Critical and Radical Social Work • vol 3 • no 2 • 309–19 • © Policy Press 2015 • #CRSW
Print ISSN 2049 8608 • Online ISSN 2049 8675 • http://dx.doi.org/10.1332/204986015X14320477877474

voices from the frontline

Towards a socially just social work practice: the liberation health model

Jessica Kant,[1] jess@liberationhealth.org
Boston Liberation Health Group, USA

This article discusses the 'liberation health' model for social work practice and explores how this model may be used to bring conversations about race and class into the therapy room. It begins with a review of mental health social work teaching in the United States and moves on to demonstrate differences between traditional and liberatory practice methodologies. The term 'liberatory' is used in this article to refer to a variety of anti-oppressive theoretical frameworks, with an emphasis on the work of Paulo Freire and Ignacio Martín-Baró. Additionally, the author demonstrates interviewing strategies for bringing conversations about intersectionality into the therapy context.

Introduction

Therapy without context

Although many methods exist and are widely taught for understanding the intersections of race, class and gender in academia, the link between this and direct practice is under-addressed in social work pedagogy. In the United States (US), the majority of graduate students looking to pursue a career in social work follow what is referred to as a 'clinical track', which predominately trains new social workers for a career in individual counselling (Reardon, 2012). Clinical tracks in most social work schools emphasise modernist and intra-psychically focused theories such as cognitive-behavioural therapy (CBT) and motivational interviewing, alongside relatively newer methods of family therapy that focus on brief treatment.

Psychodynamically focused practice teaching, which prevailed prior to the elevation of CBT in US social work pedagogy, made a similar misstep, in so far as it tended to look to drives, fixations and childhood experiences with family members as the root cause of the many problems that service users came to therapy to address. Dynamic theories were heavily focused on the experiences of white clients, particularly upper-class Europeans, which offered little insight into the lives of working poor people and people of colour in North American cities (Almeida et al, 1998: 415). Moreover, psychoanalytic practice was largely guilty of perpetuating sexist and mother-blaming attitudes that are still prevalent in many North American schools of social work. Object relations and attachment theories, which focus on the important early years of a child, have paid insufficient attention to the impacts of racism and internalised oppression, which factor largely into the affective landscape of young parents, particularly those from lower-income areas and communities of colour.

Critics of mental health education in the US have argued that graduate schools are designed to train white therapists, whereby both clients and practitioner are treated as *de facto* white (Hardy, 2008). Other critics have argued that social work schools have abandoned the mission of serving underprivileged people altogether, in an attempt to professionalise (Specht and Courtney, 1994). In the course of this professionalisation, teaching for social work and other allied mental health professions has contributed greatly to a literature that seeks to define service users and patients by a cluster of symptoms, training therapists to participate in the totalisation of their clients (Madsen, 2007: 31; White and Denborough, 2011: 65-6). Additionally, the need for reimbursement, particularly in the US where healthcare is a capitalist enterprise, and the use of diagnostic codes for the purpose of remuneration, have led to an increase in tangible motivation to use these ways of understanding service users and the problems in their lives.

One of the early North American movements to challenge these ideas was known as the rank and file movement – a frontline social worker-led movement heavily involved in the unionisation of social workers – which was seen as a recommitment to grassroots organising in American social work (Reisch and Andrews, 2001: 61-87). It is from this and two other traditions that liberation health is drawn.

The popular education and liberation psychology movements

A pioneer in the field of education, Paulo Freire had been tasked with developing a literacy programme for poor farmers in rural Brazil. When Freire examined dominant teaching methods and attempted to make these relevant for his students in Brazil, he found that then-current pedagogy was not only inadequate for addressing the needs of his students, but also, in his estimation, oppressive as well. Freire wrote grimly that educators were practising a 'banking model' of education, by which he meant that teachers were treating students' heads and minds as empty vessels in which to bestow knowledge (Freire, 1992: 58-64 [1970], 2001: 30-4). In this banking model, where the role of teacher and student are absolute, the student experiences themselves as an '*object*', by which education is a practice that is done *to* them, rather than *with* their collaboration and input (Freire, 2009: 42).

Freire postulated that a critical pedagogy would require a more nuanced, reciprocal relationship. This reciprocity would help to move students relegated to an object position to that of a subject, which he referred to as someone who is in a relationship with the world around them. The role of education, Freire (2001: 76) believed, was to help students to learn to 'read the world', to understand the forces of oppression around them and to renegotiate these relationships to allow for learning to be both relevant and transformative. Freire's literacy programmes experienced unparalleled success, accounting for his recognition as a thought leader in education around the world.

In subsequent years, Freire's critique of education, and the formation of the popular education movement, were picked up by Salvadoran and Jesuit psychologist Ingacio Martín-Baró. Martín-Baró recognised a similar oppressive structure in the field of psychology as reported by Freire in the field of education. Martín-Baró believed that psychology was playing the role of oppressor, both upholding social norms and perpetuating the subordination of therapy service users (Martín-Baró et al, 1994). He documented that then-modern methods of psychological practice treated patients

as people to whom therapy is done, rather than people to be collaborated with. Such a practice was inherently colonialist, and reproduced power structures within the therapy context. Martín-Baró thus adapted Freire's methodology to counselling practice, creating a paradigm that sought to deconstruct power relationships and the messages that reinforce them.

The liberation health framework for social work practice

The liberation health framework for social work builds on these legacies of anti-oppressive thought. With the ideas of Freire and Martín-Baró at the core of liberation health practice, the framework seeks to provide a space for service users and social workers to think critically about the problems for which they are seeking treatment.

This first requires the discovery of a view of the problem 'in its totality'. To do this, workers elicit information relating to the personal, cultural and institutional factors that influence their lives (Belkin Martinez, 2005; 2014: 23). Given the problem-saturated view promoted by a medical model of clinical practice, many service users come to social workers with long stories having been written about their lives, which detail at length diagnoses, developmental milestones, family and addictions histories, among other things. These constructs, while important, are imposed on service users by people outside of themselves. These details often make up the traditional biopsychosocial assessment. However, the traditional biopsychosocial assessment in and of itself does not capture the entirety of a problem, and classical formulations leave out what may perhaps be the most important information.

Beginning the triangle: personal factors

To visualise a problem in its totality, liberation health practitioners often utilise a diagram featuring a triangle, with each point representing the contributing factors to a problem. The three points are designated as personal, cultural and institutional factors. Service users are invited to name the problem they are experiencing using unique language that is meaningful to them. This is put in the centre. The practice of using family-specific language has a long and important tradition in post-structural family literature and is essential to centralising the experience of the family. Below you will find the stories of families who have interfaced with both traditional and liberation health practitioners. As such, traditional means of understanding problems will be juxtaposed against liberation health assessments that include issues of race, class and other avenues of oppression. These will be set in a liberation health triangle.

For example, a family is referred to services following a young child's 'behavioural outbursts' at school. The child and his mother are subsequently interviewed by school staff, who observe tension among family members, leading to a referral for family services. A host of earlier providers have documented that this child meets the criteria in the *Diagnostic and statistical manual of mental disorders* (DSM-IV-TR; APA, 2000) for attention deficit hyperactivity disorder (ADHD), and medication is suggested by a psychiatrist. An understanding is woven over multiple subsequent assessments in the years prior to the start of family therapy services that this child is in need of mental health services and such an understanding becomes intrinsic to how the family views the problem.

The factors listed in the referral, as well as other personal factors, make up the first point of the triangle. These may include demographics such as:

- age;
- gender (and gender identity);
- race and ethnicity;
- sexual orientation;
- family context;
- intergenerational patterns; and
- diagnostic and medical information.

Cultural factors: exploring cultural messages

To allow for a more complete view, a social worker interested in liberation health practice begins by inviting the family to explore the messages they have received as a result of this diagnosis. These explorations reveal deeply painful messages about the stigma of raising a child with mental health needs. The parents reveal feeling judged and shamed when they take their child to doctor's appointments. During an interview, the mother shares how frequently she is asked by nurses whether or not she used drugs or ingested alcohol while her son was in utero. From here, the second portion of the triangle begins to list cultural factors that are contributing to the strain on this family. While these may be listed as concepts (eg, racism, classism and the celebration of individualism in North American culture), they may also be recorded as the messages themselves. Some of these painful messages, as have been relayed by families to this author, are elucidated below:

> 'If a child is born with special needs, it must be because the parents did something wrong.'
>
> 'If parents were able to raise their children properly, they would be able to pay attention in school.'
>
> 'All children who misbehave do so for attention, and should be treated as such.'
>
> 'If a child has trouble concentrating or sitting still, they will not be successful in life.'
>
> 'Children who misbehave in school must come from "broken" homes.'

Consider the following conversation with a mother whose son was suspended from school after a history of involvement with school disciplinarians:

Mother:	'I used to get this tightness in my gut when I would go to his school.'
Author:	'All the time, or at particular times?'
Mother:	'Whenever the school would call, and I'd have to go down there. It would just hurt.'
Author:	'Do you have an idea of what it was that was contributing to the tightness?'
Mother:	'I can hear it in their voices – "your kid is acting up" means "what the hell are you doing wrong?"'

Author: 'What message do you hear when that happens?'
Mother: 'You're a bad parent and you have a bad kid.'

Other factors already named in the 'personal factors' column contribute to this parent-blaming. Families of colour often report feeling particularly blamed and are extra-cognisant of the judgements being rendered upon their families. The following statement was recorded during an interview with this author and a family whose young son, a student of colour, was consistently under intense scrutiny at his mostly white school in a major metropolitan area in the US: "When I hear them talk about my son like that, when they use the word 'aggressive', I know what they mean by 'aggressive'. They mean he's a thug. And they mean a thug ... like all the other black kids."

Cultural factors may take other forms, such as prejudicial beliefs around sexuality and gender identity. These are often tied to institutions as well, and can often help to make the tie between personal, cultural and institutional more explicit. These messages may be elucidated in various forms and come out in many different ways. A colleague of this author reports working with a man whose history of suicide attempts and suicidal thinking are fundamentally tied to messages around homosexuality that began in early life. A conversation revealed that the service user's motivation for suicide centred on being 'undeserving of life'. Although it would be possible to work to ameliorate the distress caused by these thoughts, it is equally important to understand where they come from, as cultural messages are supported by larger social structures. A liberation health interview revealed explicit statements in support of this belief coming from the service user's own faith institution, leading to larger conversations about the validity and worth of these statements. Introducing new information in this case included exploring clergy and religious activists who have worked to tear down the idea that Christianity is incompatible with non-heterosexual identity. The deconstruction and challenging of these ideas is referred to as 'deconstructing dominant discourse' (Kant, 2014).

Often, conversations around cultural messages offer the opportunity for what Martín-Baró referred to as 'introducing new information' (Martín-Baró et al, 1994). Martín-Baró believed that structural oppression was upheld principally by the notion that things have and always will be as they are, or more pointedly: 'nothing can change' (Martín-Baró et al, 1994: 30). Practitioners looking to fight oppressive discourses should therefore look to become students of radical history movements. Working with the man described above, it would be helpful to explore how the notion that 'homosexuality is a mental illness' was driven from psychiatry by dedicated lesbian, gay, bisexual and transgender rights activists who successfully fought to remove homosexuality from the DSM, and are now currently working to ban so-called 'conversion therapies'.

Institutional factors

A complete analysis of the problem requires a third and important category of information to be recorded – the institutions that families interface with in pursuit of remedying the problems that affect their lives. As demonstrated above, institutions themselves can contribute greatly to oppressive conditions by the messages they perpetuate, but also through structural and institutional racism. It has long been

documented in sociology literature that black students, particularly black male students in the US, receive considerably harsher punishments in school than their white counterparts for the same offences, and consistent reports reveal a much greater willingness on the part of school personnel to involve law enforcement in school discipline when young men and boys of colour are involved. In 2013, Kiera Wilmot, a 16-year-old African-American student, was expelled from school in Bartow, Florida for doing an experiment she found on YouTube that involved combining cleaning supplies and aluminum foil to generate smoke (Klein, 2013). Wilmot performed the experiment in a bottle which unexpectedly burst, and Wilmot was accused of building an explosive device.

Despite the long tradition of unpunished senior pranks in suburban white communities, Wilmot was expelled and threatened with charges.

As suggested by Martín-Baró, families should be encouraged to identify who benefits from the perpetuation of oppression and oppressive ideas. When asked if there is a benefit to perpetuating the story of the 'aggressive black male', a mother identified:

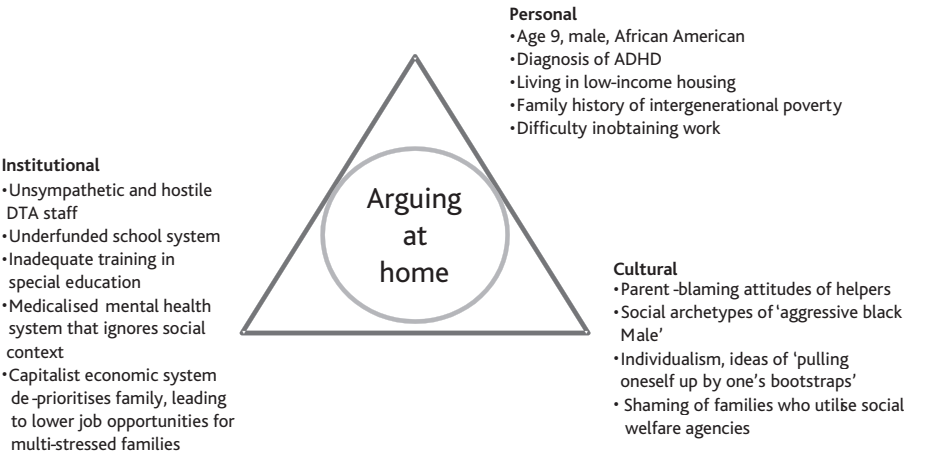
Mother:	'The thing is, they don't know how to handle my son. This is a way of saying "it's not our fault", and not taking responsibility. This is a way of saying "don't blame us, we would help him, but he's just some thug and that's beyond our control".'
Author:	'So, this story is a way of not taking responsibility?'
Mother:	'Exactly. Not our fault. Don't blame us.'

Schools are not alone in perpetuating structural oppression. For example, families have reported feelings of dread visiting the Department of Transitional Assistance (DTA) building in Boston, through which Massachusetts' residents obtain food and rent subsidies from the Commonwealth. At the entrance, armed guards in black fatigues stand watch. Parents often report being disallowed to speak until spoken to and treated with blatant disrespect. Such an environment is disquieting at best, but should be considered pathogenic in the context of the lives of families. An article published by the American Orthopsychiatric Association found that families facing raids from Immigration and Customs Enforcement (ICE) were often subject to military-style tactics, leading to profoundly increased rates of post-traumatic stress and hypervigilance (Capps et al, 2007; McLeigh, 2010).

Given the example of the DTA above, let us reconsider the previous family with the information now documented. Figure 1 illustrates the different factors placed into triangle diagram.

> A student, who has been given a diagnosis of ADHD by previous providers, is having trouble in school. Communications between the school and the student's mother leave her feeling shame associated with dominant messages about parents of children who present with behavioural challenges. These feelings of shame are exacerbated by a climate in which students of colour are disproportionately singled out and leveraged with harsher punishments at school and in the juvenile justice system. Thinly veiled comments produce feelings of alienation that contribute to already present feelings of vulnerability on the part of the parents, who in turn become increasingly on

Figure 1 : The liberation health triangle



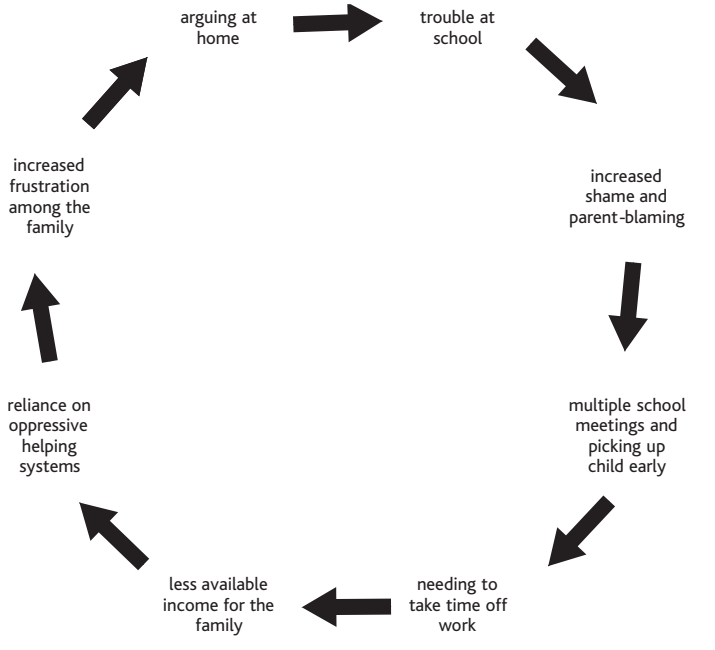
> edge about their son's behaviour. This increase in tension, fuelled primarily by caring for their son's safety, wellbeing and future, leads to a much greater likelihood of argument and discord at the family home. The parents report feeling more likely to yell or vocalise frustration for smaller infractions, which in turn leads to an increase in hostility between the parents and their son.

It is not difficult to see how such a pattern of interaction would lead to previous providers observing what appears to be a poor attachment and frequent discord at home. Re-assessment continues:

> Frequently needing to attend impromptu meetings at school requires the parents to take fewer shifts at work on an already tight budget. A low minimum wage means that the shifts that the parents are able to make are decreasingly able to meet basic needs, requiring the family to rely on supplemental nutrition benefits. When the family visits the transitional assistance office for help, they are greeted with degrading and frightening treatment from armed guards and hostile staff. The degradation from support systems contributes to negative feelings around the household, ultimately supporting and fuelling more resentment at home (see Figure 2).

An analysis such as the one above shows a distinct departure from the original problem-story. The family discord had been attributed to the child's psychiatric condition and to poor parenting. Now the chief agent of discord in the family's life is seen as cultural messages of stigma and racism as well as structural oppression. This family has renegotiated the story of their lives based on their own terms and beliefs. Additionally, they have been assisted in locating the problem as an outside stressor, impacting their entire family as a unit. The family has been given the opportunity to reject self-blame, and identify the real cause of arguments at home as being the effects of having a young son of colour in a poorly funded school system in a city

Figure 2: Cycle of factors reinforcing family stress



with a grim history of racial oppression. Viewed from the lens of Freire, we see how this family has moved from a subjugated 'object' position to a 'subject' position that allows for them to have opinions and influence on the problems in their lives.

While it is beyond the scope of this article to argue the existence or aetiology of psychiatric conditions, the author seeks to demonstrate how the context within which a problem exists greatly impacts and defines the problem itself. That is to say, the same family attempting to make ends meet in a country with a living wage would experience the pattern described above quite differently (and likely with a reduced strain), as the financial impact would be greatly lessened. As such, connecting the family to community activists seeking to raise the minimum wage would be an effective and appropriate social work intervention.

De-ideologising and creating an action plan

Families collaborating in liberation health practice are invited to identify vectors of oppression and explore how they might regain agency in the face of these challenges. As shown in both the popular education and liberation psychology movements, momentum comes from connecting to the issues that matter to those we work with, and greater impact is seen when these connections are made at both macro and micro levels. For the families whose children have been greatly pathologised by larger helping systems, it has been an essential part of healing to become more active in both redesigning service delivery for their children and participating in the broader movement of parents who are seeking systemic changes. Families whose children were taken by homicide in Boston have many opportunities to participate in organising against violence and the structural racism that supports this violence through local survivor-led movements. Taking an active role in these organisations and movements

fulfils Freire's idea of becoming a 'subject', someone who, upon recognising the oppressive factors that influence their lives, renegotiates their relationship with these factors through actively engaging in the struggle for change.

Vinick and Swenson (2014: 156-67) provide a powerful example of a family who were originally referred for social work intervention after a student, a resident at a housing development, was identified participating in a videotaped fight on a school bus that was posted on YouTube. The mother of the student identified that one of the chief stressors in her life was finding adequate supervision for her children on the bus. Due to disparities in bussing for members of this housing development compared with the community at large, students had to walk a considerable distance to the bus stop (or all the way to school). Parents working multiple jobs were often unavailable to provide supervision, leading to many parents being faced with the difficult choice of adequate supervision or a family income. As children of different ages often attended different schools, this also prevented a parent or family member from being able to walk with all their children. This revelation, that there was a concrete link between the stress facing families and the lack of bussing, led to an organisation of residents, who successfully campaigned to have a bus stop moved directly outside of the development, where supervision was available.

Conclusion: continuing exploration of liberation health practice

Although it is the belief of this author that social work literature is often presented without context and de-emphasises the impacts of oppression, this is not uniformly true of all models of practice. Emerging practices from the family therapy literature offer social workers opportunities for collaborative practice methodologies. Almeida's cultural context model provides a comprehensive exploration of how the Institute for Family Services in the US joins families in conversations about issues of race, class and gender (Almeida et al, 1998), while post-structural and narrative therapy literature offers a means of scaffolding these complex and emotional conversations that decentralises the role of the therapist, allowing families to reclaim expert status in their lives (Madsen, 2007; White and Denborough, 2011). The frameworks illustrated by these authors have contributed greatly to the practice described above.

While the therapy world was developing a practice for identifying the roots of counterproductive and hurtful thinking in earlier personal experience, Freire and Martín-Baró were looking for those roots in the world in which their students and service users lived. When describing questions that would be put to the group during his culture circles (meetings where community members were invited to discuss and deconstruct elements of culture as part of his literacy campaign), Freire (1992: 116) wrote: 'Along the same lines, it is indispensible to analyze the contents of newspaper editorials following a given event: "why do different newspapers have such different interpretations of the same fact?"'.

Like those participating in Freire's culture circles, we as liberation health practitioners constantly strive to hold up pieces of the world around us and ask: 'How do you know this information?' and 'Who benefits the most from this story's existence?'. Liberation health practice seeks to maximise service users' ability to ask these questions, identify the factors of oppression that are impacting their lives and take action.

While liberation health does not dismiss the importance of biological and psychological factors, it seeks to broaden the discussion to address the cultural and

institutional factors that play an equally important part in people's lives. Liberation health subverts dominant methods of social work methodology by asking: 'What other questions aren't we asking?' and 'How can we join service users in the struggle for a better world?'.

Note

[1] Licensed independent clinical social worker.

References

Almeida, R, Woods, R, Messineo, T, Font, R, 1998, The cultural context model: an overview, in M. McGoldrick and K.V. Hardy (eds) *Re-visioning family therapy: Race, culture, and gender in clinical practice* (2nd edn), New York, NY: Guilford Press, 415-29

APA (American Psychiatric Association), 2000, *Diagnostic and statistical manual of mental disorders: DSM-IV-TR* (4th text revision), Washington, DC: APA

Belkin Martinez, D, 2005, Therapy for liberation: The Paulo Freire methodology, www.bostonliberationhealth.org/documents/freiresummarysimmons.pdf

Belkin Martinez, D, 2014, The liberation health model, in D. Belkin Martinez and A. Fleck-Henderson (eds) *Social justice in clinical practice: A liberation health framework for social work*, London and New York, NY: Routledge, 9-28

Capps, R, Castaneda, RM, Chaudry, A, Santos, R, 2007, *Paying the price: The impact of immigration raids on America's children*, Washington, DC: National Council of La Raza

Freire, P, 1992 [1970], *Pedagogy of the oppressed* [*Pedagogía del oprimido*], New York, NY: Continuum, 1992

Freire, P, 2001, *Pedagogy of freedom: Ethics, democracy, and civic courage* [*Pedagogia de autonomia*], Lanham, MD: Rowman & Littlefield

Freire, P, Freire, P, 2009 [1974], *Education for critical consciousness* [*Educação como prática da liberdade*], London and New York, NY: Continuum

Hardy, KV, 2008, On becoming a GEMM therapist: work harder, be smarter, and never discuss race, in M. McGoldrick and K.V. Hardy (eds) *Re-visioning family therapy: Race, culture, and gender in clinical practice* (2nd edn), New York, NY: Guilford Press, 461-8

Kant, JD, 2014, Becoming a liberation health social worker, in D.B. Martinez and A. Fleck-Henderson (eds) *Social justice in clinical practice: A liberation health framework for social work*, Abingdon and New York, NY: Routledge, 29-43

Klein, R, 2013, Kiera Wilmot, 16, arrested and expelled for explosive 'science experiment, *Huffington Post*, 1 May, www.huffingtonpost.com/2013/05/01/kiera-wilmot-arrested-science-experiment_n_3194768.html

McLeigh, JD, 2010, How do immigrations and customs enforcement (ICE) practices affect the mental health of children?, *American Journal of Orthopsychiatry*, 80, 1, 96-100

Madsen, WC, 2007, *Collaborative therapy with multi-stressed families* (2nd edn), New York, NY: Guilford Press

Martín-Baró, I, Aron, A, Corne, S, 1994, *Writings for a liberation psychology*, Cambridge, MA: Harvard University Press

Reardon, C, 2012, 'Case' and 'cause' in social work education — a balancing act, *Social Work Today*, 12, 2, 20

Reisch, M, Andrews, J, 2001, *The road not taken: A history of radical social work in the United States*, Philadelphia, PA: Brunner-Routledge

Specht, H, Courtney, ME, 1994, *Unfaithful angels: How social work has abandoned its mission*, New York, NY: Free Press

Vinick, A, Swenson, C, 2014, Working in public housing, in D. Belkin Martinez and A. Fleck-Henderson (eds) *Social justice in clinical practice: A liberation health framework for social work*, London and New York, NY: Routledge, 156-67

White, M, Denborough, D, 2011, *Narrative practice: Continuing the conversations* (1st edn), New York, NY: W.W. Norton