

RETOOLING MENTAL HEALTH PRACTICE FOR RACIAL RELEVANCE

By Gail K. Golden, LCSW, Ed.D

I want to begin by saying a little bit about how I got to where I am, because it has been suggested to me that it is helpful to let people know that I come to a critique of our profession not as an outsider, but as someone who was and is very much on the inside.

I have worked in clinical practice for many years, and have been blessed with many benefits of success. I have had a good clinical practice, became the clinical director of a family service agency, and published several clinical papers. Most important, I was helping people, and that is always very rewarding.

In the early 90's I was urged by a colleague to attend an Undoing Racism Workshop offered by the Peoples Institute for Survival and Beyond.* I have always likened that first experience to getting glasses after a life of extreme visual impairment. I continued to connect with the PISB whenever I could. Slowly I began to review everything I was doing in a new way, through an anti-racist lens. That brought my thinking about the work I was doing, that we are all doing, to a new place. I am only in the beginning of what I know to be a lifelong journey. Racism is deeply embedded into every aspect of our culture and institutions. Everyday I see something I did not see the day before. I have no answers. But I have started asking better questions and seeing things in new ways.

I think that any of us who are doing mental health, or counseling work need to stop what we are doing and start asking an important question. How do we know what we think we know? If we have gotten any kind of training, we have been taught from a body of knowledge which most of us assume to be pretty reliable. But really, what makes it true.

And when I say we, I of course, am certainly talking about those of us who are white, who are doing mental health work. But I also know that people of color who work in the helping professions are getting the same kind of training, often drawing on the same theories and sources. I think we all need to take another look at what we have learned.

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.

Joel Paris, in his excellent book, *Myths of Childhood*, observes that most theories about mental health have been generated by professionals who treat fairly distressed people who come for help. Clinicians do not see random members of the population. Our clients represent a small percentage of the population and perhaps the most vulnerable. Many people survive outrageous assaults against their being without any professional help. We have not developed most of our theories from them. Maybe we still do not know how most people live. And I am not at all sure that we know how different kinds of people live.

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 Beyond, 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.

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.

- 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)?

- 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?
- How do white human service providers assess people of color who are reluctant to seek or utilize help at white agencies?
- What are our thoughts about how psychotherapy might help an African American adjust in a racist society?
- Could there be a connection between a community's history of enslavement and racist oppression and their current child rearing practices?
- What kinds of survival strategies have been helpful to many African-Americans as they have had to navigate two different cultures?
- 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?
- What might be the relationship of an African American woman to a white women in an authority position. What is the historical background for this experience?
- What about the relationship of an African American woman to a white man?
- 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?
- 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?
- 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?
- When making assessments, are we able to identify the resilience and assets of people who are not like ourselves?
- 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?
- 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?

- Does our profession's commitment to credentials hurt our ability to expand our range of services?
- 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).

It is uncomfortable and difficult to disassemble foundational concepts, or to ride the waves of a paradigm shift. I was angry and resentful when, after many years of successful practice, I was moved to question and rethink some of what I was doing. But it has also been, in time, exciting and energizing to be part of a movement that is creatively and passionately working for human empowerment and liberation.

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CULTURAL COMPETENCE: WHOSE CULTURE?

By Gail K. Golden LCSW, Ed.D

It is now a given that social workers need to be culturally competent. This of course is necessary in our increasingly multi-cultural society. In the world of human services in the United States, people from all over the world are often receiving direct services from providers with traditional Western European backgrounds. Accordingly, many of us are now reading books and articles, or attending trainings which teach us about people whose culture differs from our own.

We are offered information about the cultures of Latinos, Asians, Africans, African Americans, Indigenous people, people from the Caribbean and the Middle East. Many of us have spent a lot of time going to trainings that purport to make us better practitioners.

What is mostly missing from the course content is an analysis of American culture, which is also white culture. Peoples of European descent hail from countries as varied as Ireland, Russia, Italy, Greece, Norway, and Germany. Yet upon arrival in the United States, all of these varied groups were strongly encouraged to assimilate, to de-emphasize their differences, and to participate in the culture of whiteness. Since this country was founded by white Christian men, for their own benefit, it has always been extremely advantageous to be considered a member of that group. Therefore, groups from Europe who were not considered white when they arrived here eventually were folded in to the white melting pot, either by choice or by default. They became Americans, with membership in a white, American culture. (Billings, Brodtkin). It is like being homogenized.

White culture is so prevalent and so dominant in the United States of America that it is invisible, like the wallpaper. We do not think about it. It is an aspect of White privilege, and also the privilege of being a world power, that our culture is the norm, the standard against which all other cultures are measured and judged. And yet, if we are not totally clear about our own values and beliefs, we are in a poor position to understand the cultures of other people, and to work in relationship with them.

White American culture, while mostly not visible to those who live it, is very noticeable to those who are not white and who derive from other parts of the world. Members of marginalized communities spend a great deal of time trying to understand our dominant culture, because their survival depends on it. In fact, other people sometimes study us to learn how to survive when they come to this country. (Kohls) What do they observe?

They observe that those of us who consider ourselves white Americans place a high value on individualism and self-reliance. We prize independence. Our psychology tends to equate mental health with autonomy, and being able to separate from the family in order to move out into the larger world. We also tend to see competition in a positive light. Our entire socio-economic system assumes that competition will bring out the best in us, and contribute to the common good. (Katz, Kohls). Other peoples sometimes are puzzled by this and by our seeming lack of kin and community allegiance, our 'me first' orientation. Accordingly, they view our educational system as more competitive than

cooperative. They find us action oriented, and comfortable exerting control over our environments.

Other people also see White Americans as being heavily focused on time... 'time is money'. We are future oriented. We tend to think that change is a good thing. Other cultures may place a higher value on tradition, on preservation, on emphasizing process over speed. White Americans also have a long history of believing that hard work is rewarded. If we try hard enough, we will prevail. This is the basis of the Horatio Alger myth.

American culture is often admired for producing people who are inventive, productive, forward thinking, freedom loving, open to new ideas, informal, and inclined to value what is unique in each person. The United States is seen as offering unparalleled opportunities, many important freedoms and chances to improve one's financial circumstances. But our culture, our values and attitudes, can also create confusion and dissonance for people.

For example, the Horatio Alger myth does not address or incorporate the hard and unrewarded work of many oppressed and exploited groups. Our culture is quick to assume that unsuccessful or poor people are lazy, rather than to recognize that some groups here have been systematically exploited and deprived of their fair share of the American Dream. This is exponentially important, since Americans also tend to equate wealth with worth.

We also have a view of history, which is steeped in the primacy of Western tradition and Christianity. Our telling of history can be insensitive to the experiences of people in countries whose land we took or colonized. Our frequent rationale was that we were exporting a higher level of civilization. This attitude served to negate cultures, traditions and religions in other parts of the world. We often tend to think that if something is good for this country, then it is universally good.

Finally, the most essential aspect of White American culture is that it rests on an assumption of white superiority. The idea that 'white' represents the apex of civilization has been an important idea throughout our history. This was formalized with a racial classification system developed in Europe in the 18th century. (Billings). A specious system, now scientifically discredited, it nonetheless still resonates around the world today. The promotion of the idea of white superiority was necessary to the building of empires, the commandeering of resources, and the exploitation of laborers (Wise).

It has been so ingrained in American consciousness that the integration of schools, military units, housing, restaurants and even water fountains had to be accomplished through monumental struggles and loss of life well into the second half of the 20th century. It is a function of white privilege in the United States, that, large numbers of white people maintain, that racism is no longer a problem (Wise). They hold to this belief despite the fact that people of color tell us that it is a problem they continue to live with every single day. One of the many privileges of being a dominant culture is that we get to define reality.

Good social work practice demands that we know who we are, how we are perceived, our national history in relation to other peoples of the world, and the assumptions that form our core belief systems. We perceive reality through a set of lenses. If we do not know how those lenses are calibrated, it is hard for us to assess our visual field. It is important to learn about other cultures. It is more important to know that our own cultural biases skew how we view those cultures, especially because of our pre-eminence in the world.

Most of us are very familiar with the concept of countertransference, the idea that we may inadvertently project our own conflicts into our work with a client. In the same vein, we are all vulnerable to cultural countertransference: the tendency to project our cultural norms and biases into our work with unfamiliar others. Our willingness to identify and acknowledge those views will make us more effective social workers with all of our clients.

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THINKING OUTSIDE THE BOX: A NON-TRADITIONAL APPROACH TO COMMUNITY MENTAL HEALTH.

By Betsy Benjamin, Gail Golden and Rose Leandre

This article chronicles the evolution of a promising collaboration, which may have value for other human service providers. It is an account of how one white, middle class agency (VCS Inc.) has partnered with a grassroots Haitian organization (HACSO) to provide some culturally relevant mental health services. Many of the concepts that informed this project were gained through years of Undoing Racism training offered by the People's Institute for Survival and Beyond (PISAB).*

The real roots of the partnership began with relationship building. The Clinical Director of VCS and the Executive Director of HACSO had a number of opportunities to work together in community groups. Regular association generated mutual respect and opportunities to learn about the work that each was doing. VCS staff made a commitment to support HACSO. Attended its events and fundraising efforts, and offered to serve on the HACSO Board of Directors. The Executive Director of HACSO provided valuable information and insight into the needs and concerns of her community, which enhanced the capacity of VCS counselors. Her agency was also an important referral source when VCS clients required assistance with concrete needs.

HACSO is an agency in Spring Valley NY, home to a large Haitian community. HACSO provides a wide range of concrete services, including assistance with immigration issues, enrollment in Health insurance programs, filling out forms, housing, employment, Cancer screenings and much more. HACSO basically functions as a walk-in agency. People come when they have a specific need and are served the same day, whether or not they have an appointment. Clients are accustomed to patiently sitting in the waiting room until it is their turn. HACSO has a very small but devoted staff. No one is turned away and the staff works hard to meet the needs of the community.

VCS is a family service agency with a unique tradition of training lay volunteers from the community to provide skillful counseling for very low fees. VCS has received many awards for its work and has come to be seen as an important part of the service delivery system in Rockland County.

VCS has an office in New City NY, the county seat, but will also meet in village libraries and houses of worship with those clients who lack transportation. Because of our low fees and willingness to see clients off-site, many grassroots agencies refer to us. Nonetheless, the ED at HACSO felt that there were mental health needs in her community that were not being well addressed. It was her experience that when clients came to her for help with concrete services, they often began to share other personal and family problems with the HACSO staff. Because clients seemed to have a pressing need to talk on a personal level, it took a longer time for staff to make referrals, fill out forms and complete other necessary tasks.

Also, HACSO staff was not trained to deal with serious depression, domestic violence, grief and loss, post traumatic stress and a host of other issues clients presented. The

two agencies began a series of conversations about how VCS could be more helpful to HACSO clients. This process was energized by United Way of Rockland County, which invited agencies to partner in order to address a series of identified 'basic needs'. More accessible mental health services for uninsured consumers, were one such identified need. More bilingual mental health services were also needed. The two agencies were given a grant to address this problem.

We developed a tentative working plan. It began by offering the VCS counselor training to the HACSO staff so that they would be more familiar with our work and thus feel comfortable referring their clients for counseling. HACSO staff would then identify those clients who might benefit from one to one counseling. VCS professional staff would offer intake appointments on site at HACSO. HACSO staff would assist with translation if that were necessary. Once an assessment was made, VCS would provide a volunteer counselor who could meet with the client on a weekly basis, at HACSO if that was most convenient. With the United Way grant, VCS also would increase its effort to recruit more bi-lingual counselor trainees from the Haitian community.

The HACSO ED was concerned that pre-scheduled, once-a-week counseling sessions might not prove 'user-friendly' to her consumers. They were accustomed to coming to HACSO when they had a pressing need. They were used to having that need attended to in a timely manner, usually on the day they walked in. The idea of having to wait several days for an 'intake', or of coming for counseling when there was no crisis was not normative. Nonetheless, we decided to go forward with our pilot project in the spirit of the PISAB which urges us think outside of the box and to take our direction from the community we are trying to serve.

The VCS Assistant Clinical Director assumed responsibility for implementing the project in September 2007. She met regularly with HACSO staff to discuss launching the program and helped develop publicity materials. Her ensuing dialog with the case managers conformed to the ED's comments about the expectations of HACSO client base.

The Associate Clinical Director had attended the PISAB multiple times. As a result, she was well acquainted with the need for white people to listen to the voices of people of color. In the meetings with HACSO staff and the ED, she elicited crucial information about the needs of HACSO's clientele. The HACSO staff doubted that the traditional white middle class counseling model would work. But at the time they could not think of a viable alternative. So, while the both partners had questions about the design, they agreed to proceed and try to learn from ensuing experiences and mistakes.

In the next several months, HACSO staff made referrals for intake appointments at the HACSO office. Appointments were not kept. However, there continued to be a steady stream of HACSO clients eagerly discussing personal problems while filling out forms or arranging for other services discuss. The ED and the caseworkers continued to meet to dialogue with the VCS Associate Clinical Director about how to get these clients to utilize the available service.

The VCS Associate Clinical Director continued to reach out to the community, follow up

on referrals and worry about the lack of utilization, especially since she continued to be told by HACSO workers about their clients desperate need for counseling. About 6 months into the initiative, she had an epiphany. The people were coming to HACSO, and pouring out their life concerns and stresses to the case managers. The case managers had already completed the VCS counselor training.

Why not create a “paradigm shift”? Rather than spending a part of their “case work” time listening to the clients’ mental health concerns, then calling VCS with a referral for intake, **the case managers themselves** could counsel the clients who were already in front of them. It made perfect sense. These workers had formed a helping relationship with the clients and the clients have a trust in the organization. The ground was already fertile for a counseling alliance to grow. The VCS Associate Clinical director could provide ongoing supervision and support for the HACSO workers. This would give them the opportunity to enhance their counseling skills, provide the clients with a much-needed service and deliver what the clients already expected: i.e. when clients appeared at HACSO they would receive help with their problems within a very short period of time.

The VCS Associate Clinical Director met with the HACSO ED to discuss the idea of “shifting” the mode of service delivery. The caseworkers already were performing many different tasks to help the clients, but whether the ED would be willing to have them counsel as well remained a significant question. The HACSO ED, a very bright, committed, visionary thinker, immediately accepted the idea and was hopeful that we might be on to something. She set up a meeting for the Associate Clinical Director to speak with her two caseworkers about the new plan.

At this meeting, the workers had many questions and concerns. Implementing the plan required a shift in perspective. The workers had been viewing their job of providing concrete services and the job of counseling as two separate functions. They did casework; they referred clients to VCS for counseling. The original idea of the grant was “save the caseworkers time” by having another agency do the counseling. This fits with certain traditional social work concepts about how to deliver services. In retrospect, it now appears to make much more sense to take care of all the clients’ needs together. However there were still challenges to overcome.

The caseworkers and the ACD continued to meet and talk, building relationships. They concretized a plan. One early obstacle was the workers concern about whether they could actually “counsel” their clients. Since the workers had taken the VCS counselor training they were aware of the differences between the role of counselor and the role of caseworker. They worried about their ability to integrate the two roles into a helpful model.

A very large component of the VCS Associate Clinical Director’s job is to train and supervise lay people to provide effective counseling. Fear of lack of competence is normative for new counselors and is ameliorated by processing the counselors’ feelings in supervision. As she and the caseworkers met in supervision over time, the workers began to develop better counseling skills, experience some mastery and competence in their new role and, as a result, became more comfortable “wearing the counselor hat”. After awhile, the caseworkers and the HACSO ED began to notice that certain clients

were beginning to return to the agency when they had no concrete needs but just wanted to process something with their caseworker.

Besides working through the caseworkers normative “beginner’s anxiety” another challenge was that this new way of working would omit the professional assessment part of the VCS model. (All VCS clients have an intake with a professional social worker to determine whether or not they are appropriate for work with a trained layperson. If they need a higher level of care, they are referred to the Rockland County Mental Health Clinic.). The workers and the ACD developed a map for implementing this idea in a safe way. The caseworkers and the ED were already referring clients whom they thought were in need of professional care to the County Clinic.

In essence, they were already doing an essential component of the traditional VCS intake process by making these referrals. But, what happens when someone comes to intake, seems appropriate for lay counseling, and later in the process appears to need a higher level of care? This is often manifested by the caseworkers' feelings of being overwhelmed. The solution resides in ongoing clinical supervision. If the ACD concurs with the workers assessment, the client would be referred to the clinic. If the problem isn't the clients' increased need, but rather is countertransferential, it is worked through in supervision as well.

Between supervision meetings with the ACD, the workers have access to the ACD and the rest of the VCS clinical staff for purposes of consulting about a particular client about whom they have concerns. So far this plan has worked well. Rose Leandre, Executive Director of HACSO shares a number of very helpful observations about this project. The following is an adapted transcription of a conversation with Rose, which took place on November 21, 2008.

Rose says that in her community people only tend to seek help when they feel like they are in a crisis, or in her words ‘feel frantic’. This program has been effective, in her view, because it works with this concept. People can drop in and talk when they need to. Rose differentiates between a ‘social crisis’ and a psychiatric crisis. People who feel overwhelmed by their lives and who have no close family or friend to whom they can vent tend to hold things inside for too long, and are at risk of making poor decisions. Poor decision-making then aggravates the crisis which can lead to complete chaos.

People who are first generation immigrants have many real stresses to cope with, including all of the issues related to adapting to a new country, and the serious economic and social stresses, which can be part of that experience. People who can talk about their situation when it is still in the category of a social crisis can be helped to vent their feelings and to identify what is going on in their lives.

They can be helped to make sound decisions before they become overwhelmed and depressed, often withdrawing as their lives descend into complete chaos. Making timely support available through the HACSO case managers offers consistency and support which Rose observes is making a huge difference in the lives of some of her clients.

Without this kind of preventive intervention these clients, in Rose's experience, can become psychiatric crises, eventually warranting serious diagnoses and professional psychiatric intervention.

Rose cites the recent example of a young immigrant couple who came for support almost every day for a period of time. He has a problem with addiction and she is pregnant. Through the almost daily support of the HACSO case manager, he has achieved three months of sobriety and has gotten a job. She has stopped smoking and is taking much better care of her self.

Rose observes that many of her clients have problems with self-esteem and relationships. She says that without people to talk to, many of her clients tend to become very agitated and very loud. They have trouble getting their thoughts straight and can present in a manner that could seem bizarre to professionals unfamiliar with the language and culture.

Rose says that her case managers have learned, through supervision, how to 'talk people down' and to help them organize their thoughts. Again, she feels that such clients initially resist the idea of coming for counseling by appointment, especially on days when they are feeling calm and when there is not an immediate crisis. However, Rose also makes the important observation that after a period of time when people have used the drop in service to deal with crisis situations, they become more open to the idea of regular weekly counseling in order to try to get to the roots of the felt emergencies. In this way, 'Band-Aid' counseling can eventually morph into something that looks like more traditional counseling by appointment. However, without the first level of 'Band-Aid work', people do not have the chance to experience the ways in which talking can help. (This ends the interview with Rose Leandre).

Based on our experiences so far, we think that this model of service may have promise for other community based organizations which are not mental health clinics per se but see many clients with a variety of issues, including personal and emotional needs. This model would need to be adapted to the specific needs of different communities and different kinds of agencies. The success to date with HACSO suggests that it is worth the effort to stretch our thinking about how to deliver mental health support to various communities and to continue to explore non-traditional ways to support people with 'social crises'.

* The People's Institute for Survival and Beyond (PISAB), is a national and international collective of anti-racist, multicultural community organizers and educators dedicated to building an effective movement for social transformation. The People's Institute for Survival and Beyond, affectionately known in the community as The People's Institute, considers racism the primary barrier preventing communities from building effective coalitions and overcoming institutionalized oppression and inequities. Through Undoing Racism™/Community Organizing Workshops, technical assistance and consultations, PISAB helps individuals, communities, organizations and institutions move beyond

addressing the symptoms of racism to undoing the causes of racism so as to create a more just and equitable society.

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WHITE PRIVILEGE AS AN ADDICTION*

By Gail K. Golden, Ed.D, LCSW

As we come to understand something about institutional racism, we begin to have some clarity about how people of color can be made ill by endless and unrelenting assaults against their very being. We learn about internalized racial inferiority and the toll it takes on people of color. We begin to understand the impact of racism on the physical, emotional and financial health of people of color.

What we are much less attuned to is internalized racial superiority and the ways in which being part of a dominating culture creates its own pathology, that of white privilege. The following are some preliminary observations about distorted thoughts and feelings precipitated by Internalized Racial Superiority.

1. Our ideas about what is normal are very culture bound in ways we often do not see.
2. We have an exaggerated sense of the rightness of our own ideas and opinions, often diminishing contributions of people of color. ('White is Right'.)
3. We have a sense of entitlement, which can create an exaggerated sense of outrage when our expectations are disappointed.
4. Even those of us committed to social justice feel we can pick and choose when and where to speak out when we perceive racist behaviors.
5. We feel guilty for our participation in a racist society and often want our guilt to be assuaged by people of color.
6. We tend to argue with people of color about THEIR experience. The idea that we know better is one of the ultimate expressions of the exaggerated sense of rightness mentioned above.
7. Those of us who are white and who count ourselves successful tend to believe that we have earned our success through hard work and focus. We rarely see that unearned benefits associated with whiteness have contributed to our prosperity.

In thinking about these manifestations of internalized racial superiority and the ways in which we as white people fail to give up these behaviors, I have begun to think about White Privilege as an addiction.

American Society of Addiction Medicine observes:

Addiction is characterized by impairment in behavioral control, craving, inability to consistently abstain, and diminished recognition of significant problems with ones behaviors and interpersonal relationships. Like other chronic diseases, addiction can involve cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive.

In a racist society, those of us who are called white passively enjoy the benefits of whiteness. We do not have to DO anything in particular for the system to continue to work to our benefit. But we certainly enjoy the benefits, whether the enjoyment is conscious or unconscious. And I believe that we are psychologically dependent on the rewards of privilege. We tend to perpetuate behaviors that support inequity, despite the negative consequences of which we are aware.

In AA, people talk about stinkin' thinkin'. This refers to the disordered thought process that accompanies addictive use of a substance. As I have suggested above, I maintain that along with the psychological dependence on the feelings and rewards of power and dominance, white people think in a disordered way about race, power and privilege.

Yet as white individuals, we have choices. We can opt for the sanity of anti-racist acts and thoughts. But because of the addictive nature of power, I believe we need to commit to a lifetime of active, intentional recovery work, in the same ways that alcoholics always have to work at sobriety. Addicts who are seriously committed to their recovery, continuously work to support their progress. They can never assume they are finished with their work. It is ongoing.

AA has steps to recovery. I am suggesting that those of us who are called white need to think seriously about overcoming our addictive relationship to power, dominance and privilege and am suggesting our own twelve steps in a lifetime of recovery work:

1. We admitted we were powerless over our socialization into a racist society.
2. We came to understand that working to undo racism could restore us to sanity.
3. We came to understand that we could not do this work alone and made a decision to accept leadership from people of color.
4. We make an honest inventory of how we participate in racist policies and practices.
5. We begin to address these wrongs by learning and teaching accurate history.
6. We pledge to educate ourselves and organize to undo racism, always remaining accountable to people of color.
7. We recognize that this is a lifelong process. It is a way of life that must be guided by Undoing Racism Principles.

8. We commit to learn how internalized racial superiority has distorted our thoughts and assumptions, and work to clarify our thinking.
9. As white people, we have been oblivious to the racism in our families, schools, offices, faith communities and we seek to address such wrongs wherever possible. If we are gatekeepers, (i.e. control access to resources), we will work to allocate these resources more equitably.
10. We agree to learn to celebrate our own culture so we do not exploit the culture of other peoples.
11. We will seek to learn how racism was created so we can improve our conscious awareness of the sometimes, invisible arrangement that perpetuates racism.
12. We commit to carrying our antiracist message to other white people.

Ron Chisom, co-founder of the Peoples Institute for Survival and Beyond, teaches us that racism dehumanizes, and anti-racism humanizes. For those of us called white, there are many challenges as we confront our addiction to power and privilege. The work to undo racism is hard, but Ron also teaches us that it gives us life. There are real rewards for working to recover from our addiction to white privilege.

*All of the ideas in this piece have been learned from or inspired by The Peoples Institute for Survival and Beyond (PISAB). PISAB is a national and international collective of anti-racist, multicultural community organizers and educators dedicated to building an effective movement for social transformation. Their two and a half day Workshop, Undoing Racism is a life changing introduction to anti-racist thinking and organizing.

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