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Structural Whiteness in Mental Health: Reexamination of the Medical Model Through a Lens of Anti-Racism and De-colonization

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Abstract

With increasing attention on the deleterious effects of trauma across the lifespan and the intersection with racism, the topic of racial trauma has become an important subject in the quest for racial justice. There is ample evidence of the traumatizing impact of everyday racism leading many trauma researchers to include this as a marker of adverse childhood experiences (ACEs) due to their strong association with negative health outcomes. Despite this growing acceptance of the reality of racism as trauma, the current Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM V) definition of trauma excludes many such experiences unless the individual is, "exposed to death, threatened death, actual or threatened serious

injury, or actual or threatened sexual violence" through direct exposure, witnessing the same, or learning of such trauma in a close relative or friend (National Center for PTSD, 2019). The only form of indirect exposure that is included within the DSM V definition of trauma is that of professionals exposed to "aversive details… in the course of professional duties." This article will critically examine the harmful effects of such narrow definitions of trauma in terms of mental health within communities of color. Specifically, this article will explore ways in which the current mental health paradigm and associated structures may reproduce colonialism in mental health care in the U.S., which can result in more harmful diagnoses when posttraumatic stress disorder is too narrowly defined and excludes chronic conditions such as racism and poverty as primary drivers of symptomatology.

Introduction

An increasing number of authors, who have written about the realities of racial trauma, have presented compelling evidence of the traumatizing effects of racism and present frameworks to explain mechanisms by which racial trauma is transmitted (Comas-Diaz et al., 2019; Williams, 2015; Williams et al., 2021). Various health-related disparities and negative health outcomes have also been found to be related to exposure to racism (Harrell et al., 2003; Vlessides, 2019). Further, multiple authors have noted significant racial and socioeconomic disparities in access to mental health treatment, diagnoses, and prescribing practices (Gara et al., 2018; Koodun et al., 2021; Perzichilli, 2020).

While this growing body of research focusing on racial trauma is an important advancement in our understanding of mental health issues in Communities of color, few authors have explored ways in which current diagnostic manuals exclude everyday racism from their definitions of trauma. Furthermore, the exclusion of exposure to racism from current definitions of

trauma has not been considered as a contributor to the harmful and racially disparate diagnosing practices that have been revealed in numerous studies. In this article, we will discuss these issues using a critical theoretical approach by examining the connections between contemporary issues in mental health with historical critiques of how these practices and structures have historically minimized and excluded the experiences of Black, Indigenous, and People of Color (BIPOC) populations. We will also examine the ways in which privileged definitions of trauma have become accepted, which includes secondary exposure for mental health professionals while excluding the pervasive primary and secondary exposures faced by communities identified as Black and Brown for generations. In addition, the ethical questions this raises for social workers who profit from continued adherence to these narrow definitions will be examined. The overall utility and justification for social workers to continue to participate in a medical model of service delivery will be critically examined.

Grounded in Critical Theories

Policies and organizational changes affecting the industry of mental health in the 1990's came in the form of new insurance business models called Health Management Organizations (HMO's). This new model prioritized profit over care. DeLeon, VandenBos, and Bulatao (1991) note,

> Individual HMOs [could] exercise considerable latitude in the eligibility criteria they develop[ed] for outpatient MH services and in the range of such services provided. Thus, the extent and costs of MH services provided [were] actually dictated less by law and regulation than by how HMOs interpret and implement them. Some psychologists have argued that most HMOs do not provide psychotherapy, as they claim; rather, what HMOs provide are a few hours of "crisis intervention" that is labeled as "psychotherapy" (p. 22).

Clients seeking mental health support were required to be labeled with a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis to

restrict costs and have it paid for by their health insurance. It seems that gone are the days when people, without having to receive a pathologizing DSM diagnosis, could access mental health services to help them process and manage daily life stressors and have health insurance cover a portion of the cost.

With the advent of this medical business model of health care, social workers have become increasingly embedded in corporate medical and mental health systems. We should be concerned about our identity as social workers being rooted in the degree to which we have become, and continue to be, assimilated into the dominant, capitalist belief systems about human service work and the ways in which we are increasingly viewing the people we serve as "consumers." As the social work profession becomes more embedded within and "legitimized" by the corporate medical system, we also increasingly assimilate ourselves into what Marx calls a "distorted consciousness" (Allman, 2007), which allows us to distance ourselves from the macro structural conditions that contribute to the economic systems that oppress our clients. Giroux (1997) uses the term "hegemony" which describes the process by which the public is powerfully indoctrinated into a way of thinking about the world not by using force but rather, "mediated via cultural institutions such as the schools, the family, the mass media, the churches" (p. 48). The profession of social work is increasingly in danger of losing its commitment to critical social work praxis as we allow ourselves to be co-opted by a capitalist version of who our clients are, and in defining and delineating what our role is in providing services. Increasingly, we may unwittingly become complicit in the reproduction of systems of inequity and oppression.

The mental health care "arm" of the social work profession is increasingly adopting the view and subsequent practice that clients' problems are pathologically located within their own individual inability to negotiate the world around them. Many social workers have bought into the distorted version of what is "normal" as defined by a capitalist hegemonic system. In the examination of the legacies of a colonialist paradigm that is embedded into

macro structures and micro practices of mental health care in the United States, West Indian political philosopher, and psychiatrist Frantz Fanon's (1967) observations about psychiatry and colonialism are unfortunately still relevant today. In his seminal work, *Black Skin, White Masks,* Fanon writes, "Every colonized people...every people in whose soul an inferiority complex has been created by the death and burial of its local cultural originality– finds itself face to face with the language of the civilizing nation...He becomes whiter as he renounces his blackness..." (p. 18). As a result, this article seeks to examine several ways in which our mental health paradigm and the associated structures reflect an assimilationist approach to a Whiteness version of mental health and by extension the degree to which the capitalist mental health care business model in the United States is reproducing these kinds of colonizing practices as well as implications for how the profession of social work may be complicit.

Relevance to Global Social Work Practice and Ethics

Acceptance of restrictive conceptualizations of trauma is of unique importance to social workers given our ethical imperative to advance human rights and social justice. As noted in the 2021 Code of Ethics:

> Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity (National Association of Social Workers [NASW], 2021).

This commitment to rectifying social injustice sets the social work profession apart from other mental health disciplines. The diagnosing disparity impacting marginalized groups is not the first critique of the medical model of mental health care. Other authors have noted the harm of pathologizing

individuals for their adaptations to unjust systems in which they live (Smith et al., 2009). Clinical psychologist, Dr. Robert Guthrie (1991), asserts,

> ...psychological diagnosis is in itself often misleading and tells us little about the client; however, it reveals much more about the environment in which the observer finds the individual...behaviors labeled as bizarre in one culture might be considered acceptable in another culture even when these cultures are contiguous rather than separated by continents or great distances...normalcy categorization and labeling follows the needs of the power holders in a given society (p. 33).

What Guthrie communicates is especially important when discussing the ongoing and oppressive collective experiences of African Americans in a White supremacist country. Guthrie (1991) borrows from Fanon's ideas that Black children may grow up with certain thoughts, feelings, and beliefs that are completely normal within their community but are deemed "abnormal" by mental health structures that operate from an overly focused medicalized paradigm that is grounded in a White lens. The White supremacist view says that "White" is the yardstick upon which everyone is measured. Fanon (1967) asserts,

> Where the negro makes contact with the white world, a certain sensitizing action takes place. If his psychic structure is weak, one observes a collapse of the ego. The black man stops behaving as an actional person. The goal of his behavior will be The Other (in the guise of the white man), for The Other alone can give him worth (p. 154).

From a structural racism perspective, Fanon's ideas speak to the emotional and psychological toll that this kind of constant code-switching can take on the mental wellbeing of BIPOC populations. Specifically, that there is a built-in form of oppression in our society that requires people who are not White to deny their Blackness, Brownness, Indigeneity to "adjust" to the White supremacist and dominant world view of "normal."

History of PTSD Diagnosis and Related Controversies

The conceptualization of the posttraumatic stress disorder (PTSD) diagnosis has been politicized since its inception (Hermann, 2015; Van Der Kolk, 2014). Prior to its acceptance as a legitimate psychological disorder in 1980, soldiers who returned from war with disturbing symptoms were likely to be labeled as weak or, at best, as suffering from what is referred to as "shell shock." Once PTSD was added to the diagnostic manual, the disorder was thought to only affect war veterans and few others were considered for this diagnosis. It was not until the feminist movement shined a light on the pervasiveness of domestic abuse and sexual assault that these experiences were legitimized as potential pathways to develop posttraumatic stress disorder.

Some authors have pointed out the inadequacy of the DSM V PTSD diagnosis in capturing the complexity of many people's trauma experiences. Hermann (2015) notes that the diagnostic manual emphasizes, "circumscribed traumatic events" to the exclusion of "prolonged, repeated trauma" (p. 119). Indigenous scholars, Hill et al. (2010), similarly identify that the Western conceptualization of trauma focuses on "a singular episode" and ignores ongoing stressors such as "forced assimilation/acculturation, current oppression, and how the daily indignities visited on people of color symbolize strong memories of historical and continuing injustices" (p. 42). Further, Bessel Van Der Kolk (2014) notes,

> ...the lack of reliability and validity did not keep the DSM V from meeting its deadline for publication, despite near-universal consensus that it represented no improvement over the previous diagnostic system. Could the fact that the APA has earned $100 million on the DSM-IV and is slated to take in a similar amount with the DSM V... be the reason? (p. 167).

Van Der Kolk joined with other trauma researchers to propose the addition of Developmental Trauma Disorder to the DSM V to better capture the experiences of those exposed to chronic trauma. This proposal was rejected,

and the PTSD diagnosis remained largely unchanged to focus on experiences of discrete traumatizing events to the exclusion of ongoing adverse conditions. These inadequate diagnostic frameworks resulted in organizations such as the Child Trauma Academy to stop relying on the DSM framework for trauma study (Perry & Szalavitz, 2017). Unfortunately, many organizations cannot ignore the DSM definitions due to their reliance on reimbursement for services. These financial considerations give the DSM great power in driving professional practice decisions, including what to include and exclude from clinical assessments.

Evidence of the Traumatizing Effects of Racism

The notion of racial trauma is beginning to receive increased attention from the mental health community (Comas-Dias et al., 2019; Harrell et al., 2003; Shonkoff, 2021; Vlessides, 2019; Williams, 2015; Williams et al., 2018; Williams et al., 2021). Harell et al. (2003) reviewed numerous studies that support the notion that racism and discrimination elicit physiological arousal, which is a core component of the stress response associated with other traumas. Others have pointed to the negative health effects associated with exposure to racism that are consistent with harms associated with other adversities (Williams, 2015). Another phenomenon noted in the literature is known as the immigrant's paradox (Hill et al., 2010). This concept is based upon research findings that the pressure and stress related to a perceived need to acculturate into America's dominant norms is associated with increased rates of substance abuse and other negative health outcomes within groups whose cultural norms might otherwise conflict with American values. A related experience overwhelmingly associated with Communities of color is that of pervasive historical trauma. The cumulative effects of psychological scars based upon historical loss and massive mistreatment have been found to transition across generations. Despite multiple studies validating these stressors as legitimate traumas, these experiences found

largely within BIPOC communities continue to be excluded from DSM conceptualizations of trauma.

To promote more inclusive definitions of trauma and adversity, Vlessides (2019) calls for the inclusion of racism in the list of Adverse Childhood Experiences (ACEs) many providers screen for within pediatric practices. Williams et al. (2018) propose the use of a new screening tool, the UConn Racial/Ethnic Stress and Trauma Survey, due to the propensity for racial trauma to be overlooked in traditional PTSD assessments. Nadine Burke Harris (2018) has been a pioneer in this area of practice by implementing universal ACEs screening into her pediatric practice. Her screening tool includes exposure to racism in the conceptualization of ACEs. This contributes to comprehensive efforts to address the negative health outcomes associated with elevated levels of adversity from the earliest stages of development.

However, the above does not represent the practice norm. For example, Popp et al. (2020) surveyed 48 pediatric providers about their procedures for ACE screening. The results showed that approximately 90% of providers who participated in the survey believed that screening for some ACEs should occur within pediatric practice. In contrast, less than 40% of those respondents reported conducting any such screening in their clinics. The fact that this study did not include exposure to racism in their definition of ACEs is further evidence that this issue is still overlooked by many trauma researchers and service providers. Dawes (2020) notes the harmful impact on African Americans and other marginalized racial groups when these issues are ignored by White providers by stating,

> You fail to check in with your clients of color regularly about racism. Yet without your invitation to name and express their pain, these clients suppress deeply held emotions in a room in which they ought to feel at their most free. You do not shy away from other forms of suffering. You ask your client if they are suicidal, you check in about their phobias and compulsions, you fill out mindfulness worksheets as you have been trained to do. Yet do you not go *there* with your clients of color, as though you await their permission — where is your training then? Would you

> neglect to ask about sexual trauma if you had not experienced it your-self? You fail to check in with your Black and Brown colleagues, or if you do so, you pass over the discomfort and move to more neutral ground. You leave behind abandoned, unattended souls in your unwillingness to 'say the wrong thing.' Even after healing from other traumatic events, racial trauma remains ongoing and ignored (paras. 9-10).

Few authors have considered the White privilege and racial bias inherent in the DSM V conceptualization of trauma. The current DSM definition of a trauma is:

> The person was exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s): direct exposure, witnessing the trauma, learning that a relative or close friend was exposed to a trauma, and indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics) (National Center for PTSD, 2019).

It is notable that experiences of everyday racism and discrimination would be excluded from this definition unless the racism is accompanied by extreme violence that is directly witnessed or experienced by the individual or an individual close to them. Ironically, the mental health professionals who contributed to the diagnostic manual carved out an exception to this necessity of direct exposure for fellow practitioners, who could theoretically be traumatized by learning of the aversive details of trauma in their work, often referred to as secondary traumatic stress.

While this present article does not deny the prevalence of secondary traumatic stress among trauma professionals, there is considerable doubt that professionals are more vulnerable to this phenomenon than the general public. Trauma professionals are trained for this work and come to expect this exposure as a known occupational hazard. Many people experiencing trauma and seeking care from social workers have unique life experiences (e.g., economic insecurity, unsafe neighborhood conditions, chronic secondary exposure to traumas experienced by loved ones and

acquaintances), which may make them more vulnerable to trauma exposure than the professionals who treat them. In addition, individuals who are indirectly exposed to the traumas of members of their racial or ethnic community are often ill-equipped to make sense out of these situations. They do not have the training or professional support to help them process these situations. Individuals from Black and Brown communities might feel that their lives are quite like strangers who they see in media images experiencing racially traumatizing incidents. It is notable that the American Psychiatric Association released a specific statement eliminating media exposure from the definition of trauma, reiterating that to qualify as a trauma it must be, "first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television, or movies unless work-related)" (American Psychiatric Association, 2013, p. 271). In addition to these indirect and/or media exposures, experiences of racial bias, microaggressions, and discrimination have also been shown to elicit physiological stress responses. These experiences are qualitatively different from those of most mental health professionals who can leave the office and return to the relative safety and tranquility of their home environments.

A concept that might be more useful in describing the circumstances of some of our most vulnerable clients is continuous traumatic stress (Eagle & Kaminer, 2013). Continuous traumatic stress (CTS) is a useful descriptor for some of the most marginalized and oppressed groups in the world and was originally proposed by anti-apartheid mental health professionals in South Africa. Continuous traumatic stress describes trauma that is pervasive, unpredictable, chronic, and significant in scale. Authors have labeled situations of war, refugees, and endemic community violence within the CTS framework. Hill et al. (2010) similarly argue that race-related stressors should be viewed as even more harmful than single-episode traumas. The reason for seeing racism as uniquely traumatizing is that this experience is a near-constant reminder of one's marginalization, can occur continuously (without time limits), and pervades multiple aspects of someone's life, from school to healthcare to community interactions.

Continuous traumatic stress is distinct from the PTSD conceptualization, as the trauma exposure is ongoing and often inescapable, rather than existing in the past, as implied by the posttraumatic stress disorder conceptualization. The DSM V definition of trauma is limited to events that typically have a beginning, middle, and end, whereas CTS better reflects the life experiences of those trapped in dangerous communities without hope for escape or improvement in circumstances. Other hallmarks of the CTS conceptualization are that symptoms consistent with PTSD are noted (e.g., increased arousal, avoidant behaviors, negative mood) but are recognized as being adaptive and expected, rather than pathological and ongoing. In this framework, fear is viewed as realistic and necessary, rather than a target for professional intervention (Eagle & Kaminer, 2013). A reimagined non-colonialist approach in working with these clients would embrace a non-deficit paradigm where they are viewed as having critical knowledge to offer professionals in how this adaptation occurs. Thus, creating a partnership with mental health professionals versus an approach that privileges the medical and/or mental health provider as the singular expert needing to instruct clients on what is best for them. This recognition changes the target of intervention from an individual pathological approach to the necessity of addressing harmful environmental factors in which it would be nearly impossible for anyone to thrive. This change in basic assumptions would decenter the focus of work on the individual client and instead might call for interventions that empower the client toward action in their own community toward social change efforts. Better yet, group-based approaches could be developed to promote mutual aid and empowerment among those facing similar oppressive community conditions.

Decolonizing Approaches to Recovery

The medical model of intervention (individual psychotherapy and medication) is the dominant paradigm for trauma recovery in America. Watkins et al. (2018) review various models of psychotherapy to compare efficacy of

each without consideration for other recovery pathways. Additionally, the Mayo Clinic (2022) website lists two treatment approaches for PTSD, psychotherapy, and medication. These approaches to recovery reflect Western values of individual pathology and responsibility for healing despite many experts in the study of trauma calling for more inclusive healing practices to be more widely considered.

Other authors have questioned dominant models of "evidence-based" psychotherapies, such as cognitive behavioral therapy, for lacking cultural relevance for clients from marginalized backgrounds (Rogers-Sirin, 2017). This is an important contribution to the conversation as to how traditional psychotherapy approaches reinforce Western values of "normalcy" and fail to connect clients' difficulties to "...broader, historically situated information about the ways women, people of color, and economically disadvantaged individuals are harmed by systemic injustice" (Rogers-Sirin, 2017, p. 65). However, this critique stops short of questioning the overall utility of individually based psychotherapy and instead calls for integration of feminist and more social justice focused individual models of therapy.

Alternatively, Van Der Kolk (2014) recommends a variety of pathways to recovery, all of which can be accomplished outside of psychotherapy. Included in Van Der Kolk's model are dealing with arousal problems, mindfulness, relationships, rebuilding rhythms and synchrony, learning to tolerate healthy touch, and taking purposeful action. To address arousal issues in trauma survivors, Van Der Kolk specifically recommends yoga practice, tai-chi, and other non-Western approaches to healing. "In contrast to the Western reliance on drugs and verbal therapies, other traditions from around the world rely on mindfulness, movement, rhymes, and action" (Van Der Kolk, 2014, p. 209). These activities can also help to rebuild rhythmic systems of engagement that are disrupted by trauma through cultural practices involving song and dance. Mindfulness practices help traumatized people to rebuild mind/body connections which allows survivors to fully embrace their feelings rather than seek to numb or avoid these.

Human connection through authentic relationships is another critical component of trauma recovery that is best achieved through natural support systems within families and communities. The ability to tolerate healthy touch is often achieved through therapeutic body work which might include massage or other body-based approaches. Taking action might involve activities ranging from completion of a self-defense class to participating in theatrical reenactments of moments of helplessness in which survivors can mobilize their internal resources and effectuate a different end to their story.

Similarly, Perry and Szalavitz (2017) criticize the inadequacy of the medical model of care for childhood trauma survivors,

> In most public mental health clinics, the average number of consecutive clinical visits is about three… Ten years of abuse, neglect, humiliation, marginalization - twenty placements, two grade-levels behind in school, speech and language problems, sensory integration issues, no friends, no family, no social skills, impulsive, inattentive, dysregulated, attachment problems, hundreds of evocative cues from years of maltreatment, now in a new foster home. *We approve twenty sessions of Trauma Focused-Cognitive Behavioral Therapy for all of that* (p. 336).

Further, Perry and Winfrey (2021) note that the medical model overemphasizes medication and psychotherapy-based interventions. This shows consistency with Van Der Kolk in emphasizing the importance of connection to others, regulation through rhythm and dance, and grounding survivors in a set of values and beliefs that allow them to make meaning out of their difficult experiences.

This is consistent with the healing models offered by Indigenous authors such as Suzanne Methot (2019) who emphasizes movement, balance, connection, and relationships. She suggests a "spiral-like" approach that integrates the following elements of safety, control, creation of narratives that connect past and present, a process of grieving, and rebuilding connections to self, the larger world, and to others. Methot (2019) believes this comprehensive approach allows survivors to return to a grounding in the present, a

key element of trauma recovery often referred to as mindfulness. In contrast, Methot notes that traditional micro-focused approaches "...cannot possibly address all of this in an individual, let alone the long-term, cyclical intergenerational transmission of trauma within families and communities" (p. 279). Other Indigenous scholars question Western approaches to trauma recovery as over-emphasizing, "individualistic and confessional values of 'coming to terms' with traumatic experiences" (Hill et al., 2010, p. 44). They suggest more culturally relevant approaches that include community rituals, traditional spiritual practices, partnership, community mobilization, holism, and environmental sustainability and connection.

Flaherty et al. (2019) provide another compelling model of mental wellness grounded in community through their conceptualization of the social determinants of health. They promote the idea that, "mental health is delicately woven into the fabric of community, the health of which is only as strong and stable as its members" (Flaherty et al., 2019, p. 30). They suggest moving away from Western notions of disease and disability that are currently applied to mental health and instead to focus our assessment and intervention on social determinants of health including interpersonal wellbeing, income stability, quality of and satisfaction with life, employment, and working conditions. Others have added access to housing, healthcare, and safety into this conceptualization. One of the central recommendations offered by this article is to connect mental health and trauma recovery work to larger peacemaking efforts due to the interconnection between these in building and maintaining healthy communities. Applying this framework to current mental health paradigms would add credence to the micro-level practitioner working to engage clients in macro-level advocacy and community organizing efforts. These practices promote client agency and empowerment in the process of effecting meaningful changes to oppressive conditions within their communities.

One common theme across authors who question the utility of talk-based psychotherapy as the primary pathway to recovery from trauma is the need for survivors to re-regulate body systems that trauma disrupts (Van

Der Kolk, 2014; Perry & Szalavitz, 2017; Methot, 2019). Because trauma is stored in the body and often manifests physiologically, simply talking about it does little to heal the primary distress that many survivors experience. Mental health providers can play a vital role in educating survivors about these mind/body connections and lend their support to practices such as yoga, dance, and other movement approaches. Further, mental health clinics could integrate these approaches into more holistic constellations of services. When working with members of historically marginalized groups, movement-based approaches grounded in the client's native culture can be particularly impactful in reconnecting to one's history and ancestral practices.

The added benefits of non-psychotherapy models of trauma recovery are widespread. Specifically, these approaches can be delivered in community-based settings that are accessible and affordable. Many of these approaches do not depend on pathologizing diagnostic processes nor insurance coverage or reimbursement. These models emphasize culturally relevant approaches that help to reconnect individuals with traditional sources of healing and connection.

Conclusion

As a social work profession, we must ask ourselves tough questions such as, are social workers in the United States leading the way in promoting more socially just and culturally inclusive pathways to mental health and wellness? Unfortunately, this does not appear to be the case. The social work profession and the current mental health paradigm in the U.S. continue to privilege the practice of individual psychotherapy by designating the independent clinician as the highest level of licensure in most states (SocialWorkGuide.org, 2022). This shift in focus to an individualized, expert-driven approach to healing is contrary to the historical roots of the social work profession, which was grounded in mutual aid and community-driven approaches to empowerment (Morgaine & Capous-Desyllas, 2015). We believe

the field of social work could play a vital leadership role in establishing professional standards for macro-level community-based practitioners who are poised to play an impactful role in trauma recovery, especially within marginalized communities. This might involve social workers in efforts to further the knowledge base of the efficacy of community-driven efforts to reduce the prevalence and impact of trauma on vulnerable individuals. In addition, social workers could lead the way in redefining "clinical" social work to include macro focused-community-based approaches to healing. In contrast to an exclusively micro-based paradigm where a single "expert" is the sole means of support and healing with a focus on individual pathologies, a reimagined mental health paradigm is needed. This would rely on community strengths, including individuals, families, friends, native healers, for example. Helping clients to better understand the harmful social structures that contribute to their distress would be central to helping people create transformed narratives about where the pathology lies - within these social structures, not the individual. However, to do this, the social work profession will need to examine the structures in place that create a false binary of the macro-micro division as it relates to human behavior and how we can begin to blur that binary so that human behavior and coping are contextualized within racist social and economic structures towards a more liberatory paradigm of mental health.

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