the stigmatized conditions (Jarrett 1996). Additionally, multiple stigmas can further ostracize individuals from their community. One of the consequences of a person having a stigmatized characteristic is experiencing discrimination from others (Link and Phelan 2001). The more stigmatized characteristics a person has, the more discrimination that person will feel. Stigmatized traits are associated with having limited access to social and economic resources as well as continued rejection of these resources (Link and Phelan 2001). Thus, I argue that having limited access and economic resources is associated with stigma. Characteristics such as having a low income, low education level and a minority status are all stigmatized traits associated with marginalization in society. The limited power and access to resources that individuals and communities have who are minorities and have low income and education levels suggests that these attributes are socially marginalized.

According to Philippe Bourgois (1996:249), social marginalization is embedded in “ideological murk” that creates structurally contained “... social misery rooted in histories of politics, economics and cultural domination.” Thus, marginalization is

exclusion in society based on personal characteristics that have historically and politically been associated as undesirable. It involves a degree of suffering due to being contained by social structures, including schools and health care institutions. At the same time people actively resist marginalization by taking control of stigmatizing medical labels and treatments. Individuals make efforts to find agency in a medicalized and marginalized world.

Personal Agency in a Medicalized World

Although many mind and body problems come under the medical gaze, and this approach has negative consequences, the medical world does not have complete control over what people do with their bodies. People are not passive. Individuals can resist the medicalization of their bodies. Individuals labeled as having an illness may or may not fall into medical ascendancy depending on what they view as their best interest (Lock 2001). When people take on the “good patient” role, it is an active decision; it is a way to engage in treatment, not be a passive patient (Lupton 2004:127).

Foucault (1977) and Good (1992) maintain that patients inevitably are socialized into the “patient role.” Patient role refers to specific interactions with service providers and others based on the categories and etiologies as defined by the institution (Good 1992). Borrowing from Das and Das (2007), I argue that it is indeed possible to avoid the patient role, whereby the labeled individual does not act within a prescribed set of confined rules and expectations as laid out in institutional policies. It is not the “patient role” into which individuals are inherently socialized once given a diagnosis; rather it is the individual’s reaction and interpretation to the diagnosis, or label, into which a person is socialized. By this I mean that the way in which the person gives meaning to

a particular label is embedded in their experiences with both their community and the institutional culture. Together, community culture and school culture build a family's understanding about what the label means

People are active participants in their diagnosis and treatment. While they may be subject to rules and labels of the medical institution, they work within these confines using their own ideas and resistance. For the many who do engage with medical labels, it is their choice based on their own perspectives. Of course those perspectives are influenced by social discourse about medicine, but there are other influences as well, such as personal experiences, local narratives and individual understandings of the body. Together, community and medical institutional culture build an individual's understanding about what the label means and influence how she chooses to interact with that label.

Thomas Szasz (2007) views all of psychiatry as medicalization of behaviors, acting as a coercive force rather than a cure. He refers to psychiatry as a moral, social and political enterprise whereby mental health problems are not medical problems but rather moral, social and political problems. Although other scholars (Kleinman 1980; Digby 1985) have also noted that psychiatry has moral, social and political dimensions, Szasz fails to recognize that many people choose to seek out psychiatric assistance. This is important because according to Szasz, all of psychiatric treatment is coercive for people who engage in deviant behavior. However, it is possible for a person to make a choice to get treatment on his own volition due to his personal desire to alter current behaviors or emotions. Certainly this person's desires to change his behaviors are

culturally influenced, but in such cases, psychiatry plays an important role in helping individuals be happy by fitting into the societal norms.

Positive Aspects of Medicalization

For some, the process of medicalization is a way to cope with a problem with the body or mind. The emotionality associated with an illness influences the type of role people take in their medical treatment (Lupton 2004). For problems that are less disruptive in one's daily lives, individuals are more likely to disregard medical treatment. For particularly severe problems, people may put their trust in medical staff in hopes that they can help them. Medicalization can be helpful when the medical practitioner is respectful of a patient's and their families' concerns and is willing to accept their engagement in medical treatment on the patient's own terms (Broom and Woodward 1996).

When medical anthropologist Susan DiGiacomo (1977) was diagnosed with cancer, she found herself struggling with her trained critical eye and resistance to medicalization. While she wanted to retain control over her body and medical treatment, she also found it comforting just to trust the doctors and have faith that biomedicine could fix the problem. She explains that sometimes trusting in the biomedical model can have benefits for the patient as well as society.

Medicalization can also help normalize and naturalize a problem. For example, the label of post-traumatic stress disorder can help individuals feel that it is normal to experience a horrific event and experience mental problems. By medicalizing the effects of a traumatic event, the focus is shifted away from the abnormalities of the

individual and towards the event itself (Conrad 1992). This can make a person with such an experience feel better about problems they may have due to that event.

The process of medicalization further acts a coping strategy by validating a person's claim of being sick by being supported by an institutionalized authority (Broom and Woodward 1996). Many parents said they felt that something was wrong with their child before they ever received any guidance or treatment for their behaviors. When a teacher or other school staff member suggested that their child could benefit from behavioral or mental health care services, they said they were pleased to hear that their child's behavior could be medically defined and that there were options to help their child. Having a medically recognized condition is often the most efficient, if not only, way to receive services to address mental or behavioral health problems (Holmqvist 2008).

The parents I interviewed who had children receiving school-based mental health services all said that they were glad to have their children receive such services. They interpreted the labels and treatment associated with these services as a helpful tool for understanding their child's behavior. Each parent said that he or she was concerned for his or her child and was glad to learn that he or she had a mental health problem. For them, the medical label and treatment was comforting because they felt that something could be done to help their child. All but one of the parents I interviewed said that they felt the mental health services had a positive influence on their child's behavior. The remaining parent, Gwen, said that she had not seen any improvement in her child's behavior, but she still felt that her daughter Patricia should attend counseling sessions because they "... will eventually do some good." When asked what she meant

by “good,” she replied “... won’t get in trouble no more.” By trouble, she was referring to her daughter’s behaviors in school and with her friends. Patricia had been in fights with other children, and she frequently was reported to have yelled and used cuss words when speaking to her teachers. Her mother felt that counseling could help such incidents from occurring.

My daughter is naughty. She misbehaves, and I just don’t know what to do. The school told me she has a problem anger management issues. They said she could go to counseling, and I said, “Sure. Why not?” If they can get that girl to behave, I think it is a good thing. She gets in so much trouble. It’d be good if they could do something about that.

The medical label became a sort of coping mechanism. Medicalizing her daughter’s behavior as an anger management issue that could be resolved through mental health treatment gave Gwen some hope about her daughter’s behavior. She was not happy with her daughter’s behaviors, and she accepted treatment through the schools.

Integrating a Medicalized Condition into Daily Life

Although there may be differences between community and school, they both may have some shared understandings of the labels that are administered within the institution. Even when there are cultural differences in interpreting behaviors and categories, there is often some overlap in the interpretations of labels between the

service providers who label and the individuals who are labeled (Stein 1990). Due to the varying interpretations and beliefs about mental health, the way in which individuals in schools label and treat a mental health problem is a process of negotiation with institutional policies and the people they serve. Robert Edgerton (1964) argues that the process through which a person is labeled as deviant is a social transaction that varies depending on the context in which the label and treatment occur. I argue that being labeled as having a mental health problem is also a social transaction that varies based on the context. Being labeled as deviant suggests that a person is abnormal, but the abnormality may or may not be based on a physical or mental health problem. In fact, in many cases, deviance as a label may be more of a commentary on character rather than health status. In contrast, being labeled with a mental health problem suggests that the behaviors associated with the problem are not necessarily in the control of the individual.¹⁰ The medicalized label of behaviors is understood by others based on social perceptions of that label. Social understandings develop through media and anecdotes that spread about people with medical labels. The label affects the way an individual and families perceive themselves and how others perceive them in the context of the label.

When a child is labeled as having a health problem, the family will find a strategy to deal with the label given to the child's illness and the perceptions associated with it, including the varying perceptions of family, individuals in the institution and in the community (Ablon 1988; Bluebond-Langer 1996). If the label is accepted to any

¹⁰ This was certainly not always true, and in some cases mental health labels may still be associated with poor moral character or lack of personal control. However, today there is more acceptance of people labeled with mental health problems as having actual health issues rather than moral issues. This does not mean that those with a mental health label are always openly accepted, but the stigma of having a mental health problem has shifted somewhat away from moral stigma to health stigma.

degree, the parents may learn how to manage the tasks of getting their child the services the child needs while trying to live as much as possible like the family did prior to the diagnosis (Bluebond-Langer 1996).

Parents experience stress and must adapt with coping mechanisms to confront the changes the label and subsequent treatment have on the family's emotions, obligations and role expectations (Ablon 1988). A child's health problems often mean that "... roles, duties, obligations and priorities change as family life is interrupted by the burdens of care and treatment" (Bluebond-Langer 1996:12). One technique frequently used to cope with a stigmatized trait or behavior, such as a mental health problem, is to normalize that trait or behavior in order to make life seem more ordinary. One of the main ways people normalize their stigmatized trait is by integrating with a group of people who share that particular characteristic. Becker and Arnold (1986) use the deaf community as an example. The inability to hear is a medicalized and stigmatized trait in larger society. To cope with being stigmatized, a deaf person may make efforts to integrate with other deaf people, making most of his or her social interactions with people who also cannot hear. By doing so, being deaf is no longer a disadvantaged trait; rather it is considered normal among the group (Becker and Arnold 1986). Similarly, families with children who have mental or behavioral health problems may seek support from other families who are dealing with the same type of medicalization of their child's behavior.

Bluebond-Langer (1996) argues that another primary coping strategy is developing routines so that each family member has a role in which to help with daily household activities as well as helping the child with therapy. The same strategy may

be adopted for a family with a child who receives mental health services. One mother with whom I spoke said that she and her husband had a schedule for taking their son to counseling sessions at a local hospital. She said that they took turns taking him and picking him up from his sessions. They also took on specific roles to disciplining when he became upset "... as part of his disorder." She said that by working together, along with their son and his counselor, they learned to manage his mental health treatment. For some, developing routines that involve the help of multiple family members and friends is not always possible. Many families have one parent and little social support so that delegating routine tasks is not an option.

For most families time and money are limited, so the requirements for treatment may be altered in order to allow the parents to handle both the prescribed therapies while dealing with everyday experiences of work and family responsibilities. Children and their families may choose to engage in some treatments and not others. The decisions on if and how to engage with treatments are based on personal constraints on everyday life (Bluebond-Langer 1996). One father I spoke with said when his daughter was referred to a psychologist outside the school, he chose not to accept the referral. He explained that he had to work everyday, and he was not available to take her to appointments across town once a week. He felt that the school counselor could provide just as good of treatment for his daughter, and he did not see the need for all the efforts needed to get his daughter to completely separate appointments.

The decisions are also based on how the parents interpret the label and service options. The meanings that families give to the label and the labeling institution influence the way that families can and will adapt their strategies for dealing with a

child's health label and prescribed treatments. Tara, the mother of the son in middle school who opted to send her son to a counselor outside the school, contrasted with aforementioned father. She interpreted her son's services as a private matter that should be provided away from his peers. She was available to take him to appointments off of school campus and chose this option because she felt her son would be more comfortable and, therefore, be more receptive to treatment.

Families have a need for a sense of "normalcy" and "control" when a child suffers from a health problem (Bluebond-Langer 1996). The need to normalize is especially important for mental health problems because unlike physical illnesses such as cancer or cystic fibrosis, mental illness implies the loss of normal cognitive function. The loss of "normal" cognitive functioning is associated with the loss of one of the most highly valued human characteristics (Stein 1990). As discussed early, the loss of a highly valued trait creates a great deal of stigma associated with that loss (Ablon 1982), and therefore the need for strong strategies for coping with not only the illness itself, but the stigmatized label of having a mental health problem.

A number of factors affect the way in which a family responds to a child being labeled as having a mental health problem. Such factors of the health problem include "... the degree of its visibility, the social acceptability of the handicap, the socio-economic level and cultural values and attitudes of the family, ... [and] the manner in which the parents are informed of the condition" (Ablon 1988:3). Initial reactions to the label may be fear, shame or denial, but depending on the strategies the family has to cope with the new label, the family will eventually learn to adapt to the label and the treatment (Bluebond-Langer 1996; Ablon 1988). Adapting does not necessarily mean

full acceptance of the label as defined by the institution, nor does it necessarily mean to follow the prescribed treatment for the mental health problem. Adaptation refers to the alteration of everyday life experiences as a result of a health problem, or to the label of having a health problem (Ablon 1988).

Negotiating a Medicalized World

While Gwen and other parents were willing to accept the medical labels and treatments provided through the school, no parent I interviewed said that they actively sought treatment. All mental and behavioral health treatments were recommended to them by a school staff member. Most of the parents I spoke with said they had concerns about their child's behaviors before services were suggested by school staff. For many parents, they simply did not know what options were available through the schools. They had wondered what they could do to help their children "succeed in school" and "stay out of trouble," but they were not familiar with the school-based services and felt they could not afford a psychologist. Tara, like other parents I talked to, said she was pleased when a teacher told her about services available in the schools. While she ultimately opted out of the school-based services and opted for off-campus services, she said her son's school was a good starting place. The school was a conduit to getting her son into services she felt really helped him get better grades, stay out of fights, and respect authority. School teachers and social workers said that some parents will come to them and ask for help, but it is much more common for a staff member to contact parents to offer suggestions for students who have exhibited what they consider signs of at-risk behavior.

The term “at-risk” references behaviors that are considered to put a student at a high level of risk for negative consequences such as poor health, quitting school before graduation, or entering the criminal justice system. What constitutes at-risk behaviors is in part based on statistics and in part based on subjective opinions about whether behaviors are categorized as appropriate or inappropriate. Behaviors that frequently are considered at-risk which often lead to a student being identified as needing mental health care treatment include use of tobacco, alcohol or other drugs, skipping school, extreme lethargy or aggression in the classroom, angry outbursts, or the inability to concentrate (Grantmakers in Health 2010). School staff all agreed that these behaviors usually indicate an emotional or mental health problem with a student. Parents shared the perspectives of school staff about their child’s behaviors. They agreed with staff members when their child was labeled as having at-risk behaviors, and they were ready to accept treatment. With regard to labels and the need of medical treatment, there was congruency among both the community and school cultures. However, divergence in perspectives and attitudes occurred with the process of treatment and the roles that each group took in the treatment activities.

While parents accepted medical labels and treatment, they often had different ideas about the treatment process than school staff members. School staff members, including teachers, social workers and school counselors, said that many parents simply are not involved in their child’s education or mental health treatments. One teacher said that parents need to learn better parenting skills.

Some parents are knowledgeable and some are not. Society as a whole

is so into instant gratification and are not willing to put in the work themselves. They rarely take on initiative of their own. It is important to empower the parents to take care of their own needs and the needs of their child. They need to be more proactive.

The sentiments in this teacher's comment were shared by other staff members. The notion of "parenting skills" is a type of folk term. A folk term refers to words or expressions people use to convey specific meanings in relationship to other things (Spradley 1979). In a sense, folk terms are a type of cultural symbol. The folk term "parenting skills" symbolizes the types of behaviors school staff felt parents should have when interacting with their children. It is a way for school staff to understand parents. During many of my interviews and informal discussions with staff, I was frequently told that parents just aren't involved in their child's school experiences. Some staff said they felt that it was the stigma associated with their child needing extra services, whether the extra services were academic or mental health. They felt that many parents were in denial of their child needing additional support to help them succeed in school. However, my interviews with the parents did not suggest that parents were in denial of their child needing services. Rather, they had different ideas about the process of getting their children into school-based mental health services and the role they felt they should take in the services.

For example, Nina said she felt like some services that were offered to her son Todd were not necessary. She initially was pleased when the school offered counseling services to her son. However, Todd did not like the sessions, and she saw little

improvement. They were referred to a hospital psychiatrist outside of the school, and she followed up with appointments with that doctor. Her son liked the off-campus psychiatrist, so Nina decided to withdraw Todd from the school counseling sessions. She said that when she did this she felt like Todd's teacher disapproved of her decision.

His teacher said that Todd could benefit from sessions with both a psychiatrist and school counselor, but he doesn't like him [school counselor], so I don't see a reason for him to go. They may think I am making a bad decision, but I like the outside school services.

There are less distractions in the hospital than at school.

It was important for Nina to make decisions about her son's treatment that she felt were best for him. While she completely accepted that her son could benefit from mental health services, she wanted to be in control of his treatments. She explained that she agreed that her son had medical problems that could be addressed through counseling. Further, she was actually relieved that there were mental health services that could address her son's behaviors that she felt were getting him into trouble. However, she did not think that it was necessary to follow all recommendations for treatments. She was happy to listen to options, but she ultimately made decisions based on what she felt was best for her son.

When a child is medically labeled, parents negotiate the social control that comes with being labeled with a medical problem, wanting to retain control of their own bodies, and finding comfort that the biomedical treatment can solve their problems.

Like many medically labeled individuals and their families, parents will maintain an active role in their diagnosis, treatment and evaluation of the medical service they and their children receive (Gabe and Calnan 1989).

CHAPTER VI: INSTITUTIONAL CULTURE

One of the earliest applied studies of institutional culture was the Western Electric research program commenced in 1927 (Whyte 1978). In the company's attempt to understand its workers, scholars from multiple disciplines were hired as consultants to conduct research on the organization and behavior of employees. Included in this study were several anthropologists who researched the informal organization of workers to understand them as a cultural group within the organization. Publications from this project involved many anthropological studies, including Warner and Low's (1946) study of strikes among factory workers and Gardner's (1945) seminal handbook *Human Relations on Industry*. One of the primary findings of these studies was that employees had their own form of organization and understandings of their roles in the institution that was separate from the formal organization of the institution. From an anthropological standpoint, the informal organization of the workers was examined as a cultural phenomenon within the institution. The organizational culture was not just a set of rules and policies of the organization; rather it was a dynamic engagement of the official and unofficial organization, attitudes and behaviors of the employees (Whyte 1978:130-132).

This early research and the subsequent publications looked at the informal culture of workers as a way to "... help business organizations solve their human problems" (Whyte 1978:130). Today, institutional research among anthropologists has evolved to help not only the businesses with their "human problems," but to help the workers and those served by the organization (Rhodes 2004). By understanding how individuals behave in the context of the institution and give meaning to the services

provided by the institution, we can begin to address gaps in perceptions of purpose and roles. Disparities in access to services can also be identified to help develop more appropriate and effective services that meet the needs of both groups.

A great deal of research has been conducted on the clash of cultural health and healing models, examining the discord between the professional, biomedical model and the folk, or non-professional, models (Kleinman 1980:254). From Arthur Kleinman (1972) to Paul Farmer (2003) a critical eye has been placed on the biomedical model as excluding the values and methods of non-biomedical health models. And while the critical medical anthropology literature has offered great insight to the discrepancies between the dominant medical culture in the United States and the non-biomedical culture, the clash of cultures goes beyond the cultural differences between scientific-based medicine and non-science-based approaches to health care. The biomedical model may provide guidelines for the service provider's behavior within the institution, but it does not necessarily define what they actually do (Stein 1990). Rules are established within the institution to guide the behaviors of the community members, yet individuals may not follow the prescribed rules of behaviors. There are many different ways to interpret and experience health and healing. Even when health care providers and those they serve share a common health model and "... come from the same cultural background, they view ill-health in very different ways...their perspectives are based on different premises, employ different system of proof, and assess the efficacy of treatment in a different way" (Helman 1990:86). When individuals integrate multiple models of health into their daily lives, the diversity of interpretations and experiences in health and healing are further magnified. Merrill Singer and Hans Baer

argue that "... health is an elastic condition that must be considered within an encompassing sociocultural context" (2007:64). I further argue that health care institutions are also elastic and must be understood in a "sociocultural context" of both the providers and the community served.

The development and delivery of health services is affected by the culture of the "medical consumer" as well as the institutional, or "local-practice," culture of service providers (Gesler 1991:47). There is no single model of biomedical health care. It is not a homogeneous or unchanging system. Howard Stein (1990) and John Campbell (2000) argue that Kleinman and other critical medical anthropologists put too much emphasis on the importance of the biomedical model and only tangentially discuss the issue of institutional culture, and "... the problem of its impact on individual well-being or on patient accounts is not explored in any depth, in part because he [Kleinman] focuses on a specific form of patient-practitioner discourse" (Campbell 2000:111). It is the 'other' part of patient-practitioner discourse, the community-institutional discourse and interaction, I explore here.

A Clash of Cultures

A group of researchers, including a medical anthropologist, concluded from a five-year study of a community mental health center in Ontario that "... mental health system was itself a distinct culture, and that many of the challenges identified by the informants could be conceptualized as clashes between the mental health system culture and the culture of newcomer [consumer] groups" (Westhues, et al 2008:706). Similarly, I found that the school-based mental health care system was its own distinct

culture with both overlap and distinction with the community culture. I discuss these institutional cultural elements throughout this chapter.

It is important to understand the cultural attitudes and behaviors of individuals from both groups. In order to understand health care and what is needed to have an effective health care system, it is necessary to understand both the medical professionals and the consumers (Nader 1973:9). While institutional culture is certainly influenced by the biomedical model of care, each institution has its own structure and discourse that influences the behavior of the employees and those serviced by the institution. I adopt the definition that institutional culture is the way that "... everyday activities, decisions, factions and relationships actually work within an organization" (Britan and Cohen 1980:14). Looking beyond the prescribed rules and behaviors of the institution, it is essential to seek to understand how people who work within and are served by the school-based mental health system *actually* behave and interact. Although there are defined institutional rules, those rules only partially tell the story of the organization. It is important to understand how people act and interact in everyday life, and how those behaviors mutually affect both individuals in the institution and those served by it.

In order to understand the health care and what is needed to have a more effective system, we must understand the medical professionals as well as the consumers (Nader 1973:9). There is no single model of health care. It is not a homogeneous or unchanging system. Not only are there a variety of models of health care, but there is great variation within single models. Howard Stein (1990:27) argues that the identification of "... who and what should be treated, selection of admissible clinical data, choice of therapeutic modality, and expectation of outcome are themselves

based upon value-laden modality.” The specific values of the organization direct the behaviors of the service provider and the patient and family. For example, the way in which a person is identified as needing mental health services is determined by the organizational priorities and policies. And how an individual responds to being identified as needing services is directly related to the method in which they were identified. The “... clashes in power, authority and knowledge in the clinical setting can shape patients’ ideas and affect their behavior in daily life, sometimes for the worse” (Kingfisher and Millard 1998:447). Miscommunication can occur due to differing understandings about what “should” happen held by the service provider and those receiving services. There is often a “... gap between a health care provider’s intentions and perceptions of the intended beneficiary (Gesler 1991:3).

My interviews with both parents and school staff suggested that the two groups understood the other very differently. During interviews and observations, I heard school staff members often say that they felt like the parents did not engage in their children’s schooling. Comments were frequently made about parents not being able to help their children with educational and mental or behavioral health care services at home. The barriers to educational and other school-based services that were most often given by school staff were poverty and lack of parenting skills due to poverty. One program coordinator referred to this phenomenon as “educational poverty.”

Many parents lack the ability to continue the educational process at home. The biggest barrier to school services is the poverty that that the families come from. This includes educational poverty. Parenting

styles are different... How they [parents] view education is different. They view education as the school's job and don't think they have the skills to do it.

This type of discourse was not infrequent when talking to school staff. A teacher shared these sentiments.

Lots of parents are guarded and defensive. They don't seem to be willing or supportive of school services. This is a very poor neighborhood, and they [parents] don't have the skills needed. We do have many parents who are very supportive of school services, but we also have many parents who are not involved because they have too many of their own issues they have to deal with. Mental health services go on the back burner. They have a learned helplessness, and they very rarely will take the initiative on their own to get their kids into services.

At same time, another school staff member makes efforts not to blame parents.

Some parents are less open to what the school has to offer, especially those who have had bad experiences with the school in the past. It is the school's responsibility to make it a comfortable environment where parents can come for services for their children.

This type of discussion suggests that there are specific staff understandings of parents based on poverty. Many staff understood poverty as the cause for parents not

behaving or engaging in services the way in which staff felt was appropriate. Both students and parents were viewed as victims of poverty. School staff explained parental behaviors not as a form of agency but rather as a negative consequence of poverty that they just cannot avoid. While the first two interview excerpts suggest a belief in the culture of poverty (Lewis 1966), the latter implies a problem with the school culture. Together they both imply that there is a sort of conflict between community and school culture.

According to Paul Willis (1976), who studied in a working-class neighborhood in London, the conflict between schools and the local community is class-based where the students and their families struggle with domination by the schools and active resistance to such domination. While I agree that there is a type of social control of the schools over the students in terms of influencing student behaviors and values, I argue that struggles between the school staff and families are not always a class-based struggle. I am not overlooking the fact that many of the parents lived in a very poor, urban area while most of the school staff lived in middle class neighborhoods in suburbs around the city, but I think the class difference is only one form of differences between staff and family. I argue that the discrepancies lie in the conflict between school and community cultures. The poverty in which many families live on the Westside certainly influences their culture. However, when poverty becomes a blaming tool for parental behavior, it implies that parents would act differently, and inherently better, if only they had more money. This perception of poverty homogenizes poverty. It assumes that lacking resources is inherently equivalent to one single experience, but people experience poverty uniquely. Individuals will not necessarily share experiences,

perceptions or beliefs based solely on having limited resources. Blaming poverty also suggests that the behaviors of the middle and upper class are more desirable while the behaviors of those with limited access to resources are simply unavoidable negative consequences of being poor.

When I interviewed parents, I did not hear stories about active resistance against the control of the schools and staff, nor did I hear complaints about any sort of domination of the schools. Rather, I heard stories about parents searching for assistance from schools and the misunderstandings that occurred due to different beliefs and understandings about the role of schools. When Nina's son Todd was referred to a school counselor as well as an external psychologist, she was pleased to receive the referral. She said that she felt the school was a good catalyst to getting Todd into mental health services. However, when she and Todd opted to engage only in the external services, she felt that the school staff pressured her to continue with the school counselor even though they did not want to engage in the school-based services. While she saw the school as very helpful in getting her son into mental health services, she felt the school took on a greater role in administering the services than they preferred. To Nina, the primary role of the school was to offer families referrals and let them know what treatment options are available, but it was the role of the family to make the decision on what services to accept.

Parents often talked about "not knowing what do" and having a child who is "out of control." Some school staff may hear these comments and feel that the parents do not have the parenting skills necessary to help their child become less "out of control." As a result, school staff may offer services or suggestions for at-home

activities to parents based on what they learned in their training or from their own experiences as parents. Parents may hear these suggestions, but the guidance offered may not resonate. For example, Patricia told a story about how a teacher suggested that she sit down with her daughter, who was frequently angered, every night with a chart to label the feelings of the child throughout the day. Patricia thought this was a bad idea because it would trigger teasing by the older children in the house and only exacerbate the child's anger. The first time she tried to sit down with her daughter to fill out the chart, her daughter squirmed in her lap and refused to look at the chart. Her brothers laughed at her, and this caused her daughter to squirm even more until she was eventually released from her mother's lap. She tried one more time with similar results and decided that it just wasn't a good exercise. Patricia reasoned, "Why would I want to do something that angers my child more? It makes no sense to me."

It is likely that charting feelings was a technique that the teacher learned in her training and had perhaps been a helpful tool for some children. However, such techniques are based on the values and assumptions of the schools, not necessarily those of the community. In New York, teachers and social workers are required to have a Master's degree, and counselors at least have a Bachelor's degree. Their educational training and subsequent job experiences enculturate them into their professional roles as school-based service providers. Professional service providers have their own "... values, theories of disease, rules of behavior, and organization into a hierarchy of specialized roles..." and have acquired "... high social status, high earning power, and the socially legitimated role of healer" (Estroff 1981:86). The role that staff take on is in a large part guided by their education and how their position is defined within the

context of the school, and a staff members' positions within the school affects their goals and attitudes (Rhodes 2004). Frequently, the staff members' goals and attitudes differ from the families they serve.

Gesler (1991) distinguishes between the cultures of professional and nonprofessional systems. The difference, he argues, is that professional systems "... tend to codify knowledge in a more formal way and also have formal schools for training" (1991:16). Schools are staffed with professionals who have specialized training in their respective fields, and such training affects how they perceive their work and interpret their roles as service providers. Professional training is part of the development of the culture within the workplace (Rhodes 1991). The discourses of school-based service providers and the families they serve suggest that they have contradicting views of the policies and goals of the medical institution. Service providers are not necessarily taught in their training to take the perspective of those they serve. Their training is based on a specific set of assumptions and theories of how things *should* work. Often this training does not take into account other sets of assumptions or the practicality of the everyday life of parents.

School staff may have the best intentions for their students, and from my experiences in the school I believe that most do, but intentions may fall short of the needs of the community. A mutual understanding between the school staff and parents is also a necessary component. When suggestions are made by teachers, social workers or counselors that do not seem relevant to students and their parents, they are naturally going to be less inclined to follow through with the suggestions. When parents gave

examples of feeling understood by a teacher or counselor, they said that they felt they were receiving the best services possible.

I was thinking about it [mental health services] before. It was good that the school got involved. They helped me get services faster. And we found a counselor he really likes. She seems to get him, and he really likes her. I guess she understands what it's like, you know, to be tempted. She doesn't make him feel bad. He is better. He has had less referrals this year. He is doing better.

To this mother, it was important that her son found a person to talk to who understood him and the difficulties of being a young male living in an urban environment. This does not imply that there are not difficulties for women or for men living in the suburbs, but it does suggest that it is important for service providers to realize that the challenges are different. For this family, feeling understood was key to feeling like the counseling services were helpful and relevant.

The Blame Game

In Gerry Rosenfeld's (1971) ethnography of a Harlem elementary school, he found that the teachers differed from each other in their perspective about the role and responsibilities of the schools. From the teacher's perspectives, they were responsible for teaching those who they were considered teachable and punish those who they felt were lazy or refused to take the subordinate role in the formal structure of the school.

The students, however, felt that the teachers made assessments before they even knew the children and their capabilities and that there was little use in making efforts to be good in school. The students who were labeled “bad” or “lazy” felt that if the teachers perceived them poorly then it was not possible to ever be a “good” student. The students expressed that the schools were really only for the “good” students, those students who made good grades, never disrupted class and had nice clothes and used the proper words.

Rosenfeld (1971) argued that different perceptions of the school created different experiences within the structure. For the teachers, all students could do well if they just applied themselves and followed the rules. For the students and their families, only students who the teachers labeled “good” would do well and gain the advantages of an education. In a sense, the teachers thought the students determined their fate in the school while the students felt the teachers determined their fate.

Thirty years later, I found both school staff and families less willing to blame each other for problems in the school. Both groups agreed that school staff and parents were both in part responsible for a child’s education. When perceptions and behaviors did not align, efforts were made not to blame parents or teachers, but rather the ‘system’ became an avenue for blame. In lieu of blaming individuals, social structures became the object of blame. But through blaming systems, individuals felt personal guilt for being part of such systems.

Parents said they felt schools were designed not to take into account individual needs. They wanted school staff to understand their lifestyles. By lifestyles, they were referring not only to the challenges of raising a child in a poor urban neighborhood, but

also their values and beliefs about what is best for their children. According to one mother, the school needed to respect her decision not to force her daughter to go to the school counselor.

If she wants to go, she will go. If she doesn't, then it's not going to help anyway, so why go. The schools just need to let us make decisions. We aren't helpless just because we are poor. We may just not agree that we should force our kids to do something they don't want to do.

Parents said that they were not looking for staff to blame their living conditions and lack of resources but rather acknowledge challenges of living on the Westside. Many parents expressed that they felt that teachers and other staff blamed them under the guise of blaming poverty. By using poverty as a reason for a child's behavior, school staff induced guilt on the parents for not providing better for their children. Even though many staff said they made efforts not to blame the parents, many parents felt like they were being held responsible for their child's problems based on their low income status. Many parents felt that their values and parenting skills were not accepted as purposeful and reasonable by many staff members.

Staff members have preferences on how parents should be involved in their child's life based on their own cultural norms and their training. There are hegemonic ideals in schools of what it means to be a good parent (Jones 2008). School staff have authority to make assessments of children and their parents based on these ideals. In efforts not to blame parents, many staff use poverty to explain parental behaviors that

do not align with school norms or expectations. Poverty becomes a sort of red herring whereby blame appears to be diverted away from parents but in actuality makes parents feel doubly blamed for being poor as well as not being “good” parents. Staff indicated they had good intentions when they use poverty to explain parental behaviors and parents’ lack of conforming to what staff consider appropriate parental roles, yet parents find this approach insulting. To parents, using such an approach to understand parents suggests that their behaviors and beliefs about parenting are not as legitimate as those of the school staff. One mother, Gloria, told me she was tired of hearing about how teachers were “... so understanding about living in poverty and they just want to help.” She said it was insulting for teachers to pretend they knew what it was like to live in the neighborhood she lived in or to raise a child in that environment.

Parents felt that by blaming poverty, staff are implying that the parents *would* share beliefs and act and in ways that are congruent with school norms and expectations if only they were not poor. To parents, this attitude prevalent in the schools suggests that the parents on the Westside were somehow inferior to parents in wealthier neighborhoods. Parents believed that their beliefs and parenting styles were just as legitimate as that of the school staff members and should be treated as such.

Another common structural blaming phenomenon was the blaming of “culture.” Culture is frequently used by teachers “... as one of the primary explanations for everything from school failure to problems with behavior management and discipline” (Ladson-Billings 2006:104). Many of the school staff I interviewed gave culture as the reason for children behaving in ways that are not congruent with school norms. They also used culture to explain why parents were not involved in their child’s schooling or

mental health services. Culture becomes a catchall term to explain any differences between school and community norms.

This tendency for blaming culture as an explanation is a way to avert blame from individuals. Like blaming poverty, however, blaming culture has negative connotations. For parents, blaming culture does not alleviate them from blame, but rather it puts blame on their community. Gloria, the mother discussed above, asked during our interview, “What do they [the teachers] know about black culture?” She told me that to her, the way teachers talk about about African American culture is also insulting. She said it makes African Americans sound like they “don’t know how to parent. I know how to parent, and it is not a cultural thing. I am a good parent, regardless of my culture or my being black.”

While there may be cultural differences, the ubiquitous use of cultural disparities as explanations for any differences derides the legitimacy of those differences. Like anthropologists, school staff appropriate the term “culture” to represent differences between parents and themselves (Feinberg 1994).

Mrs. Thompson, a staff member at a Westside elementary school, said that working with parents in the neighborhood was very difficult. She said the parents are often “guarded and defensive.” While she recognized that mistrust by parents is often due to previous poor experiences with the schools, she said that she felt that it is also a “cultural thing.”

In the community there is a lot of shame associated with mental health problems. We [teachers] have to battle cultural barriers, but culture

is starting to change. We are chinking away at the armor.

For Mrs. Thompson, culture is to blame for parents choosing not to engage in mental health services for their children. Like poverty discussed in the previous section, culture is something to be “overcome” so that the parents will join the teacher’s point of view about services and what is best for their child. But also like poverty, the culture on the Westside is not homogenous nor does it imply lack of agency of parents. Another illustration of culture as a blaming tool is that several teachers said they were often frustrated when parents refused to return their phone calls and often said that it was a cultural barrier between schools and parents. When a teacher says that the reason a mother does not return her phone calls is because of cultural differences, two things are implied. First, it suggests that the mother is not making an active decision not to call but does not do so because she is a puppet to her culture. Second, it implies that the mother’s culture is flawed in some way. To the teacher, returning her phone call is the appropriate response for a parent. When culture is given as the culprit for her failure to call, then it suggests that the mother’s culture is bereft of appropriate etiquette. To many parents, these implications make them feel like they are being treated like incompetent parents.

The tendency to use culture as a catchall explanation is also problematic because it often becomes a proxy for race (Ladson-Billings 2006). By saying that a parent’s behavior is due to his or her culture, school staff are not necessarily talking about a homogenous neighborhood culture but rather the culture of a particular race. For example, several teachers discussed parents in terms of the Latin community or African

American community. The following quote from a teacher exemplifies how school staff use race and culture to explain why parents do not engage in mental health services for their children.

Nine out ten times parents want what is best for their kids and go with our recommendations, but one out of ten parents doesn't want help. They say, 'My kid is fine.' This is usually in the African American community. In the African American culture there is a lot of shame associated with mental health problems. We have to educate them what it means to get treatment to help them change their minds.

The first two sentences suggest that when parents want what is best for their children, they will inherently follow school staff recommendations, thus implying that those parents who do not want the schools help do not want the best for their children. The assumption here is that the school staff know what is best for children, and only parents who do not care about their children would not follow their recommendations for treatment.

The following two sentences suggest that there is a homogenous African American culture out there whereby all members, and specifically members of this group, feel shame associated with their children receiving mental health services. Of course there is no single African American group, and there were many reports of African American families pursuing mental health care for their children through the schools. Further, a sense of shame associated with mental health treatments is not

isolated to the African American community. People of a variety of races, classes and genders express shame and embarrassment when they or a family member have received some type of psychiatric services. Yet, the teacher points to African American culture as the reason for parents choosing not to engage in mental health services for their children.

The final sentence again suggests that the school's staff know what is best for students and parents, due to their culture, and those who do not need help to learn. Taken together, these five sentences demonstrates that blaming culture, especially racialized culture, does not take away blame from individual parents but rather acts as circuitous method to reproach parents for making decisions that do not align with the school staff's recommendations for students. It certainly sounds better to blame a community system (i.e. culture) as not being conducive to school services than to blame a parent for not caring about their child, even though blaming culture ultimately does the latter. Parents recognize this paradox and do not feel comforted by the absence of individual blame. Rather, they feel that blaming culture is a way to demean their values, decision-making processes, and ultimate decisions about engaging in services for their children.

The problems associated with blaming culture do not mean that there are not cultural differences. In fact, the contradictions in the perceptions of the appropriateness of blaming culture demonstrate cultural differences between schools and the local communities. While school staff thought blaming poverty was a positive approach to understanding parents in the community, parents felt this approach was offensive. The difference in perceptions is rooted in training and everyday experiences. Many teachers

said that they received some training on multi-culturalism, albeit limited training, where they learned discourse that encourages the use of the term “culture” as the contributing factor to differences between school and community perspectives. However, the term culture is not defined, and school staff are left to interpret what it means to be culturally different.

When cultural differences were cited as reasons by school staff why parents did not become engaged in their children’s school-based mental health service, I asked what they meant by the term culture. The answers varied greatly. To some school staff, culture of local families referenced their beliefs and interpretations about school and school-based services

CHAPTER VII: NEGOTIATION OF POWER IN SCHOOLS

The contradicting perceptions of school staff and local families are more than just unfortunate miscommunications; they also influence the delivery and effectiveness of the educational and health services provided by the schools. There is a power dynamic embedded in the school categories, goals, services, and interactions that gives authority of the institution (Rhodes 2004). School culture is embedded with policies that are created and expressed under the guise of being “neutral” but often fail to achieve impartiality (Shore and Wright 1997:8). School policies often do not account for personal beliefs and understandings of the school and the services it provides. While some families may share in the school understandings of student expectations and goals as a community institution, they also adopt their own perceptions and beliefs about the role of the schools based on their local community norms and values. School and community cultures are like a Venn diagram with independent and overlapping norms, values and beliefs. There are some common components in schools and communities, but there are also many differences between the groups. Consequently, the misalignment of perceptions and values with the goals and policies of the school can lead to misunderstandings between school staff and parents. They also can further exacerbate perceived inequalities in the school. Individuals may be treated differently, or perceived to be treated differently, because of differing perceptions of the purpose and expectations of the services provided by the school as well as diverse understandings of categories used by the staff members.

There are cultural biases in the evaluation instruments used to assess a child’s mental status. For example, when psychiatric tests are given, language and education

levels are often ignored. This can lead to individuals being labeled as having a mental health problem when it may just be a difference of cultural understandings (Fabrega 1995). Psychiatric assessments do not always consider language barriers, cultural differences, economic status or social marginality and, thus, are often inaccurate and result in labeling individuals with a disorder (Rogler, Malgady & Rodriguez 1989). Intrinsic to the labeling of a child as needing mental health care is its derision of that child and the need to correct the behaviors associated with the mental disorder; psychiatric treatment is thus "... controlling if not actually coercive and potentially stigmatizing" (Fabrego 1993:167).

Due to public school's institutional position in the community as educational and cultural producers, schools hold symbolic power. The use and negotiation of specialized knowledge is a way to gain symbolic power in an institution, including public schools (Estroff 1981; Rhodes 1991; Hansen 1997; Rhodes 2004). Symbolic power is legitimized power that is transmitted through symbolic exchange that is based on shared beliefs and provides legitimacy to institutions through institutional language that customizes, stereotypes and neutralizes with "delegated authority" (Bourdieu 1991:109).

Schools have a specialized authoritative knowledge that gives them power to give labels and subsequent treatments to students that are considered 'right' because they are believed to be the authority on all things related to children and their progress as students. Authoritative knowledge refers to knowledge that a community as a whole considers "... legitimate, consequential, official, worthy of discussion and appropriate for justifying particular actions..." (Jordan 1997:58). The difference in knowledge

between the school staff and the local community creates a hierarchical system, with the schools at the top of the knowledge tower and the community at the bottom. This gap in knowledge creates an unequal distribution of power between the institution and community (Davis-Floyd 1997).

Schools are considered to have such specialized knowledge because of the social assumptions made about the training of school staff and administrators. There is a basic supposition that if you work at a school as a teacher, psychologist, social worker or case manager that you must have completed appropriate training and received certifications that legitimizes your ability to label and treat children. The legitimacy of the authority of school employees is not reduced by the fact that such trainings and certifications are provided and received by the same overarching institutions (i.e. government accredited education institutions). Rather, it perpetuates the beliefs that the public education system has authoritative knowledge and that such knowledge is passed onto all those individuals who work at schools through the same system. Schools provide staff members with access to specialized knowledge gained through their training and position within the schools. Their authority in the schools and community is legitimated through this specialized knowledge (Rhodes 2004).

This specialized knowledge influences how school staff interact with students and parents. Assumptions are made in the schools that staff have specialized knowledge about what is best for students and better skills in teaching, disciplining and medicinally treating students than the local community. These assumptions are passed on to the community through interactions with school staff and parents. Parents become aware that staff have specialized knowledge and may internalize the authority that

comes with that knowledge (Labov 1982). This does not mean that parents do not challenge this authority because they certainly do, and I provide examples of this in the following sections. However, parents are aware of the symbolic power of school staff. My research suggests that symbolic power is played out in schools through labels, access to space and flow of information.

Labeling in the Schools:

When a child is labeled and put into a category that suggests he or she may need special treatment, a sense of authority is pressed upon them. Labels and categories can create stigma for families served by the school, further marginalize them and perpetuate inequalities in the schools. In ethnographic literature, the process of labeling an individual by an institution is often presented as a form of control (Estroff 1981; Rhodes 1991; Fabrega 1993). Labels are given as a way to categorize individuals and provide information about how that individual is perceived and treated in the context of the institution and often in the community as well (Estroff 1981). For example, when a child is labeled as being depressed in school, such a label determines how that child is served by the school and how others in the school interact with that person. The effects of the label act as a form of control by prescribing certain treatment for that individual (Estroff 1981; Rhodes 1991). If the label becomes known within the community, it can also affect how family, friends and neighbors perceive and interact with the labeled child. Labels and categories can create stigma for children and their families that further marginalizes them and perpetuates inequalities.

I found the potential stigma from a child's peers to be a particular concern for many of the mothers I interviewed. One mother said that while she was glad her son was able to get counseling at school, she wished for a more private setting. The counselor's office was located just outside the main school administrative office. She said her son had been teased for going to counseling, and he sometimes did not attend his sessions because he did not want others to see him.

While the effects of an institutionally defined label in the community may not be intentional by the institution, the labeled individual still may feel the influence of the label outside the institution. Parents and their children must adapt to new perceptions and learn to interact in the context of that label both in and out the institution which provided the label (Estroff 1981; Stein 1990). The meanings of labels that are given to an individual are learned and understood by that individual through interactions with the institution from which the label is given (Estroff 1981; Barrett 1996) as well as interactions in the community (Stein 1990). Individual reactions to those labels are the product of not only the interactions with the institution, but also the understandings that are acquired through the neighborhood and community culture (Stein 1990).

Research suggests that "... all types of societies show a natural inclination to medicalize deviant behavior" (Fabrega 1993:186). However, the types of behavior that are considered 'deviant' and how those who exhibit such behavior are treated varies greatly. For example, many biomedically defined mental health disorders "... may not be recognized or handled as sickness in some communities" (Fabrega 1997:5). The categories and terms used to label a mental health problem may seem inappropriate for

some individuals who do not have a shared understanding of terms used by staff in the schools.

The meaning that individuals give to the labels is derived from two main aspects of that person's life: the community in which that person lives (Fabrega 1995; Barrio 2000) and the interactions with the school as the labeling institution (Barrett 1996; Lovell 2007). The categories and discourse of each group are the avenue by which individuals understand and interact with a given health label. This is not to say that they are separate understandings, rather they both interact to give the label meaning (Stein 1990). The mutual interactions of experiences and narratives about how a label is given and what the label means affects how families will interact with the school and staff members. Together, community culture and school culture build a family's understanding about what the label means.

Through the process of navigating community and school cultures, families may question the treatment or labels given to their children. Although schools have symbolic authority in the community, symbolic power is a process that is negotiated by all people involved (Hansen 1997). The idea that school staff "know best" is not necessarily assumed by parents. Parents question the legitimacy of the authority of school staff. As parents navigate through the schools and community understandings of schools and labels given by the schools, they take on an active role in interacting with the schools and affiliated labels and treatment of their children.

One father said that when his daughter was labeled as she "could benefit from counseling," he said he was skeptical. He decided to opt out of counseling sessions for his daughter.

My daughter acts up some, but she don't need counseling. They don't know. They give counseling for any kid who acts up. Sometimes kids just act up. It don't mean they have a problem.

While the other parents I spoke with were more agreeable to have their child go to counseling session, this father's sentiments questioning the authority of school staff were shared by other parents. One mother said that she knew her son needed some help and was open to the idea of having her son receive counseling at school, but she did not accept it when he was diagnosed as having bipolar disorder.

He is not crazy. He just has some problems, you know. I think counseling could help, but that don't mean he is crazy. They say he has bipolar. What is that? It means he has ups and downs is what it means. What kid don't have bipolar then? He just needs a little straitening out.

So, while parents often accessed mental health services offered to their children through schools, they also understood them from their own perspective, not necessarily the perspective of the school. They negotiated services, labels and their roles in the services in a way that made the most sense to them based on their perceptions of their child, the local school and the label. The legitimacy of the authority of the staff is not necessarily assumed by the local community. Staff cannot force parents to behave or think certain ways. School culture is embedded in policies that label students and often

are challenged by the families they serve. School staff and parents must negotiate and work within the context of school policies and each other's beliefs about what should happen and how they perceive their own and each other's roles in the context of the institution (Rhodes 2004). As I discussed in chapter five, families do not inherently adopt a "patient role" as described by Good (1992). They make personal assessments about what they think their child needs. Their assessments are influenced by the norms, values and expectations of the community and the school.

Flow of Information and Access to Space

The use and negotiation of space and information is a way to gain symbolic power in an institution (Estroff 1981; Rhodes 1991; Hansen 1997; Rhodes 2004). Individuals within a school are separated based on their roles within the institution. Different roles provide different levels of authority, knowledge and power. Space is a primary method used in institutions to separate the service providers and those served by an institution. Spatial division provides a means to express the roles and status of each individual within an institution (Foucault 1977; Rhodes 1991, Estroff 1981). Foucault (1977) used a prison to exemplify his theory. In a prison, the prisoners are separated from the community simply by being forced to live in the institution. They are further separated from the guards by being placed in cells. Within the prison, space is used to establish authority and submission by the guards and inmates, respectively. The guards have access to multiple areas in the prison, including private offices, inmates' cells and recreation areas in the prison and the community outside the walls of the prison. Conversely, the inmates are restricted to areas designated for prisoners. The

privilege of space allocation gives guards status in the institution. Similarly, space in schools is used as a way to define the individual's roles and status in the institution.

The public schools on the Westside have a variety of layouts, but one thing they have in common is that the main administrative office is located near the front entrance of the school. The reason given for this is so that visitors can be seen by the administrative staff. All visitors are required to check in at the main office, and by placing the office near the front entrance, the staff can have a greater awareness when there is a new visitor. The reason given for this policy was safety. One staff member said that you never know who might come through the doors at a school. Having visitors check in was viewed as "just a precaution" against potential individuals who wished to harm either the students or staff members.

When I began volunteering at one school for two years, the doors to the front entrance were unlocked during school hours. However, this changed occurred during my second year there. The doors were locked, even during school hours. All visitors had to ring a buzzer and be let in by a staff member. Before being admitted, a staff member would view the camera located at the front of the door and make a decision whether or not to let the person at the door enter the school. When I asked one staff member about the new system she said that the school had wanted to have the security system for a long time and that everyone was glad to have it installed. Another staff member said she felt the students were safer with the new security.

While at the school, I never did see anyone not be admitted upon arrival. I asked several staff members who they thought might be kept out by the added security. I was told that they didn't have anyone in particular in mind, but they had heard stories

about people in the community coming into schools who “didn’t belong.” I inquired what they meant by not belonging. The most common response I got was people who did not have children at the school or had no reason to be at the school except just to look around. Several staff members said that it just wasn’t safe to have people who didn’t have a defined reason in the school to be there. So, the reason given for the installation of the security system was to make staff feel safer from community members who might want to visit the school but did not have children in the schools. I found this somewhat alarming since public schools are community institutions that are meant to be open to the community. I was interested in finding out what community members felt about the added security. All parents I interviewed said they thought it was good to have extra security in schools because “you never know.” What don’t you never know, I inquired. I was told that you just never know what can happen, so it is best to be extra safe, especially when it comes to children. I asked one man who lived in the community but did not currently have any children in the school what he thought about the new security at the local school. He said he was not aware of it but agreed that the extra security was probably a good measure to keep the children safe. Even he, the man argued, had no reason to be at the school, so he would expect someone at the school to question why he was there if he were to visit.

Both staff and community members agreed that they thought it was a good policy to have the extra security. Although no one could pinpoint exactly from what they thought they were protecting the children, the security system made them feel safer. There was no particular threat against the school, but people had “heard stories.” One father said when he dropped his kids off at school, he waited until they had entered

the building before he drove away. “You just never know what can happen,” he said, “It is better to be safe than sorry.” He had heard about kids being abducted in the schoolyard and didn’t want to take a chance with his children.

Enough media coverage of threats and harmful events in other schools made people wary in their own schools. As an anthropologist, I could not help but view the added security from a perspective of the symbolic power of schools to make decisions about who belonged and who did not belong. However, after talking to parents, I realized that they saw this type of power not only acceptable for schools, but also an *obligation*. Several parents said they felt it was the job of schools to keep the children safe. Schools were obligated to keep their staff and students safe, and if extra security could do this, then all agreed that it was the appropriate measure for the school to take. And perhaps if I had a child in school, I too would welcome added security measures.

Even though school staff and community members thought the security system was appropriate for schools, schools still retain a sense of power about who could enter the building. Although I did not witness or hear about someone not being allowed into the building, the school did have the power to not admit a visitor. Even when a specific power of an institution is desired by staff and the local community, such as security at a public school, the symbolism of that power remains. In schools, the flow of people is managed through security measures. It could be a security system with cameras and buzzers, or simply an office located near the front entrance. Schools as a public institution become less public. Only those who are deemed to belong are allowed to enter. Those who are not seen as belonging are subject to rejection. While it may be done with the “good of the children” in mind, the power over public space is restricted

to a specific group of people. Thus, public schools retain symbolic power over the space of their building.

In addition to separation of space between school staff and local families, there is also separation through the flow of information. Symbolic power of a school is developed and negotiated by both staff and family through symbolic use of information (Estroff 1981; Stein 1990; Rhodes 1991; Hansen 1997; Rhodes 2004). Students have files about their progress in school, extra services they receive, and any other comments teachers, counselors or social workers want to insert. A file is an important method used in institutions to keep information accessible only to designated staff (Estroff 1981; Rhodes 2004). Information about a student is kept very confidential, frequently even from the student and his or her family. While staff maintain that students' files are kept confidential for their privacy, the chart symbolizes authority of the schools to create, alter and secure such a file. The file is off limits to those without special authorization, setting a distance between the staff and families. Not only does the file symbolize the special knowledge of school staff, the file is also a way to contain students by defining and labeling them (Rhodes 2004).

The progress of a student in school is communicated to parents through notes sent home and phone calls. Progress reports are required by all teachers and are the primary way that teachers communicate with parents. These are formal, written documents sent to all parents as a way to notify parents about their children's progress, behaviors, and interactions in school. If a student is progressing and behaving in ways that are congruent with school norms and expectations, little other communication may be made. One mother I spoke with said that she was glad her daughter performed well

in school, but she sometimes wished for more personalized communication with the schools. While written progress reports state both the positive and negative aspects of a child's progress and behaviors in schools, many parents said that they only received personal communication when their child was misbehaving. Several parents I interviewed said they dreaded phone calls from the school because it meant that their child had gotten in trouble again. One mother said she wished her daughter's teacher would call when her daughter made an A or played well with another student rather than just when her daughter got in trouble. Instead, she said she only got personalized communication from the teacher or school social worker when her daughter *got in trouble again*.

Many teachers and program coordinators also said that they were frustrated that they only talked to many parents when they were concerned about a child. One teacher said that she was really frustrated with the system of communication between parents and teachers. She felt like she just didn't have the time to call all the parents on a regular basis, so calls were usually restricted to when she felt like she really needed a parent to be aware of poor progress or specific behaviors, usually problem behaviors, of a child.

There is too much emphasis on the bad, not enough on the good.

Sometimes we call with good news, but usually not. We just don't have the time. Relationship building is key, but that can be hard when we don't have the time to build those relationships with every parent.

Lack of time was frequently mentioned as a reason that teachers did not talk more to parents. Many teachers said they only had to call parents when it was “severe.” Severity was based on personal subjectivity, depending on the teacher’s perspectives of particular behaviors. However, all teachers agreed that once a child’s behavior reached what they deemed to be “severe” that they would phone a parent. They also agreed that they would like to call all parents as a general family check in, but they felt they just did not have time to phone all of their student’s parents. Parents also said limited time was a contributing factor as to why they did have interactions with school staff.

Teachers said that they felt that one of the primary ways to contact parents was at Open House that was held one evening each fall. This requires parents to come to the school building and seek out their children’s teachers. Teachers and parents viewed Open House very differently. While the teachers felt that this was a very important night that parents should attend, many parents viewed it as an unnecessary obligation or felt uncomfortable at entering the schools. This is an example of the difference in school and community cultures. While some parents did attend Open House, they also expressed their frustration about the evening. From the teachers’ perspectives, parents should be responsible for attending the event and contacting the school with questions and concerns about their children. The teachers felt they were warm and welcoming to all parents who attended the Open House or contacted them during other times in the school year.

Many teachers also said that when parents did initiate contact with them, it was often hostile. One teacher said she dreaded getting phone calls from a parent because it usually meant she was going to get yelled at for “doing wrong by a child,” such as

giving a student a poor grade or sending him or her to detention. Another teacher said she had one mother who came to regularly observe her daughter's class. At the end of her observations, the mother often critiqued the teacher on her teaching style and methods. Teachers occasionally felt attacked by parents and did not always look forward to their interactions with them.

Many parents said they did not feel comfortable coming to the schools, especially if their child had gotten in trouble at school. They said they felt judged by teachers. This feeling was tied into parents' experiences about feeling blamed for being poor and a bad parent. These feelings of judgment influenced the interactions that transpired between teachers and parents about their children. According to one mother, school staff could be insensitive to parents.

Schools are always telling us what to do, like we don't know. Every time I talk to my kids' teachers, they always tell me what is wrong with them and what needs to be done to fix them. Maybe nothing is wrong with them. Maybe it is the teachers that have something wrong with them.

Teachers thought parents should be equally responsible for taking the initiative to contact the school to stay informed about their child's progress. They felt that they were welcoming to all parents. Parents, however, said they frequently did not feel comfortable coming to the school or calling teachers. Because of this discomfort, they often did not contact the school or participate in school events. Parents felt that teachers should make more efforts to contact them to provide a more welcoming environment.

These disparate perceptions of parent-teacher interactions influenced the flow of information about students' progress and behaviors in school. Information flow was stunted because of incongruent perceptions about interactions between teachers and parents. While limited time certainly played a role in the poor communication between the two groups, the differences in perceptions of individual roles and treatment of the other played a larger role. And because of the school's authoritative position in the community, the school staff retained privileged information about students that was often not conveyed to parents. At the same time, parents participated in active decision-making about how and when to interact with school staff. Together, they negotiated school and community cultures and authority.

CHAPTER VIII: PERCEIVED ROLES OF SCHOOLS IN CHILD MENTAL

HEALTH CARE

Cultural Metaphors

Health is "... intimately connected with the way people construct reality; with the way in which communities, including administratively created communities, function; and with the way in which health expertise works" (Nader 1973-8). Without understanding how individuals from the institutional and outside communities involved in the school-based mental health system interpret a mental health label, including how they feel about the diagnosis, the etiology and the treatment, it is not possible to understand their interactions in the context of the institution in which the services are delivered. The way in which individuals construct reality in the context of school-based mental health services is embedded in their everyday experiences with the school and mental health systems. In order to understand how individuals make sense of their everyday experiences, it is necessary to understand how experiences translate into conceptual metaphors.

Conceptual metaphors reveal cultural models and act as grand symbols used to help organize an individual's life. They "... structure what we perceive, how we get around in the world, and how we relate to other people... play[ing] a central role in defining our everyday realities" (Lakoff and Johnson 1980:3). The way in which we understand the world is by interpreting and experiencing things and events in terms of other things and events (Lakoff and Johnson 1980; Becker 1997). For example, when we say that *a man is a rock*, we are mapping what we know about rocks. The metaphor

a *man is a rock* requires cultural knowledge about how the person using the metaphor understands a rock to be (Lakoff and Johnson 1980). We understand that man not as an actually piece of earth but as acting like a rock and possessing rock-like traits such as solidity, strength and tranquility. We might also speak of him in other terms of being a rock, such as saying that his face was stone or he was as unmoved as a boulder. These metaphors help us structure how we perceive that man and how we interact with him (Lakoff and Johnson 1980).

Lakoff and Johnson (1980) identify two domains of conceptual metaphors. The source domain is the concept from which the conceptual metaphor is drawn. The target domain is the concept that is described through the conceptual metaphor. For example, in the cultural metaphor “love is a journey,” journey is the source domain, and love is the target domain. We map what we know about journey to understand love. Conceptual metaphors map what we have concretely experienced to the target domain as a way to understand the target domain (Lakoff and Johnson 1980).

We use cultural conceptual metaphors in all facets of our life, including perceptions of and experiences with health and education. Both the healthcare and educational institutions are associated with conceptual metaphors by those who work within the institutions and those served by them. Educational institutes can hold a variety of roles for different communities (Schensul et al. 1985). For some, school means a place to learn and integrate social values and norms. For others, however, schools may not be associated metaphorically with ‘social learning.’ By investigating the cultural metaphors for schools among staff and local families, I sought to understand the role that both groups see the school playing in the community.

The role that schools play in a family's life is greatly influenced by how the larger community views the school. In a community where the metaphors for school are an institution of social control, a place where my kid gets in trouble or a place that tries to tell me how to raise my child, parents may be less likely to feel that the schools are a place for their child to receive any type of health services. In contrast, if a school is seen as a place of help, kindness and competence, parents will be more likely to feel that schools are an acceptable place to receive services for their children.

I found that parents on the Westside had pieces of both views of the public schools. In my formal interviews and informal discussions, parents expressed that schools were a place where their kid often got in trouble. For many, the only time the school contacted them was to inform them that their child had misbehaved or was performing poorly in school. Parent's interactions were often based on negative interactions, which colored their views of the schools and the staff. Yet, they also expressed that the schools were good community institutions that are helpful in their child's life, both academically and in mental healthcare.

Schools as Social and Health Service Providers

For parents on the Westside, schools are a metaphor for social and health service agencies. While public schools are explicitly responsible for providing students with an academic education, parents viewed schools as a place to turn when they or their children needed additional types of support or services. The similarity in experiences with both types of institutions creates a correlation in parents' minds. Both types of institutions provide families with social support and services for physical and mental

health issues. Like all cultural metaphors, the metaphor *schools as social and health service agencies* is a way to highlight and organize experiences local families have with the public schools (Lakoff and Johnson 1980).

Every parent I spoke with expressed that they not only accepted school-based mental health services; they believed that schools were actively responsible for providing mental health services. The reasons given were two-fold. First, parents said that they did not know where else they might get such services. Parental perceptions of their child's health and behaviors influence their decision-making in seeking care for their child (Janicke et al. 2001). When a parent feels that her child has a physical or mental health problem, she is more likely to seek help. Many parents expressed that their child had become "so hard to handle" that they were thankful when a school staff member offered some sort of service that might help improve her behavior. The parents felt at the "end of [their] rope" and did not know where to turn for help with their child. They expressed thankfulness when help with their child's behavioral problems was offered through the school.¹¹

Second, most parents said that they felt that schools were already such a large part of their lives that they should take a role in their students' health care. One mother explained that "... if kids have to spend so much time there, [schools] should take responsibility that the kids are healthy. Without health, kids aren't going to do well in school anyway. Schools gotta take care of both."

¹¹ It is important to note that when I use the terms "behavioral problems" or "mental health problems" I do not use them objectively. In the context of this section, I use them as described by the parents I interviewed. This does not necessarily mean that the children had a certifiable mental illness or that their behaviors were inherently bad. Rather, it means that the parents felt that their child did not behave in ways they considered appropriate and felt that they could benefit from some sort of mental health treatment.

Taken together, parents felt that schools were inherently places to receive social and mental health services. Because schools were viewed as social and health care providers, parents were very open to having their own children participate in such services. The metaphor *schools as social and health care service agencies* both supported and perpetuated parents' decisions to engage with school services in the same way they did other social and health care agencies.

At first I was a bit surprised at this finding as early literature on the public education system in poor, marginalized neighborhoods (Willis 1976; MacLeod 2009) suggests that community members are often skeptical of school services and do not necessarily view services offered in schools as beneficial to them. I was also told by many school staff members that they believed many of the parents did not like nor engaged in the school-based mental health care services. However, I found that while parents thought it was important for schools to provide mental health services to students, they also were wary of such services. Although these two views may seem mutually exclusive, parents reconcile both conceptions of schools.

Schools as Places of Censure

As discussed above, parents feel that *schools are social and health care agencies* and, thus, responsible for providing mental health services for students. At the same time, they do not blindly accept such services offered by the school. For many parents on the Westside, schools are viewed as a place of negative interactions. In this sense, *schools are censure*. Often the only contact parents have with school staff is when a child has misbehaved or is doing poorly in school. For example, one mother

said that when a school staff member called her to discuss her daughter, she knew that her daughter must have gotten in trouble at school again. She was tired of getting phone calls only when her daughter did something bad. “Why can’t they call when she gets an A on a test? No, they only call when she acts up in class.” When the only interactions a parent has with a school staff member is based on something wrong with her child, it is certainly understandable that parents are not eager to engage with the staff.

Again, we see how the metaphor *schools as censure* guides and supports families’ experiences with the schools, or as Lakoff and Johnson (1980:156), the metaphor becomes “self-fulfilling prophecies.” Stories, personal experiences and cultural metaphors interact to influence how people perceive and experience an institution. Stories about parents’ poor interactions with schools that get passed through the community also influence how parents experience and perceive school-based services. Prior experiences with and social anecdotes about an institution, such as schools, and service providers greatly affect how that institute is perceived by those seeking services from that institution (Helman1990:124). Individuals receive much of their perceptions about health practices and behaviors from their neighbors. When a relative or friend has a bad experience with the school-based mental health system and reports such an experience, this will affect whether other families in the community want to seek such services (Vega and Lopez 2001). This becomes a cyclic problem. For example, one mother I spoke with said she had heard about a neighbor’s son who attended counseling sessions at the local middle school. He came home everyday and told his mom that all the counselor did was yell at him and tell him what an awful

person he was. I was not able to interview the neighbor or discuss her son with the counselor to understand her viewpoint of what transpired during those sessions. However, the woman I did interview said that just hearing that story made her wary to send her own child to the school counselor. The stories that circulate greatly influence the perception of *schools as censure*.”

Schools as Social Support Network

While parents said they felt like school staff occasionally looked down on them because of their decisions about engaging with social and mental health services for their children, they also had good interactions with staff. As with other community agencies, schools also provided a supportive system for getting services for their children. Schools not only offered on-site mental health services, they also offered guidance about where to get additional help for their children. School staff members often were viewed as a support network where parents turned to when they felt their child needed mental health care. Here we see the cultural metaphor of *schools as social support*.

Social support is a primary factor in how individuals experience social and mental health services (Janicke et al. 2001). Parents said they saw schools as a support network that helped them deal not only with their children’s behavioral and mental health problems, but also the stresses of their everyday lives. For many parents on the Westside, everyday stressors often lead them to search for support through community agencies, including the schools. From an anthropological perspective, stress is

culturally based and affects "... the perception of the individual, and his channeling of affective response and coping mechanisms" (Anderson 1964:193).

Social support is one of the primary conditions that influences the way in which people deal with stress (Eckenrode and Gore 1981; Jacobson 1987; Thoits 1995).

Having social support networks helps individuals have healthier perceptions themselves and their environment and reduces stress (Spradley and Phillips 1972). Families living in marginalized communities, such as the Westside, often have limited social support (Thoits 1995). Limited social networks provide limited coping strategies. The perception of having social support is more influential on mental health than the actual receipt of social support (Thoits 1995:64). Coping mechanisms are often correlated with one's perceived sense of control of life circumstances, which are inversely distributed by social status, meaning the lower people feel that their status is, the higher sense of fatalism they will have (Thoits 1995). Conversely, when people have positive images of their status, they will have better coping strategies that are correlated with positive health. With limited access to material and social resources, both children and their parents experience high levels of stress but have limited coping strategies to deal with their stress (Flinn and England 1995). Although family is often a primary support system, networks beyond the immediate family are often needed (Thoits 1995). Parents on the Westside do not always have adequate coping resources, and schools often help fill this need.

Schools offer families two types of social support. First, schools provide social support as a mechanism to deal with everyday life stressors. Second, schools offer

families support through guidance and referrals to other community resources. Parents said both types of support were important but for different reasons.

Schools as a mechanism for handling stress was important because it helped families cope with everyday stressors frequently found on the Westside. As discussed in chapter three, there are a variety of stressors in low-income neighborhoods like the Westside. Extreme stress can lead an individual to poor emotional management and feelings of inadequacy (Thoits 1985:240). When people have feelings of inadequacy, they compare themselves to others to gauge whether they are “normal” (Thoits 1985). When one does make comparison with others, that person may sense his or her feelings are validated if they have support from others to help them realize that their feelings are due to stressful events and not any inherent problem within the person. However, without feelings of social support, such comparisons can also make a person feel worse, as if his or her feelings or perceptions are bad or wrong. When individuals lack social support they are less likely to feel validated. Such feelings can spiral and lead to withdrawal from others and even poorer abilities to cope with stress (Thoits 1985).

Schools provide parents with a place to express their stresses and help them understand that they are not alone. The way in which social support is incorporated into school behavioral mental health treatment greatly influences the way in which the parents and children respond to that treatment and any associated medical labels. Several parents I spoke with said that just hearing a teacher say that they have heard other parents have the same experiences and concerns about their children made them feel better. When parents felt like a teacher, counselor or social worker took on a truly supportive role, they were more likely to feel like they were “on the same side.” This

meant that when parents did not feel criticized by a school staff member but rather supported, they were more likely to trust that staff member and feel like they were working towards common goals for their children.

Having a child labeled as having a behavioral or mental health problem and as in need of services from a professional is a stressful event, especially a stigmatized health issue such as a mental health problem. The way in which families feel about a child being labeled and treated with mental health care services is largely influenced by their support systems (Anderson 1964). In addition to parents wanting to feel like school staff were “on their side,” schools as support networks were also important due to the lack of other community networks. Most of the parents I spoke with who had children who received school-based mental health services said they did not talk to other parents about their child’s behavioral problems or services they received. The stigma associated with having a child labeled and treated for mental health problems lead to parents wanting to keep it private. Parents were more comfortable talking to a supportive staff member than a neighbor about their children’s behavioral or mental health problems. While the parents may have felt some criticism by school staff, they also felt a degree of disconnect with them because they were not neighbors who would gossip about them. One mother explained:

A teacher may judge me, but at least I get to go home and not deal with it there. You tell a neighbor, and then everyone knows. There is no hiding when you tell a neighbor.

So, schools took on an important role where parents would go and express concerns about their child. In turn, school staff were soundboards for parents and also providers of services and referrals for other community services.

Many parents were unaware of the resources available to them and their children. Schools were important places where parents could go to find out the types of resources available to them when they were concerned about their child. Schools were believed to be the contact point to all types of services for children in Syracuse. One mother said that when she tried to get her son to see a psychiatrist at a local hospital she was put on an incredibly long waiting list. In response, she went to her son's teacher and was able to get him into counseling services in just a few days. Schools were seen as providing a pivotal role in making sure families got the services they needed.

Interacting with Multiple Cultural Metaphors

The three cultural metaphors for schools are *schools as social and health service agencies*, *schools as censure* and *schools as social support*. Parents conceived of schools as places of treatment, support and disapproval for their children. They are able to reconcile these positions by engaging with schools and their child's care on their own terms. Once mental health services are offered to a child, the parents are likely to accept the offer and be pleased that their child is getting treatment that they believe will help improve her behavior. However, parents remain cautious of the help offered and may not be feel comfortable coming to the school for meetings with school staff to discuss their children.

Feeling the need for help from schools but also being aware of the negative interactions school staff have with parents led parents to make efforts to engage with school-based mental health services on their own terms. Parents are active participants in their child's mental health services. Although many of the school staff I interviewed said that parents were frequently not involved in their child's treatment, most parents I spoke with said they felt they were doing what they could to help their child, including encouraging them to go to counseling sessions. While parents may not follow exactly what school staff prescribes, this does not mean that they are not interested in the services offered to their children. In fact, all the parents I spoke with took an active role in their child's mental health care. But the role they took was based on what they felt was appropriate, not necessarily on what teachers or other school staff members said they should do.

One mother, whose daughter had gotten in trouble in school and in the community for skipping class, being disruptive, getting in fights and stealing, said that she did not like going to meetings at the school because she felt like the school staff treated her like a bad mother. She said that the school staff would tell her all the ways her daughter had gotten in trouble at school and then ask if she was having any personal troubles at home, "... as if asking what I did to my daughter to make her act all crazy." She said that she liked her daughter getting treatment at school for her "crazy behavior" through counseling services, but she did not feel it was helpful to go to meetings with the school social worker, psychologist or teachers. She said she was very involved in her daughter's education by asking her about school and her counseling sessions and making sure she did her homework. To her, meetings were just a way for teachers to

feel like they are doing something when really they don't know what to do with a student. She felt the role of school was to offer mental health services and let the families decide how they want to interact with those services.

Another mother, Sara, said that she always went to scheduled meetings with her daughter's teachers because she felt that was a good way to be involved in her child's life. She agreed that schools are community agencies that are responsible for offering as many services to children and families as possible. Sara said she took advantage of all services offered because she felt it was best for her daughter, but she did not think parents should be required to accept all services offered to their children. Like the other mother discussed above, she felt that parents should be able to exercise their rights to pick and choose what services they want.

Because parents often felt criticized for engaging in services on their own terms, schools are also seen as a place of censure. The feeling of criticism that parents felt from schools was not singular to schools. Many parents said they had similar feelings with other community agencies, such as the local health clinic. For example, one mother said that when she refused a flu shot for her youngest child, she was berated by a nurse at a nearby health clinic for being an irresponsible parent. Other parents said they had similar experiences and viewed criticism as a potential consequence of acquiring services for their children at public institutions, including schools.

Several parents I spoke with echoed Sara's sentiments that schools are responsible for providing an assortment of services, but parents should be able to make decisions about what they want to incorporate into their child's life. Schools are viewed as a community agency that provides not only academic services, but also social and

mental health services. Like other community agencies, services should be available to all families but not required. Schools are perceived as a community place for families to receive services for their children, including mental health services, but they should not be coercive. Parents want to feel free to make their own decisions about how to interact with their child, school staff and the mental health services provided to their children.

CHAPTER IX: NEGOTIATING MULTIPLE ROLES

Why do schools take on mental health care for students? From a school policy standpoint, at least three reasons are frequently given. First is the belief that students who have mental health problems and do not receive services are more likely to perform poorly academically (Arcia et al. 2004; Chow et al. 2003). From this perspective, schools are obligated to provide mental health care to students as part of their educational services.

Second is the belief that students with untreated mental health problems are more likely to be disruptive to other students (Arcia et al. 2004; Chow et al. 2003). From this standpoint, mental health services are less for the individual child, but rather for the “good” of the school. Third, schools may take on the role of providing mental health care because many families lack access to health care outside of the schools. Since schools and affiliated communities such as Say Yes to Education do address many of the barriers to healthcare, it is believed to be beneficial to the families to offer services within the school building. From this point of view, the purpose of school-based mental health services is for the “good” of the community.

The reasons listed above provide explanations as to why schools offer mental health services to children from the perspective of school system administrators. But they do not explain what it means to the school teachers, nurses, social workers, and counselors to be responsible for identifying children as needing treatment and providing the services within the context of the school? How do the individuals on the front lines of the education system interpret school-based services and their roles as providers of both academic and mental health services?

Taking on Multiple Roles: School Staff as Social & Mental Health Care Providers

Ms. Barker has worked in child mental health care services for over twenty years. Currently a staff member at a local middle school on the Westside, she says she is amazed at how her role as a mental health care provider for children has changed since beginning her position with the school district. Schools, she argues, are good places for children to access some services, but it is just not practical for schools to take on the roles of primary mental health providers for students.

Schools are good for students on the borderline but don't need an In-patient setting or non-regular school. A school's role is to maintain students as students and give support for parents. Schools help address transportation barriers. But there are limits to what we can do here.

At times Ms. Barker said she felt like there are expectations for her to work miracles, not so much by the parents but by the administration. She said she felt pulled in several directions and just didn't have the time to be effective for all the students on her heavy caseload.

Not all school staff shared Ms. Barker's perspective. Ms. Brown, a teacher at the same middle school as Ms. Barker, said she felt it was the school's responsibility to provide as many services to students as possible, including behavioral and mental health care services. She acknowledged that it was not an easy task to provide such a wide variety of services and more staff was needed, but the need outweighed the difficulties

of providing such services. She said she was willing to work outside school hours to give students and families any extra support that could help the students succeed in school.

The way in which school faculty and staff perceive their roles as identifying children with social and mental health care needs and being part of the services varied among staff members. While all the non-teachers and most of the teachers said they felt that it is unequivocally the school's responsibility to identify and provide services for children who need mental health care and social services, a small number of teachers argued that it is a responsibility they have taken on reluctantly because of the pressures to do so. The latter group of staff members tended to feel particularly reluctant to take on mental health care.

The teachers who felt it was a burden to include social and mental health care services as part of their responsibility gave lack of time as the primary reason for their feelings. They felt that they did not have enough time to be part of treatment teams for students nor did they have time in their classroom to provide one-on-one support that many students needed. This group of teachers attributed their location in a poor inner-city neighborhood as a contributing factor to what one teacher calls the "... burden of misbehavior."

Such notions that poor urban areas are more likely to have students who need social and mental health services stem from both local discussion and academic research. One teacher said that he had a friend who worked in a suburban school who did not have as many problems with her students as he did. Other teachers with whom I spoke, including teachers who thought it was school staff's responsibility to provide

additional services for their students, also said that they felt particular challenges because they work in a poor urban area. While it would be difficult to deny the fact that children in urban areas are more likely to take advantage of social and mental health care offered through the school than those in suburban areas, it is important to examine access to recourses as a key contributing factor in the use of such services. As discussed above, the Westside in Syracuse has many families with limited resources who use school-based services because they address many barriers to other types of services. This does not mean that problems are necessarily less likely to arise in suburban schools. Rather, suburban students are more likely to come from families with more economic recourses and receive services outside the school, allowing the school staff to take on a smaller role in their students' services. The staff members who felt it was necessary for schools to provide social and mental health services all agreed that when a teacher takes a job in an inner city school, it inherently becomes part of his or her job to meet the needs of the students, including their social and mental health needs.

According to many school staff members, schools are responsible for providing any services that help the children to benefit from what schools have to offer. Bourgeois (1996) and Rosenfeld (1971) argue schools are the primary institute for mediating society's relationship with children, especially children living in urban areas. Thus, school "offerings" include not only academic education and the removal of barriers to academics, but also a social education and the removal of barriers that inhibit children from obtaining both types of education. Social services and mental health services offer children a tool in their social education. Through services such as individual and group

counseling, children learn to handle their emotions, interact with others and engage with society. Most of the school staff members agree that the schools are responsible for helping children learn these skills and, therefore, the schools are responsible for offering services that help build these skills.

Although most of the staff expressed that they believed that it was appropriate for schools to provide social and mental health services to children, the responses varied when asked about their specific roles in students' mental health care. Not surprisingly, the non-teachers, who are the individuals directly responsible for school-based mental health services, expressed that they felt well-prepared to be part of the process. However, most of the teachers said that they did not feel that they had the proper training. Additionally, many teachers, even those who felt schools should be responsible for providing social and mental health care services, felt that they were not well situated to include mental health care as part of their job because they were already limited on time with the students. To append additional tasks to their already crowded work day did not seem like they would be able to provide services effectively.

Being part of the treatment team is one of the most time consuming parts of taking on the role as child mental health or social service provider according to most teachers. They have to attend meetings with other school staff, and there are often disagreements about what a student needs in terms of services. It can take a great deal of time to develop a treatment plan. Also, some services require that a student leave class on a regular basis, often making extra work for the teachers to "... catch the student up to speed." In response, the teachers said that more resources are needed to

help them provide effective academics and be part of the school-based social and mental health services.

Many of the school staff said they felt the school should take on an even bigger role in social services and mental health care, but they all agreed that more resources are needed. One participant, Ms. Bishop, said that she felt that if schools are going to be effective in providing a well-rounded education to all students, social services and mental health care are necessary components. Another participant, Ms. Temple, agreed that mental health care was just as an important part of education as math or science class, but she also said that schools need to be given more resources to provide such services. The notion of limited resources came up in almost all of the interviews. Both teachers and non-teachers, even those who took on non-academic service roles reluctantly, agreed that *if* social support services and mental health care were going to be part of the public education system and have positive, long-term affects on the students, then additional support was needed for schools to be effective in providing those services. Specifically, additional staff and financial resources were the primary types of support that those interviewed felt would allow the schools to be more effective in providing mental health services to their students.

Although all participants felt more resources, including community resources, were needed if mental health care was to be an integrated and effective part of school programming, not all teachers felt that schools were necessarily *obligated* to provide mental health care. Three of the teachers said they felt so overwhelmed with their daily responsibilities in the classroom that they just didn't feel they had the time to provide additional services as well. In general, the teachers who had daily interactions with the

same students were more likely to report that they felt that being responsible for providing additional services outside of academics was beyond the scope of not only their responsibilities, but also their expertise.

Each of the participants who said that they didn't think it was inherently the schools responsibilities to provide social and mental health care services pointed out that they were not opposed to mental health care in the schools. Rather, they felt that schools had taken on the role of specialized service provider because of the lack of alternatives for the students. They were each eager to express that they were not lacking in empathy for the students who needed social or mental health services, but they felt such services were not an obligation within the classroom. Two of these staff members offered that they thought a separate classroom would be an effective way of providing services for these students. They likened such a classroom to the special education classrooms that already exist in the schools. Many teachers admitted to taking on a larger role in the mental health care than they would like. They said that they attended treatment team meetings and met with students on a one-on-one basis either because it was required by the school or because they felt the child had no where else to turn. One teacher said that his professional role identity was different than he expected when he was in school training to be a teacher. He did not know he would have to take on so many additional responsibilities.

For the individuals who said that they felt that it was the responsibility of the school to take on the role of social and mental health service providers, the primary reason given was based on the belief that such services were an integral part to education services. Rather than seeing education, social services and mental health care

as separate, these individuals felt that they were integrated services. One participant, Ms. Sampson, stated that she felt that it was important for schools to take on multiple roles in the Westside community because she felt that marginalized communities need to have positive and meaningful experiences beyond academics for the schools to have any real impact on the community.

Ms. Sampson said that by taking on a variety of roles for the children and parents, schools can provide those meaningful interactions "... that open the door for real learning to occur." She continued saying that schools are responsible for providing services that can remove barriers to learning and providing positive experiences for children and parents. Thus, by taking on the roles of teacher, mental health care provider, advocate and service facilitator, school staff are only fulfilling their job responsibilities.

Similarly, another teacher, Ms. Post, said that she felt that schools were also responsible for the social integration of children and that mental health services are part of helping children become socially integrated. She stated that schools should provide mental health care because they have a "captivated audience." By providing young students care in schools, it is possible to ensure treatment that benefits them as children and later as adults. She argued that school-based services for children at an early age are not just important to the students, but there are also future social and economic reasons to provide such services to children in Kindergarten and first grade. Ms. Post stated that offering services to young students and helping them adjust to the demands in and out of school means that the students will need fewer services later in life. The services that adolescents and adults need are costlier, both socially and economically,

than those of young children. By helping the students at an earlier age, Ms. Post maintained, the schools can help produce mentally healthier and more successful students. When asked how she defined a successful student, she said that students who did not go to jail and were able to graduate can be considered successful for many families.

Integrating Behaviors, Medical Labels and a Student's "Success"

The notion of "successful" came up in several of the interviews. The school staff agreed that it was in part their responsibility to help students become successful, but this term had different meanings for each person. For Mrs. Post the term successful referred to the successful completion of school and not going to jail. For another teacher, success referred to graduating from high school. A school counselor said that she saw success as being able to make passing grades and socialize with the other students and the teachers. For several teachers, success meant that a student behaved in class and made passing grades.

The participants also varied in how they felt success could be achieved. While the teachers all agreed that parental involvement was key to success, several non-teacher staff said that parents, teachers and affiliated school staff play an equal part in a child's life. Teachers, counselors, social workers and program coordinators have the power to discipline, label and treat students within the context of the school according to what they believe the student needs to be "successful." Each group has different degrees of authority and varying interpretations of their roles as service providers (Rhodes 1991; Hansen 1997). Due to their different positions within the school, they

have differing interpretations of the behavior of a child and the appropriate ways to handle different behaviors.

Both teachers and non-teachers¹² said they occasionally disagreed with other school staff about the status of a student. Both groups felt that non-teachers are more likely to report that a child was improving and heading towards success. According to many teachers, the reason for this discrepancy is that teachers interact with a student for more time and on a more regular basis. Such prolonged interactions give teachers a better opportunity to see "... what is really going on." The non-teachers credited the prolonged interactions between teachers and students as increasing the chances of teachers seeing all types of behaviors, including those behaviors that do not seem to indicate success. Non-teachers said this did not indicate that the student is not improving, or heading closer to success. Rather, each student, regardless of history or labels, can engage in behaviors that are considered inappropriate by teachers, and he or she should not necessarily be viewed as not heading toward a successful path. This group believed it is important to characterize success as improved behavior, defined as getting in trouble in class less frequently and improving grades.

Although school staff varied in their perspectives on how to help students find success, how they define success, and the degree to which a student could be considered successful, there was a common theme that they all felt that grades and behavior were correlated to success. This is not surprising as teachers are trained to value good grades and obedient students, predicated on the belief that such characteristics are needed to be successful in larger society. However, it is necessary to question these values. School is a place where children "... acquire the knowledge necessary for fullest participation

¹² Non-teachers refers to the counselors and case coordinators.

in our culture” (Rosenfeld 1971:4), yet there are significant differences in experiences and expectations that children have in school and at home. When expectations differ, children may behave in ways that are considered appropriate at home but not at school (Labov 1982). When behaviors are not congruent with school expectations, students may be labeled as in need of mental health services as a mechanism of control (Tuchman 1996; Rhodes 1991; Estroff 1981). The behaviors in which teachers label and treat students for engaging are classified by criteria set by the school staff.

Labeling children as in need of social or mental health services occurs in the context of the school. Behaviors that are not within the norms of the school’s expectations are frequently viewed as indicative of a student needing special care. As discussed in Chapter five, the medicalization process influences both students and school staff. For the students, being labeled with a mental health problem due to behaviors that don’t fit school expectations can stigmatize them in the school (Link and Phelan 2001; Becker and Arnold 1986; Conrad 1976). The stigma can affect how teachers, other school staff, and their peers interact with them. For the school staff, the medicalized labels influence how they feel about their roles as social and mental health care service providers.

All participants felt that labels are helpful in understanding a child and that it is important for all staff to be aware of any labels, but they differed in their perspectives on whether they felt that labels should influence a school staff member’s interaction with a student labeled with a mental health problem. There was no clear division between teachers and non-teachers. Members from both groups said they felt that labels should be noted but not determine how they will interact with a student. Other

members in both groups disagreed, saying that they felt that labels help them know how to interact with a student. For example, one teacher said that if she knows a student has the medical label of depression, she may interact differently than if she was not aware of this label. She says it helps make her more understanding and give the student the attention he or she needs.

The role that school staff took in response to the medical label correlated with how they felt about such labels. The staff members who felt that the label was an important identifying marker for the students said they were likely to use the label as determining their role in a student's life. The staff members who said they did not give much weight to a label that was attached to a student's file also said that they might give more weight to a label if they found it to be a "... true assessment of a child." This means that if a staff member saw a student exhibit behaviors that he or she believed was correlated with the label given to that student, he or she might change his or her role with that student.

Estroff (1981) and Rhodes (2004) argue labels influence how professional staff interact with clients, or in this case students. However, it is difficult to discern whether a teacher is in fact influenced by a label, even if she or he reports not being influenced. While many teachers confided in me particular labels of some students, I did not have access to records to read full reports on students. Without such information, it was not possible to make a fair assessment about the treatment of labeled students versus non-labeled students. However, I did observe one student begin counseling sessions with the school counselor. The student's teacher said that she does not care much about a

medical label and such a label did not influence her interactions with a student. I did not observe any changes in interactions between the student and her teacher.

When I asked the teacher how she felt about her student attending counseling services, the mental health label associated with such services and whether she felt this changed her role and interactions with the students, she replied that the services did not change her role or her interactions with her student. She said that she "... already knew the student needed help. I had already attended a meeting with the counselor and social worker about this student. My role changed as soon as the student showed signs of depression. Receiving counseling services is just part of the process." She also said that she felt it was important as a teacher to be part of the process of treating the student because she deals with the student everyday. She asked rhetorically how she "... could be an effective teacher if I don't even know what is going on with my students. Teachers know things about the student, like what triggers them to misbehave or how their schoolwork is affected. These things are important."

It was not directly the mental health label that influenced her interactions, but rather the belief that a child needed some type of mental health services due to what she perceived as problem behaviors. For this teacher and other school staff, the medical label and subsequent treatment simply becomes "evidence" of something they already know – that the student has a behavioral or mental health problem. For these staff members, the label and treatment are secondary to what they observe in a student. For others, the label and treatment act as a guiding tool for how to interact with a student. A few staff members said that a label indicating a child has a "problem," whether it is a mental health or a social support problem, and the related services did influence the

initial role they took with that student. For these staff members, observations of the student were secondary to the label and treatment.

Both labels and observations are understood in a particular context. There are cultural biases in these evaluation instruments used to assess an individual's mental and social health. Howard Stein (1990:27) argues that the identification of "... who and what should be treated, selection of admissible clinical data, choice of therapeutic modality, and expectation of outcome are themselves based upon value-laden modality." The specific values of the school influence the behaviors of both the school staff and their expectations of their students, and the way in which a person is identified as needing social or mental health services is determined by the school priorities and policies. How a student and his parents respond to being identified as needing services is also directly related to the method in which they were identified. Social and mental health assessments often do not consider cultural differences, economic status or social marginality and, thus, are often inaccurate and result in labeling individuals with a mental health problem (Rogler, Malgady & Rodriguez 1989).

The behaviors that a teacher expects from a student may be different from what is expected from the student at home. Children may have their own perceptions about what is considered appropriate behaviors based on what they learn at home. For example, a child may be labeled as hyperactive in school, but his parents may not perceive that his behavior is abnormal or problematic. The label "hyperactive" stems from what is considered appropriate behavior by the person labeling and "... varies as a result of the number of observers needed to agree on the diagnosis and the social position of these observers vis-à-vis the child" (Rubinstein and Perloff 1986:310).

Parents and school staff may not agree on the label of “hyperactive.” The behaviors that are acceptable at home may be viewed as problematic, or unsuccessful, in schools. Such disparities in understandings about how children *should* act can lead to child being labeled as needing specialized services (Spindler 1988).

The school staff acknowledged that they were aware that there is the occasional discrepancy between what they believe is appropriate behavior and what parents think is appropriate for their children. At the same time, the staff also said that many parents agree with their assessment of their child but are not sure what to do about their child’s behavior. It is in these cases that the staff felt that the schools provided the most effective services for their students and families. When the parents did not agree with the staff’s assessment of their child’s behaviors, many staff said that it is very difficult to provide effective services for the student. If a parent actively refuses services, the school cannot require that a student receive services unless that child is perceived as a danger to himself or others. Of course, whether a student is perceived to be a danger is subjective and has cultural biases, but it is rarely an issue at the elementary school level.

When parents did agree with the staff’s assessment of their child’s behaviors or actively asked for special services for their child, most of the staff either felt that it was their obligation to help the parents with their child’s social or mental health services in the school. For example, one teacher said she had a mother of a girl in her first grade class express concern for her daughter because her daughter had been crying a lot and was not interacting with other children. The teacher said she immediately contacted the school counselor. The school counselor met with both the student and mother, and the

daughter was referred to a mental health counselor. The teacher saw her role as a conduit to helping the mother find services for her child.

Those teachers who said they did not feel it is actively their responsibility said that they are less reluctant when the parents give their support for services. In general, the school staff all felt that they are more willing to take on the responsibility of social and mental health services when they feel supported by the parents, administration and other school staff.

Importance of Support in Managing Multiple Roles

The professional role identity of school staff depends greatly on how the staff members feel they fit into the school as a whole. Professional roles are conceptualized through their personal experiences, training, and cultural environment of the schools (van den berg 2002). For example, Jane Webber found in her dissertation research on school counselors in New Jersey that three fourths of school counselors identified themselves as counselors rather than educators while less than one-fifth of school counselors identified themselves as educators using counseling skills that they learned in their training (Webber and Mascari 2006). The counselor's identities were based on their personal work experiences and the training they felt they received as counselors. Among the school counselors and social workers that I interviewed, they identified as educators and social service and mental health care providers. They said that they used counseling and social service skills they learned in their educational training. Conversely, most of the teachers identified themselves as trained educators using skills they learned on the job to help students with social and mental health problems. At the

same time, both groups agreed that how they felt about handling multiple roles within the school was related to their training, the culture of their school and the support network they felt they had within the school.

Both teachers and non-teachers said that taking on multiple roles was “easier” when they felt supported by the school administration, other staff members and parents. The support they feel they receive is related to the overall institutional culture and policies. The school policies, organization and culture influence how school staff experience and make meaning of their daily professional lives (van den Berg 2002). The way in which school staff experience the expectations and pressures of taking on multiple roles can be understood in terms of how they feel they fit into the school (Woods 1994; Kyriacou 1987). The staff members who said they felt like an integral part of the school were more likely to feel like they were effective providers of all school-based services. Conversely, the school staff members who said they felt “distant” from other staff members were more likely to say they did not feel like they provided very effective social or mental health care services. How well integrated the staff felt in the school was heavily influenced by the support they felt they had in the school.

Lack of financial and staff support was believed to be the primary barrier to the delivery of school-based services by most staff members. School staff often lack resources to help children in their academic and social development, yet they are frequently expected to be held accountable for these services (Lawson and Sailor 2000). While many participants said they believed that social and mental health services should be integrated with education services, they did not necessarily think that these services

could be accomplished in the classroom or without additional support. Administrative and staff support was listed as the main influence on how participants felt about their individual role in school-based mental health services.

When asked what they meant by support, participants cited resource allocation, caring and cooperative staff, and communication with other community mental health systems, and feeling like others are on their side as ways they can feel supported. School staff varied in their opinions about the amount of support they felt they received. Most participants said that while they believed that more staff was needed in order for children to receive the most effective school-based services, they felt that they received a high degree of support from other staff members and the administration. The support they received from other teachers, counselors, social workers and the principal was believed to help them feel like they could play an effective role in the school-based social and mental health service system.

A small group of participants, both teachers and non-teachers, said that they did not feel like they received much support from other staff members. These individuals said that they felt like other schools got more resources, and they did not share common goals with other staff members or the school administration. For these staff members, the lack of support made them feel like they could not really be effective in being part of the school-based social and mental health care systems. They said that they felt like they were participating in these types of services as a sort of “duct tape” but that the lack of support for such services prevented any real treatment for the students. These individuals said they felt like they took on the role of mental health care provider but without the necessary support to be able to provide the proper care for students.

For schools to be effective in providing social services and mental health care to students, supports from other individuals and systems, such as other teachers, social workers, community mental health clinics and family welfare organizations, are needed (Lawson and Sailor 2000). Through collaboration, the school staff members without the training or time to dedicate to helping children with social or mental health care needs can receive support with co-workers and other community professionals. When staff members do not feel that they are supported, there is often job dissatisfaction and concern about other staff members not fulfilling their job roles (Lawson and Sailor 2000). When staff members feel dissatisfied or frustrated, they may share their feelings with other staff members. This type of talk influences how people perceive their own roles and the roles of other individuals in the school.

Jayne Morgan-Witte (2005) argues that individuals who hold care giving jobs understand their roles in the workplace through stories shared between employees. Similarly, school staff members develop an understanding of their role in the schools in part through the stories they share with their co-workers. The stories that circulate in the schools help the staff members understand their roles in the school as well as the expectations for other staff (Boje 2001). While I was visiting the schools, I observed staff members discussing their experiences with children and other teachers. Much of their conversation involved discussion about their students' behaviors or their perspectives of how well another staff member was doing his or her job. When discussions arose about other staff members, they were occasionally complaints about that staff member not fulfilling his or her job. For example, one staff member complained to a co-worker about another staff member telling her what to do even

though he did not have any authority over her. A few days later I heard the co-worker who was the sounding board in the previous conversation telling a staff member that another teacher was not taking responsibility for her student.

The stories that circulate in the school provide an opportunity for staff members to express their frustration as well as their expectations for other staff members. School staff members complain to each other about students and co-workers as a way to express their frustration, especially if that staff member is feeling unsupported.

One program coordinator told a story about how he often felt unsupported by many school staff members. As an employee of an outside agency, not the Syracuse Public School District, he felt often felt like an outsider. While this could be advantageous when dealing with parents who were unhappy with the school district, he felt it was a disadvantage when he made efforts to be part of the treatment process for students.

I think the social workers don't like my position in the school. They insist that they have a relationship with the parents and they should be the point of contact. They call themselves the "gatekeepers" to the families. It is hard to make suggestions or talk to parents because they [social workers] think that is their job. It is, but it is my job, too.

The program coordinator was sharing his frustration at feeling he had limited authority because he was not a school district employee. He did not feel integrated in the school. As a mechanism for feeling disconnected to staff in the school in which he

works, he said he had conversations with other school coordinators about the difficulties of their positions within the schools. Such conversations provided him with support from other program coordinators. He said it helped him cope with the difficulties of being “outsiders” in the school.

Although the stories and discussions in school can express feelings of stress and frustration as a means to generate support, they can also act as means to communicate support to others. On many occasions I witnessed staff glowing about a student’s performance or a co-worker’s handling of a difficult situation at school. For example, while sitting in the main office of one of the elementary schools, I overheard a teacher tell the administrative staff how well another teacher handled an upset student in the lunchroom. By talking to other staff members, school staff are able to vent, feel validated, gain support and “... let down their professional masks” (Morgan –Witte 2005:233).

Social support is a type of a coping resource that helps people deal with stress (Eckenrode and Gore 1981; Jacobson 1987; Thoits 1995). Equally important to actually having a support network is the *feeling* of having social support from others (Thoits 1995). When school staff members feel supported, they will have more positive feelings about their job. School staff members in the public schools in the Westside in Syracuse, New York are more willing to integrate social and mental health services for their students into their professional roles if they feel that they have support from their co-workers and school administrators. Most of the staff in all six schools felt that schools are responsible for providing social and mental health services to students. While some staff members felt that the schools are taking on an extraneous role by

providing these services, they also understood that schools play an important role, especially in the Westside neighborhood, to meet mental health care needs that are not met elsewhere. But regardless whether they felt that social and mental health care services were an obligation of schools, all participants said that they needed support in order to be active and effective participants in the process of identifying and treating students in need of mental health care services.

Working Outside the Box

Like parents discussed in chapter seven, school staff also negotiated their roles and interactions with school labels, services and policies. Many school staff worked outside the school norms based on what they felt would be more positive interactions with students and their families. Ethnographic institutional research (Rhodes 1991; Estroff 1981) suggests that while institutions such as schools have policies and cultural norms that encourage hierarchical levels and power dynamics, many people who work inside these institutions negotiate these policies and norms. Lorna Rhodes (1991) began her fieldwork in the psychiatric unit with optimism that community-based mental health services as being more egalitarian, integrated with the patient and community. During the course of her research, Rhodes (1991) expressed her extreme disappointment that the facilities were isolating, retained a hierarchy and did not necessarily make the patients any happier than a hospital. The short-term community-based care units were just as bureaucratic as the hospitals. However, Rhodes (1991) also found staff members who showed sincere interest in helping patients get better amid the web of bureaucracy.

The expressed emotions of staff are not prescribed formulas, but rather "... expressions of fundamental dilemmas in their position" (Rhodes 1991:10).

Similarly, I found that many school staff members made choices that benefited their students even if those choices went against school policy. For example, school policy states that students are not allowed in the teacher's lounge. However, one teacher knew that a student who became angry in class could be calmed by watching television. Although school policy prohibits the teacher from allowing the student to watch the television, she decided to let the student into the teacher's lounge to watch television in spite of policy restrictions.

School staff may integrate activities that go against school policy in order to bring in elements of the community into the schools. Staff negotiate school policies and expected behaviors with the needs of the child, even when they may not be congruent. Teachers and other school staff are not just puppets in the education and social systems. They make a conscious decision about what they think is best for the students. Although their beliefs about what is "best" are embedded in white, middle-class values (Labrov 1982), it is important to keep in mind that the decisions that most teachers make regarding their students are with good intentions with the students in mind. I found that the school staff really do care about the students and make efforts to be socially inclusive of community culture. While students may be socialized to white middle-class values in public schools, many teachers take into account the local community values and beliefs while interacting with the students.

It is difficult to assess how successful school staff are at multi-cultural inclusion in their everyday interactions with students. While many teachers make efforts to work

outside the school norms in favor of the community norms, it is not a perfect system of integration. For many students and their families, schools have a long way to go before they are truly inclusive of community culture.

Socialization in Schools

In early studies public schools were described as socializing students into a “...white, Anglo-Saxon, Protestant culture” while neglecting the cultures of “...low-income, ethnic minority group students” (Banks 1975:353). While teachers and administrators today represent a more diverse population than simply white, Anglo-Saxon Protestants, there certainly remains an overarching dominant culture into which students are socialized. That dominant culture found in schools often overshadows smaller community cultures, and students are confounded by the differences between school and community socialization.

Schools as public institutions are responsible for not only producing educated students, but also educated *citizens* who know the dominant values and customs. One of the primary roles of schools is to “... transmit the dominant values, customary behavior, and relationships between the peoples of a society” (Eddy 1978:347). The public education system is not just an academic institution but also is an institution of sociocultural transmission (Spindler 1974). Students must be able to not only demonstrate knowledge they have learned in terms of academic subjects like math and reading, they also must be able to demonstrate that they know how to behave in accordance to school behavioral expectations. Knowing appropriate behaviors involves understanding the contexts in which certain behaviors are expected. Students are

expected to actively and appropriately participate in classroom activities, but the teachers define what it means to be active or appropriate, and how behaviors are defined change throughout the school day. For example, during recess a child may be allowed to run, but during a math lesson, she is expected to sit quietly at her desk. Such knowledge can also vary greatly between home and school, yet children are frequently expected to negotiate these different contexts with little guidance. The child must be able to understand the varying contexts and recognize when she is supposed to interact or produce particular behaviors (Mehan 1982:72).

The socialization process is complex. Schools as institutions are part of a network of social structures wherein teaching and learning occur at all levels and interact with other social institutions. The services provided in the schools are dynamic and interrelated to other social institutions and cultures. When children enter school, they do not begin as unsocialized beings. Children begin schools having already "... learned modes of customary behavior, interaction, and communication with others which give expression to the values of family and community to which they belong (Eddy 1978:343). Thus, many children may not be familiar with the behaviors and values that are expected of them when they enter school. Schools can provide contradictory experiences for students. On the one hand, education is seen to provide students with opportunities, but on the other, it can also reinforce notions of racism and classism (Levinson and Holland 1996). Students are subjected to schools' ideologies about what is normal and appropriate in terms of knowledge, behavior and belief systems. For children who do not understand the categories or have been taught others,

their subjection to educational ideologies contradict and marginalize their home or community ideologies.

Many teachers I spoke with said they understood that children have been enculturated into community values and norms and try to take these values and norms into account when dealing with students. At the same time, they also expressed that they felt they are responsible for acclimating them to school values and norms as well because they felt that such attributes would be beneficial to the students as they grow up and enter the job market or higher education system. As one teacher expressed:

One of the primary goals of schools is to help students become productive members of society. Unfortunately, not all the resources are there to do what needs to be done. We are responsible for helping students succeed in life, but sometimes the parents teach their kids different things. They need to learn to be successful in their community and in school. That can be a hard task.

Because schools are charged with the responsibility of socializing students, school staff are often caught in a conundrum. On one hand, school staff feel responsible for teaching students values and behaviors that will be expected of them in the dominant society where they are likely to search for further education, employment and housing. On the other hand, ignoring or downplaying their local, community social beliefs and norms, school staff recognize that they can exacerbate confusion as well as marginalize their home and neighborhood. This means that school staff must be able to

reconcile two goals: socializing students into dominant cultural norms and integrating community cultural norms and beliefs.

Many teachers expressed that socialization can be one of the most difficult tasks. Several teachers said that it was often difficult to know how to handle a student who acted in a way they considered inappropriate in the classroom. Behaviors that staff considered inappropriate included disrupting class by getting up when they are supposed to be seated or talking out of turn, being aggressive towards other students, refusing to complete assignments, and ignoring instructions. Such behaviors could indicate that a student was socialized differently at home or a behavioral or mental health problem that could benefit from treatment. For many teachers, it was often difficult to tell if there was an actual problem with the child or if it was simply an issue of miscommunication and misunderstanding of classroom expectations.

Schools as both socializers and arbitrators between dominant and local cultures can lead to difficult role negotiation for staff. School staff are responsible for teaching socialization skills that prepare them for life beyond their local school and community, but they are also expected to create an inclusive classroom environment that encourages diversity. Teachers and other staff members expressed that it was often difficult to be responsible for socializing students to dominant cultural values and incorporating local community values into their classrooms. School staff were not the only ones that had mixed personal feelings and expectations about these dual roles. Many parents also expressed that they had contending expectations for schools. One mother said that she thought schools should prepare her child "... for the outside world, but that don't mean

they should act like their way is better than us.” For many school staff members it seemed to be a very fine line between including both in everyday school life.

While some parents agreed that socialization was an important part of their job, other parents disagreed. While many parents said they understood the importance of socializing students to behave in ways that are congruent in dominant culture for the purposes of furthering their educational opportunities and obtaining jobs and housing, they also felt that there were aspects of dominant culture that actively marginalize their local community. Dominant images and descriptions of people influence how we think about those people and affect how we perceive certain traits (Sontag 2001). For example, black men living in poor neighborhoods are often associated with gangs while homeless people are seen as mentally ill. Such people are to be feared and avoided. In poor urban areas, these images have an effect on children and their socialization. While schools may not actively seek out such images or express these ideas, they are still associated with them. Such images are seen as part of the dominant, often white and wealthy, culture. Because schools are seen as producers of dominant culture, there is a connection between what is taught in schools and what is expressed in popular culture such as the media. Such a connection influences how parents feel about the socialization that occurs in the school. One mother said she was disappointed at some of the lessons she thought her son got at school.

Schools don't think a lot of us. They think we are lazy or bad parents.

My son told me his teacher complained because I didn't make it to a meeting, she was telling my son I'm a bad parent. I don't think she

[the teacher] should talk to him about that. It teaches my kid I'm a bad parent. I'm not a bad parent. I just had to work.... Schools should teach math and reading. They don't need to teach about being a parent.

To this mother, schools were not seen as appropriate avenues for socializing students. She felt that they would "brainwash" her son, and she did not want that.

The marginalization of local culture often results in issues of the legitimacy of student behaviors based on the neighborhood norms and values when they contradict those of the school. Students may make errors relative to the classroom behavioral norms because of the differences from home norms. How school staff perceive student's actions and interactions with others in the classroom influences how those students are treated. When a student repeatedly "gets it wrong," he may be treated negatively or labeled as child with behavioral problems. However, a student's behaviors may simply be a product of social learning at home and among their neighbors. When behaviors that are reinforced at home are punished at school, parents feel that their children are taught that the school's norms and values are superior to home norms and values.¹³

No school staff openly said they felt "their" way was better; yet, by teaching and enforcing dominant culture in the school, local culture is inherently marginalized. Even when teachers make efforts in the classroom to incorporate multi-culturalism, school culture still remains dominant. When asked what types of multi-cultural efforts teachers made to incorporate in the classroom and socialize students, the most common

¹³ It is important to note that when I refer to norms and values here, I am referring to home norms and values that may differ for every family, not norms and values of individuals living in poverty.

answers were celebrating multi-cultural holidays, honoring local and diverse social advocates, and reading stories about diverse families. The concept of embracing diverse and local culture was less about incorporating social norms or behaviors and more about integrating multi-cultural celebrations and social structures such as family. It is not my intention to imply that the latter is not important because I believe that it is; rather it is my goal to suggest that inclusion of diversity should be more than just celebrating and discussing diverse individuals and social structures. It also involves acknowledging and accepting cultural norms and values that influence behaviors. This piece of multi-cultural socialization is primarily excluded in public schools. The final chapter discusses potential options for school staff to incorporate cultural values into everyday classroom life.

CHAPTER X: THEORETICAL SIGNIFICANCE

The purpose of this dissertation was to examine how school faculty, affiliated staff and community members perceive and experience schools as providers of mental and behavioral health services. An overarching theme that emerged, particularly among school staff was the perception of cultural differences between school staff and local families. The term “culture” was frequently used to explain differences between the way parent’s perceived and interacted with the schools and the way teacher’s thought they should interact with the schools.

When individuals from diverse communities interact, they develop ideas about each other and each other’s community and then convey those ideas to other people in their own community (Feinberg 1994). When people talk about interactions with individuals from another community, their descriptions are not necessarily just taken as narratives about a single person. People interpret and summarize their experiences, which in turn represents a “cultural reality” of the “other” to those in that person’s own group. They represent all people in that community. The ideas conveyed become more than just descriptions of one person’s experiences with another person. They become the descriptions of the “other’s” group, a way for people to understand the ‘other’s’ culture (Feinberg 1994).

The use of the term “culture” as a tool for understanding differences between groups of people is not new to my research. Previous scholars have written about the appropriation of the term “culture” as a way to explain why people look, act and believe differently. Starting with Lewis’ (1966) “culture of poverty” we can see he essentializes poverty as having its own specific culture whereby individuals learn

maladaptive social values and norms. He argues that individuals who are born poor are enculturated into a culture of poverty, suggesting that by the mere fact that someone has limited resources he or she is going to learn to think and act in ways that are not congruent with the dominant (i.e. wealthier) culture. He uses culture to explain why there are differences between wealthy and poor people.

Previous research has also explored the use of culture as a blaming tool when marginalized groups are more susceptible to physical or social problems. For example, when Briggs (2008) studied the outbreak of a cholera epidemic in Venezuela in the early 1990s, he found that the general public associated those who contracted the disease with the “culture” of the *indigenas*. The consumption of crabs was suggested to be the root of the cholera epidemic. Since the *indigenas* frequently ate ceviche that contained uncooked crab, especially during celebrations and rituals, the *indigenas* culture became a blaming tool for the spread of the epidemic. This rhetoric that blamed *indigenas* culture was not muted by the fact that the rituals in which ceviche was most often consumed actually occurred very rarely in the region Briggs was studying. Public health officials and practitioners perpetuated the public discourse about crabmeat and *indigenas* culture because it alleviated blame from the public health institutes. Blame could be given to a cultural cause that was beyond the scope of education or safety measures that the health officials could have provided.

Takagi (1994) explains that “culture” has been “captured” by the “powerful” for the purpose of naturalizing cultural elements and explaining differences among groups. He examines culture as something that is appropriated in public discourse to explain differences between dominant social norms and the norms of marginalized groups.

Although Takagi and Briggs are specifically talking about the political uses of indigenous Latin American culture, I use their perspectives to examine the appropriation of the term culture used in school culture to explain differences in the community. While the notion that the term “culture” is used as an explanatory or blaming tool has been investigated by other scholars, my research examines this perspective from a slightly different angle. What my research does contribute is data on how culture is used not just a tool for explaining differences, but as a *diplomatic blaming* tool that has its own set of implications. By this I mean that using the term culture as an explanatory model was done as a way to be sensitive and tactful towards the students and their families. For school staff, using culture is not a way to deflect blame from themselves, but rather a method to deflect blame from individuals. Using culture as a blaming tool was a way to avert blame from parents by assigning responsibility for parental behaviors to a cultural explanation. Yet, there are implications to this approach to culture.

I found four primary implications of school staff using culture as a diplomatic blaming tool. While these implications may not be intentional, they certainly influence how staff and local families interact and develop relationships. First, the use of culture as an explanatory method for differences between school staff and local communities suggests a lack of agency for people who live in an impoverished and under resourced community. Saying that culture leads parents to behave in certain ways suggests that parents are not making active decisions about their involvement with their children or with the schools. Like Lewis, many of the school staff “... fail to appreciate how apparently contradictory modes of behavior (like obeisance and defiance) can be

strategic responses to disempowerment” (de Roche 2008:247). Using culture to explain parental behaviors neglects the fact that parents are active participants in their child’s life, even when their behaviors may not be congruent with what the school staff think is appropriate. This approach can be a offensive to parents. For example, one mother said she stopped returning the teacher’s phone calls because she felt the teacher talked too much about her lack of a job. She said it felt like her unemployment was all the teacher cared about and did not seem to respect her decisions about her child. She said, “It was as if getting a job would make her listen to me more.” This mother did not feel like her daughter’s teacher accepted that she could make decisions just because she did not have a job and had limited income. She felt her agency was not acknowledged by the teacher.

Second, using culture as a way to explain differences has the effect of homogenizing the values and behaviors of people living in poor, urban environments. It is important to note that the use of culture by school staff to explain dissimilarities between school staff and local families is different than Lewis’ culture of poverty. Unlike Lewis, school staff did not say that poor families have been enculturated into apathy, laziness or uncooperativeness. In fact, great efforts were made to avoid such derogatory descriptions. While Lewis took a blame-the-victim approach, the school staff were very careful not to blame the victim. By using culture as an explanation for parents behaving differently than school staff wanted them to act, school staff were actively trying to avert blame from individuals. Rather, blame was assigned to the situation in which they live, referred to as culture. Yet, both approaches produce an essentializing notion of culture among poor communities.

Culture is an abstraction based on people's descriptions and interactions both within and outside the community (Clifford and Marcus 1986). Although culture is discussed as a "shared reality" there is no single homogenous experience in a single culture, but it is difficult to "... reconcile the tension between individual difference and the underlying commonality necessary for people to interact as members of a community" (Feinberg 1994:27). School staff are not taught to make this distinction and frequently use the word culture to describe elements in the local community and discuss families as if they experience those elements in the same way.

While some school staff did acknowledge the influence of multiple cultures on students and their families, many staff members talked about local families as if they exist in a single culture. Many staff members I spoke with made comments such as, "That is just the way they are. It's their culture." This is an important consequence of using culture as an explanatory model because students and their parents negotiate multiple cultures between home, community, and school. And even within these cultures, they participate in various subcultures. All these interaction influence how a student and his or her parents perceive and interact with the school. Groups of people, even in a single neighborhood, have dynamic responses to schools. Their perceptions of and engagement with school staff is an ongoing interaction with the school.

Third, using culture as an explanatory model suggests inferiority of the culture of the families, even when school staff are trying to avoid such a negative connotation. School staff felt they were able to point out differences without giving a normative statement about one culture as "better," but simply "different." While making efforts to avoid blame of individuals and to refrain from giving value statements about a culture,

essentializing and normative claims about cultures were inherent in their statements about the behaviors and beliefs they label as “culture.”

Often culture is used to explain differences in groups that do not subscribe to authoritative knowledge but rather “stigmatized knowledge” (Barkun 2003: 26). As discussed in chapter five, authoritative knowledge is the system of knowledge that has a socially dominant role in motivating people to think and act in particular ways (Jordan 1993). In schools, staff have authoritative knowledge because they are thought to be trained to know what is best for their students. When families question or go against their decisions, their system of knowledge is considered flawed. School staff argue that it is not the individual’s fault for not following recommendations or engaging in school activities; rather it is his or her culture that is to blame. For example, when a teacher talks about parents not reading to their children at home and says, “It’s not their fault. It’s just their culture” or “It’s their culture. It isn’t better or worse, just different,” she is not only suggesting that the families have a different culture. She is also suggesting that it is a single culture that leads all poor parents not to read to their children. Because she is a teacher and values reading, she is also suggesting that not reading to a child at home is an inferior behavior. This “inferior behavior” is explained as a product of the culture in which the parents live. The use of culture as a way to deflect blame has an essentializing effect on what defines the culture of the local families based on ideals. In essence, people were lumped together based on their economic resources, suggesting separate and singular cultural groups such as the wealthy people or the poor people, with wealthy culture as more desirable. This leads to the final implication.

Fourth, school staff used the term culture as a synonym for socioeconomic status. The word culture was used in lieu of class because they felt that culture was a more appropriate explanation for differences. School staff learned in their educational training and by other school staff members that it was cultural differences that lead parents to behave in ways that are not congruent with school norms while at the same time they developed an understanding that low-income status was not an appropriate way to categorize students and their families. While teachers learn little about the actual culture of local families, they are taught under the guise of cultural competency in their training to use the term as an explanation for differences, as an explanation for school failure, behavioral problems, and parents lack of engagement in services (Ladson-Billings 2006). Several teachers confided in me that they learned very little about the actual culture of the families with whom they worked. Rather, they said they learned more about socioeconomic and racial issues in their cultural competency training session. Such trainings mimic the general public discourse about culture. Culture has become a politically correct buzzword that is not just acceptable, but encouraged, as a way to explain differences between people.

Because the word culture is treated socially and educationally as an appropriate topic, they learned that it was something more acceptable to blame whereas poverty was viewed as less acceptable to blame because it took on the notion of blaming the families. Although few people I interviewed knew specifically of Oscar Lewis or his theory of the culture of poverty, they certainly were aware of the critiques of this approach to poverty and wanted to distance themselves from blaming poverty directly. Yet, these efforts not to blame class have similar consequences. The approach to

differences as “cultural” privileges the dominant middle class as having the ideal culture. Again, it homogenizes rich and poor cultures, indirectly advocating a shift towards the dominant middle class culture. School staff frequently assume that the problems with students lie in forces outside of school, such as family life or community culture, and not with classroom features, such as teaching styles or classroom expectations of behaviors. But as discussed above, people do not live in a monoculture. They are multifaceted, and discussions, trainings and social discourse about culture should reflect the dynamics of culture.

Cultural competency in schools requires more than just using the “term” culture to understand students and their families. It also requires an understanding of what culture actually is, how the multi-cultures of local families interact, and the influence that school culture can have (for better or worse) on families. The notion of culture in schools needs to be reassessed, and anthropologists can take a lead role in developing a new and improved approach to cultural competency. This notion of culture as a homogenous group is not unique to school staff. Culture as a “shared reality” is something that people in a variety of professions, including anthropology, use to understand the people with whom they work.

People in positions of authority influence the public discourse about people and culture, especially marginalized people (deRoche 2008). As anthropologists we are considered the experts on culture, even in the education system, and influence how culture is discussed in schools. Pollock (2008) critiques anthropologists for providing shallow claims about cultural groups’ interactions with the education system. She argues that anthropologists are guilty of implying a hierarchy of cultures, suggesting

that some groups are better able to stimulate and motivate children and have a greater interest in their children's education. Such an approach not only ignores diversity, but it also suggests that there are actually "better" or "worse" cultures for educational success. This discourse is important because as the role of anthropologists' increases in public and private sectors involved in generating social discourse, this "discourse" gets spread and becomes the vernacular about how to talk about culture.

It is important for anthropologists to avoid the generalized statements about specific groups in education. While anthropologists certainly specialize in seeking specific cultural knowledge, we sometimes find ourselves speaking of groups, both institutional and community groups, as being homogenous cultures. In order for cultural competency to be conveyed in a meaningful way to school staff, anthropologists need to "... seek to learn about specific practices and experiences that specific children and adults actually come to share, and ... consider those experiences' consequences for children's 'achievement'" (Pollock 2008:371). In other words, we need to keep from making the same mistake we critique other groups for making: essentializing cultural interactions within the education system.

While teachers I interviewed told me they learned a little bit about African American culture or Hispanic culture, they also said that they did not necessarily learn about specifics to African American culture in their community. Further, they did not learn about the interactions between the diverse school and community cultures. They said they learned about cultures not just in a cultural competency training but also from the vernacular that circulates in the schools, or the discourse about certain cultures. Cultural competency is more than just a formal training session. It also comes from

social discourse about culture in general. It involves more than just a shallow look at school culture or community culture. It requires the consideration of how students and their families are interacted with, reacted to, and integrated into the school and classroom cultures in everyday school practices. It also involves the consideration on how these interactions advantage and disadvantage specific students based on beliefs about a student's "culture." Anthropologists can play an important role in this process. It requires us not just to examine specific cultures as dynamic and write academic articles on the subject, but to be able to *explain* and generate social discussion about culture as dynamic and interactive as part of cultural competency discourse.

CHAPTER XI: RECOMMENDATIONS

In the course of my volunteer activities, interviews and observations, I found that both staff and local families agree that schools are in good positions to provide and offer referrals for such services. However, they differ in their perceptions about how those services should be carried out. Throughout my research I continually brainstormed ideas on ways to reconcile these differences. I wondered what could be done in order for the school district to accomplish its mission of providing an education to students while at the same time effectively meeting the needs of the community. Developing policies that integrate relationship building and social support networks are more likely to have positive influences on a child's mental health (Bhui et al. 2005). Thus, it is important for schools to foster support networks for both school staff and local families. Additionally, for school services to be the most effective, school staff and families must negotiate and work within the context of each other's beliefs about what should happen and how they perceive their own and each other's roles in the context of the institution (Rhodes 2004).

Specialized Training

One of the primary issues that should be resolved is the general ambiguity of services available and the needs of the community. For both school staff and parents, a lack of knowledge about mental health services was a significant barrier to delivery of services. Additionally, school staff also felt that they were not fully aware of what parents wanted in terms of these school-based services or external referrals. This means that education is needed not only for the students, but also for the staff and parents.

School staff said that they felt they did not receive appropriate education about mental health care issues or information about the service options for students. All the teachers I spoke with agreed that they received little training in child mental health care. Most said that they would like to receive more education on the topic in order to be better prepared to work with students who exhibit mental or behavioral health problems. According to one teacher, "... we just have to learn as we go. There are a lot of services out there. We just have to make efforts to find them." However, another teacher said that when she came to her current position in a Syracuse elementary school, she was "... shocked at the lack of services available." Taken together, these statements suggest that there is no cohesive institutional knowledge for teachers to draw from in terms of mental health care services in the schools or the local community.

Currently, teachers receive a short overview of school-based social, behavioral and mental health services as part of their initial training as new teachers in the school district. An independent training session on these services for incoming teachers as well as experienced ones who felt they needed a refresher course is greatly needed. This training would consist of three primary components: service and referral options, local family experiences and needs, and community culture.

Because many teachers are unaware of the mental and behavioral service options for their students until they are searching for them, the training would be an opportunity for them to learn early about service options. The training would be beneficial to help establish and disperse institutional knowledge about mental health care service options for students and the protocols for obtaining such services.

As part of this training session, local parents would also be invited to attend. Parents would be given the opportunity to tell their perceptions of and personal experiences with the school-based mental health services and external referrals. Such stories would help educate the staff about the needs of the local community. For many incoming staff members, the experiences and needs of families on the Westside are unfamiliar to them. To integrate the local community in this training would offer staff the opportunity to hear first-hand what it is like for parents to navigate the child mental health care system and give them insight as to the needs of these families. It would also offer experienced parents a chance to express their needs to their local school and new parents to learn about service options and strategies used by other parents with children with mental or behavioral health issues.

A final component of the training would be focused on community culture. As mentioned in the previous chapter, school staff received little training about community cultures specific to their schools. It is important to understand cultural aspects of student's behaviors and incorporate these cultural understandings into all treatments and interventions (Bhui et al. 2005). The training would provide school staff a chance to learn about local community norms, beliefs and diversity. Such knowledge is important for learning how to assess a student's behavior. As discussed in previous chapters, there are often discrepancies in how families and schools react to and interpret a child's behavior. By understanding the diversity in the community, school staff can better assess when a child has a mental or behavioral health problem and when there are just cross-cultural misunderstandings. This part of the training would be particularly

effective if given by both a parent and teacher who had experienced such misunderstandings as a way to teach by example.

An additional benefit of the training would be an opportunity for school staff and parents to build support networks with each other. As discussed in Chapter eight, school staff feel better prepared to integrate social and mental health care services when they feel supported by their peers and the school administration. A training dedicated to such services is one strategy that can help foster this sense of support for incoming staff members. Also, by offering parents a chance to tell their stories about going through school-based mental health services and referrals, they are able to build their own support networks.

As with all recommendations, the training will not solve all disparities between parents and school staff. One issue that may arise is that few parents may be open to talking about their experiences in a public space. Another issue is that even with knowledge of community culture and the needs of local families school staff may still be inclined to medicalize certain behaviors. However, the training can still be a helpful tool in bridging the gap between the two groups. While the number of parents may be small that want to openly talk about their encounters with school-based services, there are some parents who would welcome the opportunity and should be given the chance to tell their stories and teach their children's educators about their communities' beliefs, norms and experiences. Further, the specialized training can help reduce incidents of cultural misunderstandings.

Integration of Families and Communities in Treatment Teams

Charles Froland and colleagues (1981) studied 30 community institutions that partnered with informal support networks within their communities. They found that there was indeed a distinction between “bureaucratic” and “communal” cultures, and that trying to combine community networks and professional mental health services is like “... trying to link two cultures in which very different beliefs, customs and norms of exchange prevail” (Froland et al. 1981:260). Although linking the local community with professional service institutions such as schools is a difficult endeavor, Froland and colleagues (1981) argue that it can be done by incorporating family into the professional services. I further argue that linking the community into institutional practice involves not only the inclusion of family in the treatment process, but it more generally implies awareness of the community values, experiences and norms. The public schools should also be aware of the local formal and informal social support networks in the community and be knowledgeable when there is a lack of such support for families. The awareness of social support networks by services providers can help an individual incorporate his or her networks or find support in other places in the community.

While the specialized training can provide knowledge about families and their social networks, parents need to be given the opportunity to actively engage in their own child’s treatment plan. While some teachers said they seek out involvement from parents, many said that they did not. For those who did contact the parents, there was no formal contact process. Communications with parents could occur through the teacher, counselor, social worker or program coordinator. While it is important to remain flexible due to varying relationships with family, there should be a protocol to

ensure that parents are given the opportunity to be involved in their child's treatment team. There should be a systematic procedure for getting parents engaged in developing treatment teams and implementing the treatment plans rather than just a haphazard set of occasional phone calls or letters home.

For such a system to be effective in engaging parents, it is important for schools to build trust and rapport with the parents. This means that parents should not only be contacted when a child is in trouble or is having problems, but also when the child is doing well. Parents need to hear encouragement, not just the negative, in order to see schools as a positive place for support and constructive assistance with their children.

Revised Multiculturalism in the Classroom

Although schools on the Westside have made efforts to incorporate multiculturalism in daily activities, community culture remains marginalized in the classrooms. Not only should multicultural holidays and heroes be celebrated, community cultural beliefs, values and norms should be supported as well. It is important for teachers to incorporate students' home and neighborhood life into classroom structure (Shulta et al. 1982).

The schools are charged with the mission to provide socialization to students, and they can't neglect this task simply by acknowledging that everyone has a different culture. However, they can take a more multicultural approach to education to include diverse ways of teaching and learning. Teachers certainly should not coerce values and behaviors of dominant class as the only viable way to be, but rather they can offer students knowledge about such norms. Middle class values and behaviors should be

one of the many cultural attributes valued in the classroom along with a variety of other cultural values, beliefs and behaviors to create a truly multicultural classroom. People who can adapt without feeling like their own identity is being threatened or marginalized are better equipped to have both academic and social achievement. I believe this is not only true for teaching dominant culture but also in teaching diverse cultures to even those who's home culture is dominant.

One way that teachers can be more inclusive to diverse cultures while teaching socialization skills is to include both community and school cultures in the curriculum. Rather than learning their own community and home norms and values are inferior, students learn how to adapt to multiple cultures. School culture should be taught as a new and different way of thinking and behaving for students that can complement their local culture. Classrooms should offer students opportunities to display skills and experiences that might be neglected. For instance, Moll and Diaz (1993) give the idea of allowing native Spanish speakers the chance to discuss stories they read in English in Spanish. This approach would help ensure that community cultures are not marginalized but treated as equal.

A successful example of this strategy was the Academic English Mastery Program. Established in 1990 in Los Angeles, the AEMP was established to improve academic achievement for Standard English Learner students who had diverse language backgrounds. The program focused on teaching students Standard American English through positive reinforcement of being bilingual. Rather than marginalizing students' native languages and dialects, teachers taught Standard American English as a new language that offered students the knowledge and skills to be bilingual. According to

their evaluation report, Maddahian and Sandamela (2000) found that this technique was successful because it focused on teaching students to embrace both languages as equally important. The program fit into the school's mission to socialize students into Standard American English while using local language and knowledge as a teaching mechanism.

Similarly, teachers on the Westside could use such a strategy for incorporating local culture in the classroom. The benefit would be to help foster trust and respect with the students and parents. By integrating community culture as equal to the dominant culture found in schools, parents are more likely to seek and engage in school-based services for their children. Schools become a supportive ally for parents. This is important for effective school-based mental and behavioral health services.

Overall, the recommendations listed here encourage communication between schools and communities. Increasing communication improves mutual understandings between groups. The local community wants to feel respected and that schools are a safe place to turn when they feel that their child may need mental or behavioral health treatment. School staff need to gain and incorporate knowledge about local community culture and the mental and behavioral health care service options for their students. These measures will help provide more effective services that meet the needs of the school and the local community.

APPENDIX A

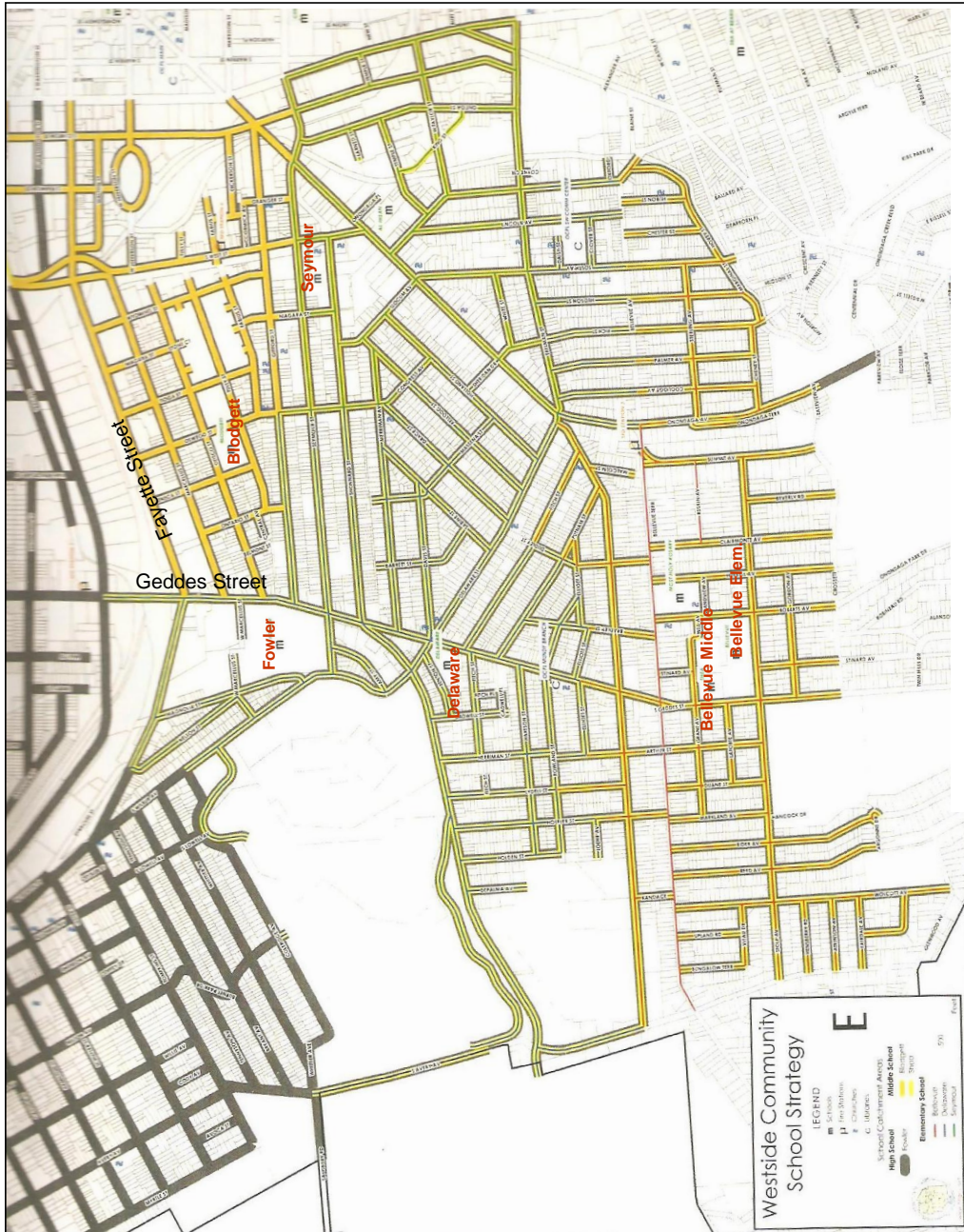
Map of New York State



(Source: http://www.newyorkstatesearch.com/maps/New_York_State_map.html)

APPENDIX B

Map of the Westside



(Fletcher 2008:23)

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Zola, Irving. 1972. Medicine as an Institution of Social Control. *Sociological Review* 20:487-504.

JILL PRIEST AMATI CURRICULUM VITAE

EDUCATION

- Syracuse University* Syracuse, NY
- **Ph.D. Anthropology Candidate (ABD)** 2011
 - Dissertation: *Meeting of the Minds: Perceptions of and Experiences with School-Based Mental Health Services*
 - **Master's of Public Administration** 2009
- Oregon State University* Corvallis, OR
- **M.A. Applied Medical Anthropology** 2004
 - Thesis: *Perceptions on Mental Health among the Wanniya-Laeto in Sri Lanka*
- University of Washington* Seattle, WA
- **B.A. Interdisciplinary Studies** 1999

PROFESSIONAL EXPERIENCE

- Adjunct Professor* LeMoyne College
Syracuse, NY 2009-present
- Teach introductory social science courses
 - Teach upper level health and religion courses
- Program Assistant* Syracuse University
Syracuse, NY 2008-2010
- Advised students on professional portfolio development and career planning
 - Coordinated activities and assessments for program development
 - Conducted program research and evaluation
- Research Assistant* Community Health Foundation
Syracuse, NY 2008
- Collected and synthesized data on the integration of mental health diagnosis and treatment in primary health care
- Teacher's Assistant* Syracuse University
Syracuse, NY 2006-2008
- Organized weekly lesson plans
 - Instructed recitation sections for introductory anthropology classes
- Research Assistant* Syracuse University
Syracuse, NY 2007
- Developed curriculum for Religion, Media and International Relations Project
- Counselor* CASCAP
Boston, MA 2005-2006
- Assisted adult mentally ill clients in creating goals for personal growth and developing plans to achieve goals
 - Provided counseling and support
- Teacher's Assistant* Oregon State University
Corvallis, OR 2003-2004
- Organized regular tutoring sessions
 - Assisted professors in grading and teaching course sections

- Intern** Ochoco Community Clinic
Prineville, OR 2003
- Conducted a needs assessment for mental health services for Mexican immigrants
- Mental Health Worker** Community House
Seattle, WA 1998-2002
- Held weekly groups for mentally ill adults
 - Provided basic counseling and support

PUBLICATIONS

- Bhatia, S. and Amati, J.P. 2010. "If these Women Can Do It, I Can Do It Too": Building Women Engineering Leaders through Graduate Peer Mentoring. ASCE Leadership and Management in Engineering. Vol 10(4).
- Amati, J.P. 2010. Outside the Classroom. Central New York Social Sciences Newsletter. Syracuse, New York.
- Priest, J. 2004. Guardians of the Red Earth. Living Heritage Trust. Colombo, Sri Lanka.

PRESENTATIONS

- Meeting of the Minds: Connecting Local Communities and Public Education through Applied Anthropology*
- Paper Presented at the SfAA Conference; Seattle, WA 2011
- Encountering a Hesitant Community: Developing Trust among a Distrustful Community*
- Roundtable coordinator for the CNY Conference on Public Scholarship in Graduate Education; Syracuse, NY 2010
- Beyond the Border of Psychiatry: School-based Mental Health Care* 2010
- Paper presented at the N.E. Anthropology Assoc. Conference; Buffalo, NY
- Anthropology as a Career* 2005, 2006
- Invited guest speaker; Somerville, MA
- Mental Health Issues among the Wanniya-Laeto* 2004
- Paper presented at SfAA Conference; Dallas, TX
- Cultural Competency in Mental Health Care* 2003
- Paper presented at SfAA Conference; Portland, OR

SERVICE

- Meals on Wheels* Syracuse, NY 2010-Present
- Deliver meals to individuals who are unable to prepare or purchase food
- SCSD Volunteer* Syracuse, NY 2008-Present
- Volunteer weekly in classrooms
 - Mentor middle school students
- Anthropology Graduate Student Association* Syracuse, NY
- President 2008-2009
 - Faculty Representative 2007-2008
- Journal of Development and Social Transformation* Syracuse, NY 2007, 2008
- Reviewed journal submissions

PROFESSIONAL DEVELOPMENT

- O'Connell Professorship Discussion Group* Syracuse, NY 2010, 2011
- Interdisciplinary discussion group on scholarship and pedagogy based on readings
- Syracuse Interethnic Dialogue* Syracuse, NY 2007, 2008
- Community discussion group on policy for Syracuse immigrant and refugee communities
- New York Latino Mental Health Workshop* New York, NY 2007, 2008
- Sessions on disparities and cross-cultural competency in mental health services
- Citizen's Academy* Syracuse, NY 2007
- Eight week session on the organization and service delivery of local government

GRANTS AND SCHOLARSHIPS

- Graduate Student Public Engagement Grant 2010
- Roscoe Martin Grant (Syracuse University) 2009
- Claudia De Lys Scholarship (Syracuse University) 2007
- Department of Anthropology Alumni Scholarship (Oregon State University) 2004
- Laurals Tuition Supplemental Scholarship (Oregon State University) 2003, 2004