

Retooling Mental Health Models for Racial Relevance

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Psychotherapy has helped many people to fulfill their creative and productive potential. Yet, its core ideas and theories have White, European, patriarchal roots. Focusing on intrapsychic issues and individual pathology, most mental health theories have failed to incorporate an analysis of societal oppression into their understanding of human behavior. This failure has created a system which has sometimes done violence to members of marginalized groups by establishing Eurocentric and privileged notions of normal.

This violence can take many forms. One is the 'diagnosis industry', which categorizes people based on deficits, symptoms, and pathologies. When this perspective is filtered through the ever-present lens of white supremacy and privilege, people of color are as damaged by the Mental Health System as they are by every other system in this country. We dehumanize people by failing to develop asset-based models which incorporate curiosity and respect about the survival skills which whole communities have had to mobilize in order to confront genocidal affronts to their being.

Credentialing is another aspect of white privilege which, though valuable in certain respects, does violence in other ways. Credentialing is a 'gate keeping' device which can exclude people with important cultural expertise from participating in program and policy decisions. This can result in impoverished and ignorant forms of treatment. (The term 'gatekeepers' refers to people in organizations who control access to resources and opportunities.)

The umbrella concept which is pervasively harmful remains white supremacy: the idea white people of European descent unconsciously hold that deep down we are really better and smarter than other groups. Moreover, white privilege assures that we are the ones who define the rules, the terms, the labels, the treatment, the problems and the remedies. We distrust people from other groups to take a turn at the helm and we resist taking leadership from people who do not look like us. In what ways, then, can we assist other people to feel well and whole?

As white people, and thus members of the dominating group in this country, we have always been the ones who get to define 'normal'. As mental health practitioners, we then determine who is healthy and who is not, how we think families should function, when and how mental health interventions should occur. 'Undoing Racism' training provided by the People's Institute for Survival and Beyond¹ enables one to review what one 'knows' through another set of lenses. As a result of this 'reviewing,' there are no easy answers. However, one gets much better at asking questions.

¹ The People's Institute for Survival and Beyond is a national collective of experienced organizers and educators dedicated to building an effective movement for social change and consider racism the primary barrier. Their highly acclaimed 'Undoing Racism' workshop has been given nationally and internationally for more than 25 years. (www.thepeoplesinstitute.org)

All persons in the United States who are perceived as non-white become part of the racial construct embedded in the history of this country. We must also acknowledge that African-Americans have a very particular set of historical experiences here. The following questions, therefore, have significance for all people of color seeking mental health services in the United States, and have particular relevance for African-Americans. This list is just a beginning.

- o How do we know that the models of human development that we learn in social work school apply to all cultural groups? Has the West over emphasized models that stress individualism and autonomy while ignoring social models which more accurately reflect other cultural experiences (and maybe more accurately reflect the human experience altogether)?
- o Embedded in the history of this country is a set of beliefs which suggest that people who try really hard will succeed and that those who do not succeed are deficient in some way. How does this influence the way those of us who have some privilege see our clients who do not exemplify American ideas of success?
- o How do white human service providers assess people of color who are reluctant to seek or utilize help at white agencies?
- o What are our thoughts about how psychotherapy might help an African American adjust in a racist society?
- o Could there be a connection between a community's history of enslavement and racist oppression and their current child rearing practices?
- o What kinds of survival strategies have been helpful to many African-Americans as they have had to navigate two different cultures?
- o If there are social rewards for being 'good' and severe sanctions for being 'out of line', how likely is it that African Americans would be authentic in settings where they are being evaluated or assessed?
- o What might be the relationship of an African American woman to a white woman in an authority position? What is the historical background for this experience?
- o What about the relationship of an African American woman to a white man?
- o How might an African American man relate to a white woman in authority? A white man? What is some of the historical background for this experience?
- o How might a person of color deal with their anger towards a white person in a mental health setting? What is socially sanctioned and what is not? How could a person of color figure out the rules?

- o Do our diagnostic categories help or hurt people? Do they help us? How? Are they flexible enough or elastic enough to incorporate experiences of oppression?
- o When making assessments, are we able to identify the resilience and assets of people who are not like ourselves?
- o If we work in agencies, are we gatekeepers? If so, do we frequently examine our rules and procedures for their impact on diverse communities? With whom do we confer to check this out?
- o Graduate schools of social work, psychology and counseling are not graduating nearly enough mental health professionals from diverse communities to mirror the changing demographics in many areas of the United States. This means that many agencies serving populations of color will continue to have staff which is largely white. As a professional community how can we find creative and culturally sensitive ways to serve our clients?
- o Does our profession's commitment to credentials hurt our ability to expand our range of services?
- o According to many research studies, the reliability of the DSM is not terrific. (That is, several clinicians who use the book and see the same patient will get a different diagnosis.) Reliability is especially poor for 'general clinicians', as opposed to structured interviewers conducting research. Why have many of us been so quick to treat the DSM like a sacred text, and how has this effected our clients. (For more about this see the Article "The Dictionary of Disorder" by Alex Spiegel in The New Yorker Magazine, 1/3/05, p.56-63.

I believe that as a profession, we need to begin asking these and other similar questions over and over. We also need to seek responses from people outside of the profession who may have important and illuminating thoughts including: people who are perceived as non-white, people from other countries, people who are not middle or upper class, people who are deeply rooted in cultures which are not 'American' (or white).

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