Lesley University

DigitalCommons@Lesley

Subverting the Narrative: Addressing Gaps in the Medical Model of Mental Health Through Expressive Arts and Critical Race Feminism Paradigms

Sofiya Kostareva
skostare@lesley.edu

Follow this and additional works at: https://digitalcommons.lesley.edu/expressive_theses

Part of the Social and Behavioral Sciences Commons

Subverting the Narrative: Addressing Gaps in the Medical Model of Mental Health

Through Expressive Arts and Critical Race Feminism Paradigms

Sofiya Kostareva

Graduate School of Arts and Social Sciences, Lesley University

Abstract:

This paper discusses the problematic theoretical underpinnings of the medical model of mental health, first examining the historical development of the mental health field. Reviewing literature on the paradigms of expressive arts therapy, critical race feminism, and the medical model of mental health, the author argues how systemic oppression in such forms as racism, classism and ableism contribute to the issues of mental health accessibility for individuals who possess historically marginalized identities in the United States. The paper concludes with a claim around expressive arts therapy's capacity toward addressing the theoretical challenges in providing meaningful intersectional care toward diverse populations through its focus on attunement and embodiment concepts, as well as the practical challenges of increasing basic accessibility of mental health services through its broad embrace of all creative modalities.

Keywords: expressive arts therapy, critical race feminism, medical model of mental health, intersectionality, oppression, mental health accessibility, attunement, embodiment

Subverting the Narrative: Addressing Gaps in the Medical Model of Mental Health

Through Expressive Arts and Critical Race Feminism Paradigms

The mental health crisis in the United States can no longer be ignored. In 2019, the National Institute on Mental Health reported suicide as the second leading cause of death in the U.S. among people between the ages of 10 and 34, with more than twice the amount of suicides than homicides in 2017 overall (2019). According to the National Alliance on Mental Illness, the average time between onset of mental health symptoms and treatment is 11 years, and only 43% of adults with reported mental illness get treatment (2019, September), meaning those in crisis have low chance of receiving life-saving services in time. Additional research consistently confirms that racial minorities utilize outpatient mental health services less frequently than their white counterparts (Young & Rabiner, 2015), parents with lower socioeconomic status struggle to obtain access to mental health care for themselves and their children (2015), and clients with acute mental health needs are chronically underserved across varying diagnoses (Jones et al., 2018).

Though directly informed by traditional healing practices of indigenous and collectivist communities, expressive arts therapy is considered an innovative approach to healing of the human psyche due to its deep commitment to practices of attunement and embodiment, where knowledge primarily extends from one's here and now experience of the body, rather than the mind (Kossak, 2009). It is encouraging that mainstream society is awakening to harmful power systems and their influence on our nations' mental health. Such systems, like white supremacy and capitalism champion those white, wealthy and able, and derive their power from coercing not only minds but physical bodies; engagement with these systems is inherently traumatic. From the work of practitioners like Van der Kolk (2014), we now know that trauma is stored in the

body and that we must attend to its presence in our nervous systems. As such, expressive arts therapy holds a potentially vital role in supporting the reintegration of the painful lived experiences of these invalidating systems. However, we know people who possess marginalized identities experience a disproportionately difficult time gaining access to basic mental health resources, so it is nearly impossible to imagine access for more specialized services like expressive arts therapy. According to Kuhn (1962), we posit that this is a consequence of an outdated paradigm of "incomplete examples" (p.24).

The question then becomes, how do we collect "complete examples" of who needs mental health and how to deliver it? Two specific challenges have emerged at the heart of this topic: 1) inadequacy of existing medical systems, which do not equitably provide services to those who need it most (Hodgkinson et al., 2017) and 2) a stigmatizing narrative embedded within the medical model, which places responsibility of treatment on the client and away from complex systems they are oppressed by (Ali & Sichel, 2019).

The author of this capstone thesis posits that expressive arts therapy is informed by a framework that is inherently primed to address these challenges, helping us develop a deeper understanding of who is actively left out of the system and how to include them. Additionally, it is the task of those trained in expressive therapies to take steps toward a much-needed transformation within the systems we manage. As an educated white female, it falls on me to critically analyze the harm caused, who benefits, and how to repair those ruptures. To that end, communities that have been systemically marginalized by mental health systems are juxtaposed to dominant progressive white liberals typically embodied by those in my demographic, who benefit both personally and professionally from unjust systems within this landscape.

In the following literary review, we elaborate upon the complexity of the issue by establishing congruence among three separate concepts: expressive arts therapy, critical race theory and the medical model of mental health.

Hadley's (2013) article on dominant narratives in society focused on the topic of challenging normative ideology and stated that "if we are not actively working toward addressing social inequality, we are in fact supporting the existing norms" (p.376). As a therapist's job is to support the healing process of every client, we rely on the inclusive and dynamic framework of expressive arts therapies to demonstrate how professionals in the field are not only ethically, but theoretically poised to advance the dismantling of societal standards that would cause harm to clients. This includes the most notable issues in the United States: lack of accessibility across race, class, and ability. To authentically begin this conversation, we turn to critical race feminist theory for a deeper recognition of oppression as it occurs through systems such as racism, classism and ableism, and how these intersect with social norms and ideological attitudes of white supremacy.

Looking at a brief history of mental health practices shows an unsurprising yet appalling progression from harmful beliefs of the past to the development of mental health standards of today. Throughout the 1800's, mental health conditions were sought to be caused by things like demonic afflictions or imbalance in the harmony of bodily functions, and thus treated through practices like exorcisms, trephining and bloodletting (Bockoven, 1976). Referred to as moral treatment, the theory behind these practices was rooted in the belief that people experiencing mental health conditions could be socially and physically trained out of their afflictions (1976).

Around this time, private hospitals and asylums like Bedlam and York Retreat became popularized, however, their main goal was to accommodate wealthy white folks (Hussung,

2016). As the number of Black and Indigenous People of Color (BIPOC) and folks of lower

economic status experiencing mental health crises grew in the 1800's, a segregated public

asylum and later a state-run asylum system developed to manage public safety, (Longden et al.,

2016, p.22). The state-run system was essentially created to address an emergency situation by a

profession only just developing an understanding of its own craft.

  The theoretical approach adopted by the field at this time closely mirrored the

"…impersonal outlook of an emergent technological industrial society" (Bockoven, 1976,

p.104), and was quickly overwhelmed with an influx of participants called "patients". Within the

walls of asylums mental health patients underwent authoritarian treatment, fueled by a belief that

they were "incurable but teachable" (p.105). Often, patients were locked up in prison-like

conditions, stripped of decision making capacity, subjected to abuse by staff, and were test

subjects for the development of experimental treatments: from fever therapy, to inducing of

diabetic comas, seizures, electroshock therapy and lobotomies. At this point, theories of mental

health transitioned to the biological model of psychosis, meaning the belief that flaws in a

person's biology caused mental health challenges.

  By the 1950's and 60's the systems were not producing desired results, and so began a

pattern of closures for asylums across the country. In their article on shifting the mental health

paradigm Longden et al. (2016) described an era of shifting social norms on mental health,

during which a significant portion of society began advocating for eradicating abuse and neglect

in the asylum systems. However, the authors argued that society's changing values were not the

main cause of the shift: put simply, asylums were a costly pursuit with no economic output.

  President Eisenhower's balanced approach to economic policy, which emphasized

decrease in spending, coupled with a public rejection of the ill-running system provided a

convenient opportunity for the government to opt out of a state- run system, and his successor,

John F. Kennedy, soon after signed the Community Mental Health Act (1961) into law.

Community mental health was meant to allow patients to be placed back in the care of their

social groups while creating a decentralized and theoretically more efficient system. However,

the budgetary cuts that came with the shutting of asylums meant a "service vacuum" and

translated to substandard levels of care (Longden et al, p.23) especially for communities of color,

which were at the time overwhelmingly burdened by the grueling battle for civil rights.

To this day, community mental health organizations provide a significant amount of

support to folks in society who are most vulnerable. We must continue to assess the efficacy of

these services to locate the gaps in our incomplete examples of the mental health paradigm.

However, authors noted that if we wish to affect dramatic change across the system, it is

necessary to look closer at the ideology of the field as a whole, not just one type of service

setting. They stated that just as the asylums that came before, we could be trying to solve the

wrong problem. Maybe the overwhelming inefficiency is not due to the structural design of our

systems, but their underlying ideological basis: confining and controlling biological diseases.

The review concludes with an explanation of arguments put forth by Longden et. al, which

identified the problem with the medical model of mental health as viewing suffering humans as

"patients with an illness, versus people with problems" (2016, p.23).

Literature Review:

"Paradigms gain their status because they are more successful than their competitors in solving a few problems that the group of practitioners has come to recognize as acute. To be more successful is not, however, to be either completely successful with a single problem or notably successful with any large number. The success of a paradigm... is at the start largely a promise of success discoverable in… incomplete examples." – Thomas Kuhn, *The Structure of Scientific Revolutions,* 1962

Expressive Therapies Paradigm

Estrella described how the expressive therapies discipline emerged out of the "counterculture energy of the 1960's and 1970's … encouraged by the emerging multimedia and performance arts movements" (2005, p.183) with the purpose of transcending and redefining traditional boundaries of expression and discovery within both communities and the self. This time of immense cultural and social revolution planted the seeds for creativity to be seen not simply as a pleasurable or frivolous experience, but in fact a basic human right with the capacity for inciting significant growth and transformation. Estrella (2005) stated that expressive arts therapy has always distinguished itself from its related disciplines of art therapy, music therapy and dance therapy through a firm belief in the transformational power of creativity to nurture healing within community and address social ails. From painting, drawing, writing and poetry, to drama, movement, music and song—expressive arts therapy embraces every form of creative expression regardless of form.

Kossak (2009) described the main considerations of expressive arts therapy as "sensitivity to individual needs, rooted in the capacity for human imagination" (p.13). It is a modality, which integrates multiple art forms either simultaneously or in carefully orchestrated transitions. Studies have shown the strength of a therapeutic alliance between client and therapist is more predictive of growth and healing than varying therapeutic orientations of the provider (Stiles et al., 2008). By combining varying art forms, expressive arts therapy works in the service of this therapeutic alliance by enhancing attunement, defined as a "mutual resonance experienced as connectivity, unity, understanding, support, empathy and acceptance" (Kossak, 2009, p.16).

Kossak (2009) described further aspects of attunement as "a kinesthetic and emotional sensing of others" (p.14) in which an embodied experience of the other emotionally, cognitively

and somatically facilitates communal states of awareness. They further described embodiment—the body-centered intelligence through which one comes to experience self in the world— and its capacity to facilitate intersubjective experiences. Through embodiment, one might come to know a truth or reality previously unknowable to them through their own understanding. Kossak (2009) explained how in expressive arts therapy, the creative process is guided by spontaneity and play, and involves a kind of resonance not only with other beings but "with a rhythmic flow of energies between self and materials, self and sound, self and space" (p.16). Speaking more broadly, Kossak (2009) connected attunement and embodiment as elements in expressive arts therapy's central aim to transform the subjective, abstract and ineffable into the tangible, felt, and the known.

Some have claimed the field of expressive arts as based on conjecture converted into pseudoscience, and thus incapable of validating itself. However, theorists in the field actively question the measures of the linear model of inquiry the medical model asks them to validate.

Levine (1997) detailed how the practice of expressive arts therapy has been scrutinized for its struggle in legitimizing itself as an evidence based practice due to the subjective and immaterial nature of meaningful experiences it provokes. However, they asserted that to be rooted in the heart of the field, it is a theoretical necessity to believe that "art making [is] a fundamental way of being and becoming fully human" (p. 432). It is necessary to remain in the realm of artistic and aesthetic rather than rational or logical inquiry when we describe the value of this discipline.

They explained how the expressive arts therapist is trained to work with the concept of "low skills, high sensitivity", meaning engaging the arts with clients who are "not expected to be artistically skilled or even especially talented" (p.433). Instead, the therapist is trained to have

higher sensitivity to sensory-based and emotional information, allowing them to attune to the state of the client and provide appropriate and timely interventions by leveraging psychic material and folding it into targeted interventions and activities.

This element of high-sensitivity promotes a nuanced approach to complex social issues through a dynamic framework not inherent in traditional talk therapy. Kwong et al. (2019) evaluated how adults living in Hong Kong with an HIV diagnosis could benefit from a creative process group. Their group provided an opportunity for clients to create meaning and overcome the challenges of social isolation from such a stigmatized diagnosis.

This mixed-methods study was based on existential-phenomenological theory, which centers expressing lived experience, imagining potential, and creating positive meaning. The authors infused movement, visual art, music and drama modalities of expressive arts therapy as a vehicle for self-expression, and gathered data through "clinical observation by the therapist intern, participants' written reflection, and semi-structured interviews with the participants" (p.11). While the quantitative findings revealed a minimal statistically significant impact in two areas: positive affect and own perception of physical health, the qualitative findings revealed that participants found significant relief by "disrupting the long-held sense of hopelessness and to construct existential meaning for life" (p.13).

Through structured interviews other participants also reported an increase in accountability around self-care practices, a growth in their self-esteem, a greater capacity for a range of emotion, and growth. The quantitative data alone did not capture these elements of self-reported growth. Yet Kwong et al. (2019) concluded that the creative process specifically "[became] a site of freedom of expression, through which to confront the unknowns, to make decisions, and to solve problems" (p.16) around reframing participants' diagnosis. This allowed

clients to experience a personally significant sense of long-lost hope, which appeared

unquantifiable.

Supporting the validity of non-linear artistic frameworks by offering an inverse argument,

Moxley and Calligan (2015) addressed the tremendous capacity of the arts to inform analytical

and logistical systems like evaluation and program planning for social issues. The authors wrote

of the arts as allowing people to "portray a particular situation or experience in graphic and rich

terms while simultaneously express[ing] a particular truth inherent in their lived experience"

(p.34). They argued that the synchronous duality of sharing and re-experiencing with others has

the potential for creating a deeper insight among people with different experiences of social

traumatic conditions, especially in human-oriented service professions like mental health.

Moxley and Calligan emphasized how creative expression "can challenge the experience,

attitudes and knowledge of people those who may have had little exposure to the perspectives of

others" (p.35) which provides opportunity for folks privileged in society to witness the realities

of those marginalized. They cited preservation of historical narrative, community building,

activism and innovative solutions as rationale for including the arts in designing human service

interventions, and present a nine-step model for enriching the process of finding comprehensive

solutions to some of the most complex questions society poses to us.

Ultimately, they concluded that there is a wealth of material present in the "evocative"

versus the "rational" because it more closely mirrors the complexity of the emotional and non-

rational human experience (p.42), but this material is often cast aside for its inability to be

presented as hard facts in a technologically-minded, modern world.

Though there is both theoretical and practical discord in the basic understanding of how

the arts facilitate healing within creative therapy fields (i.e. art therapy, music therapy, dance

therapy, expressive arts therapy), art therapists Junge et al. (2009) implored the same call to activism we find at root of the expressive arts therapy paradigm.

Authors Junge et al. (2009) shared moments from their time in a field devoted to inviting creativity into mental health treatment. "Art expression takes us to unknown places beneath the silence of words and brings the terrors of the dark into the light where they might be tamed" (p.107). They celebrated artistic expression, stating "it is the act of imagination that offers a vision of something different, better, and the resulting hope can impel us to action" (p.108). However, Junge et al. (2009) lamented that the work of an art therapist can at times feel like putting a bandaid on a gaping wound, because all they can offer clients is tools to accept and cope with a destructive world. In separate recollections, the authors (Junge et al., 2009) described the contradiction of serving folks in crisis in places like Central America, knowing the circumstances they would return to post therapeutic intervention would continue to be traumatic, calling into question if serving one client on an individualist level is enough.

Junge et al. (2009) further challenged art therapists to go away from individualism and "toward a global community in which human growth is prized" (p.113) claiming activism must be a crucial element in the creative arts therapy fields, which are deeply rooted in the experiential element of the human condition. It is exciting that other creative therapy practitioners are joining the fight toward more socially just mental health provision, but also affirming of the theoretical underpinning of the expressive arts therapy paradigm, which is inherently more accessible due to its acceptance of any and every type of creative expression regardless of culture of origin.

Critical Race Feminism

Continuing to challenge the way expressive arts therapies have been implemented, Hadley (2013) discussed harmful narratives and implicit beliefs within the field using critical

theory –a form of political analysis. Hadley (2013) discussed how we are steeped in oppressive systems such as patriarchy, Eurocentrism, heterosexism, capitalism, psychiatry/psychology, and medical science, and how these impact our clinical practices. Hadley (2013) also named main motivations in the critical theory paradigm as the following: illuminating the tension between those who desire liberation and those who are the gatekeepers of it, being invested in providing folks with knowledge intended to promote their liberation, and focusing on not only criticizing a society today but envisioning a society of tomorrow (p.375).

Hadley (2013) refers to Brookfield (2005), who emphasized how critical theory empowers us to "challenge oppressive ideology, contest hegemony, unmask power and practice democracy" (Brookfield, 2005, p.41). However, identifying ideology—defined as concepts that allow for oppression to be internalized as normal by those being subjected to abusive systems—can be a struggle, because the insidious nature of it is so "embedded in language, social habits and cultural forms"(2013, p.374) that ideology is often engrained as common sense. Hadley (2013) asserted that the most successful tool for exposing hidden ideology on a large scale is naming forms of any oppressive power dynamic and identifying the pattern in which it operates.

In practice this means calling out classism, ableism, heterosexism, transphobia, xenophobia and the like whenever they appear, and shifting efforts from eradicating individual acts of harm to tracing the roots of the systemic frameworks to which the harm belongs. As we begin to notice these frameworks more often, it also becomes easier to notice similarities in how they function. By tracing individual harmful behaviors to their systemic roots, we can recognize an undeniable pattern of falsehood: an unfulfilled promise to win if someone else loses replicated in many forms.

However, successfully identifying and exposing power dynamics on a societal scale is hard to do without an intimate understanding of own power and oppression. We can achieve this by reflecting on our own identities and how these shape our individual experience in the world. In their breakthrough article, Crenshaw (1989) coined the term intersectionality and illuminated a structural issue in U.S. antidiscrimination law by critiquing the "single axis framework" (p.139) in the context of unfair labor practices. Crenshaw (1989) demonstrated how the experiences of Black women across industries were erased when holding an industry to separate measures of gender equality and racial equality: they analyzed data on racial discrimination for Black male workers and data on gender discrimination for white female workers in the automobile manufacturing industry. The comparison of this data to outcomes for Black female workers confirmed that Black females were not being accounted for, because they experienced both types of discrimination simultaneously and to a greater degree.

Here, Crenshaw (1989) introduced a new term to address this issue: intersectionality as a framework emphasizes "multi-marginalized" individuals, and honors the dual influence of two or more disadvantaged identities in a single person (p.141). Thirty years later, intersectionality is still a highly relevant concept in the dialogue around discrimination, and is a key tool for therapists in deconstructing their own experience in the service of providing equitable and inclusive care.

Sajnani (2012) combined critical theory, intersectionality, and feminism to evaluate the merits of three theories: intersectional feminism, Black feminism and critical race feminism.

Sajnani (2012) described how the aim of infusing feminism into therapy has been to redress aspects of gender socialization—or a series of scripted behaviors and actions that correspond to our cultural understanding of gender roles. Feminist therapy also emphasizes the

following four tenets: the personal is political, insistence on egalitarian relationships in therapy,

empowering women's experiences post oppression, and prioritizing lived experience as a basis

of theory and approach (p.186). Speaking to the historical evolution of contemporary feminist

theory, Sanjnani (2012) noted that "because of economic, political, and social factors, the initial

experiences that informed this movement were those of middle-class, majority- culture (e.g.,

white, heterosexual, able-bodied) women" (p.187), which evolved out of their direct social

proximity to their straight white male counterparts.

     First wave feminism excluded BIPOC women and those experiencing additional

oppression through their class, sexuality or ability. However, second wave feminism only

halfway addressed this issue. With the goal of "equalizing power toward ending all forms of

domination, subjugation, and oppression in a patriarchal society" (p.187), this new approach was

intersectional in theory, yet still largely occluded racial and ethnic identities consideration. Even

today, intersectional feminism does not consistently and adequately address the racial tension

embedded within our society.

     Turning their focus to Black feminism, Sajnani (2012) noted that this theory does a good

job of centering the unique experiences of Black women in a society that has categorically

devalued them. However, they assert that Black feminism is rooted in the concept of "binary

standardization" (p.188), which flows out of traditional white supremacist structures that only

allow things to exist in the form of opposites (e.g. "good or bad", "male or female", "healthy or

sick", "Black or white"). Sajnani (2012) argued that paradoxically, in Black feminism, this

binary approach promotes disengagement of nuance from the conversation of what diversity

looks like among BIPOC. Sajnani (2012) references Shohat (2001), who wrote: "unthinkingly, or

unconsciously, these binarisms re-center white norms because a series of different minorities are

positioned against white hegemony and puts on hold everyone else who does not fit in either category" (2001, p.20).

Through the critical race feminism approach, therapists are tasked to adopt a more inclusive and nuanced perspective by combining elements of intersectionality, critical theory and feminist theory to challenge all white supremacy values. This means a "need to move beyond a focus on rigid and essentialist identities to an understanding of the more complex processes of identifications" (Sajnani, 2012, p.191). Sajnani (2012) asserted race as an immutable element in our daily interactions— something we cannot escape. Echoing the point made by Hadley (2013) that oppressive systems like patriarchy are simply a different expression of the same structure. Critical race feminism calls us to challenge "all expressions of the master–slave dynamic, wherein any one person or group is subjugated to the interests of another against their will" (p.189).

Heller (2010) wrote about the importance of evaluating the concept of white privilege through an intersectional lens that incorporates class. The author (Heller, 2010) highlighted that investment in whiteness is "a promise to achieving greater material success, rather than an end undo itself" (p.111). Heller (2010) questioned why theorists of white privilege place varying degrees of importance on class, when the white racial identity in the U.S. involves multiple "psychological and economic benefits, regardless of whether the individual takes an active interest or is aware of the manifestations of white privilege" (p.112).

Heller (2010) established a continuum upon which they evaluate theorists' placement: on one end are class-specific theorists, who elaborate on how class diversifies the experience of whiteness, and on the other end are class-neutral theorists, who believe economic privilege is a standard element of whiteness. Heller (2010) ultimately concluded that investing in a

comprehensive and deep understanding of the inner-workings of white privilege requires a

nuanced look at how the structures were created before, how they are protected now, and how

presentations of privilege vary broadly due to intersectionality. Eliminating a cross-sectional

look at the realities of citizens who vary across class within the white identity is antithetical to

exposing the main vehicle of white privilege, which heavily relies upon material dominance as

its foundation.

       We know race is a crucial predictor of mental health access and outcomes, and yet

through research like Heller's (2010), we are compelled to acknowledge that outcomes across

class identity exhibit a similar pattern of exclusion toward citizens in the lower class. Heller

(2010) reminded us that what's missing from the conversation is not the search for a singular

"good" or "bad" party—which does more to alienate individuals than dismantle oppressive

structures— but an evaluation of the human condition through the kaleidoscope reality of our

varied contexts.

       Young and Rabiner (2015) surveyed 275 parents of children aged 9-13 across three racial

categories (34% Black, 29% Latinx and 37% white) on how stigma, logistical challenges and

socioeconomic challenges might contribute to lack of accessibility to mental health services for

children. The researchers were interested in whether parental attitudes toward mental health care

influenced utilization of services, and whether these attitudes differed across different types of

medical care.

       After conducting a mixed model multiple analysis of covariance, factoring for

characteristics like parental education, household income, and whether children's issues

presented as internal or external, Young and Rabiner (2015) found a significant correlation

between racial and ethnic differences and predicting socioeconomic and logistical barriers.

Most commonly selected barriers included the following: "child had to wait too long to see the doctor; couldn't afford it; child's health insurance limits access to mental health and counseling services; and the clinic/doctor's office was too far away" (p.270). The data also revealed significant stigma related barriers across races. Parents commonly cited measures like "worried about child's teacher and/or school finding out; concerned that it would reflect poorly on parent; worried that child would be teased or made fun of by peers; and worried that the parent would feel too embarrassed" (p.270) as barriers to access.

Additionally, Latinx parents cited every measure as a greater deterrent to access than that of Black or white parents. Lastly, parents across all races listed higher barriers in accessing mental health care as compared to accessing medical care, rating "affordability, lack of transportation, and the distance to the clinic/doctor's office as more inhibiting for mental health care than medical care" (p.270) as reasons for lack of access.

Though the results of this study showed a surprising similarity across Black and white parents in the effect of these barriers— which is inconsistent with previous research—authors attributed these findings to study design. Young and Rabiner (2015) noted that language barriers and migrant status might pose a more significant impact on navigating complex medical systems, which could explain higher rates of reported barriers by Latinx parents. In conclusion, Young and Rabiner (2015) suggested practitioners develop cultural and linguistic competency to understand challenges clients might face when attempting to engage in treatment, and establishing a therapeutic alliance that considers the specific identities of a person or family. They noted that stigma continues to be a great barrier to access, and that in the past health policy has not been successful in decreasing said stigma. Authors suggested an improvement in

infrastructure by increasing access to public insurance and expanding number of facilities accepting said insurance may be the most effective way to increase total access.

Ali and Sichel (2019) spoke deeper to how radicalizing advocacy requires the ability to recognize intersectionality, in their article on addressing tensions between social advocacy and mental health professions. Despite agencies like the American Psychological Association including a clause in their code of conduct on culturally competent interventions and advocacy, "constraints in the lives of vulnerable individuals remain largely neglected" (p.1) in structures like theories, models of practice, and educational settings. Authors lament that despite mentions of advocacy and policy work across local, state and global levels by regulatory professional organizations, it is not always clear in the moment how individual practitioners' training and active practice of theory is rooted in larger systems of oppression.

For example, on a large scale we know diagnostic systems tend to "medicalize and pathologize the experiences of the poor and marginalized" (p.1), western rooted definitions of wellness miss the mark across cultures, and a heavy emphasis on white-centric norms in mental health theory excludes the needs of racially and socially diverse clients (p.2). However, as mental health professionals engage on such a personal level of the client psyche and professionals working with low-income and marginalized clients are often understaffed and overworked, there is little room for tending to issues of non-immediate concern.

Nonetheless, as more mental health professionals become eager to counteract oppression, knowing common threads of systemic failing is realistic through advocacy for those disempowered, advancement of movements through participation and research, and engagement in policy advocacy across practical and theoretical disciplines. Ali and Sichel (2019) pointed out that mental health professions, and psychology in particular, base the foundations of their

theories on individual transformation and often neglect recognition of how environmental factors contribute to personal struggle, which in turn limits the impetus for social change.

The authors (Ali & Sichel, 2019) described the inevitable danger in supporting clients navigate corrupt medical and social systems. "The more we assist clients in accommodating the system, the greater the risk that we develop blind spots that prevent us from appreciating the dire need to dismantle oppressive structures in the lives of our clients and others" (Ali & Sichel, 2019, p.2). The common knowledge gap mental health practitioners have around multi-level needs like navigating housing and case management services were also highlighted by Ali and Sichel (2019). As an antidote to the gap of knowledge, the authors referred to Metzl and Hansen's (2014) structural competency framework.

In this training model, medical practitioners are set up to identify the connection between symptoms of health elements of social contexts— akin to intersectionality. Practitioners are trained to recognize "consequences of inequitable structural-level decisions and institutional practices such as workplace discrimination and unequal access to housing, health care, and other resources" (Ali & Sichel, 2019, p.4). This requires an ability on the behalf of practitioners to notice patterns within individual interactions as microcosms of the whole.

Though initially meant for medical training, as research continues to show similarities between the impact of systemic oppression on both mental and physical health, Ali and Sichel (2019) extrapolated the structural competency paradigm into a psychology model. Their version involves the following elements: advocacy without perpetuating dependency, supporting advocacy goals of the client, partnering with social change organizations, and offering elements of trauma and mental health expertise in the service of policy, law, education social justice efforts. Ali and Sichel (2019) stated that while "settings do not generally make space for

advocacy work as part of the professional expectations" (p.7), engaging in small changes can create collective transformation and incorporate social justice standards as a norm within mental health professions over time.

The Medical Model of Mental Health

Longden et al. (2016) noted binarism in the field of mental health: seeing some people as either ill or healthy, instead of along a nuanced spectrum of possibility. They credit the invention of prescription drugs to the thorough propagation of our modern biological understanding of mental illness, as their development allowed us to significantly manage intensity of symptoms experienced by those suffering from psychosis in an unparalleled way (p.24).

A lasting consequence of this is its core, our mental health system still operates from a model in which we explain mental illness in technological terms that are incompatible with our human experience. For example, the Diagnostic and Statistical Manual (DSM-V), which is the only accepted source of diagnostic criteria used here in the U.S, uses behaviors as criteria for diagnosis. This perspective implies an understanding that biological abnormalities cause abnormal behavior. If we assume some stressful event activates pre-existing biology toward an outcome of mental health distress, nuanced elements of what makes us distinctly human like context become relevant but not primary agents of suffering (Longden et al., 2016, p.25). This means that though an event has to occur to activate a biological abnormality, we do not analyze these elements of context as responsible for activating said code, and instead believe that had the biology of a person been "normal" no distress would've occurred.

Longden et al. (2016) theorized that this medical model of distress is a consequence of the historically dubious process of psychotropic medication development. They described how pharmaceutical developments were discovered as capable of managing symptoms of psychosis

while the effects of these compounds were being investigated on an entirely different

phenomenon. Had this discovery been made today, many classes of psychotropic medications

that came to market shortly thereafter would have been tested in much more controlled

environments, and likely not made their way to consumers due to inconsistent results. What's

more, "no mechanistically novel psychiatric drug has been marketed in over three decades"

(p.23). Such a low rate of innovation is out of the ordinary for pharmaceutical interventions for

all other medical conditions.

Longden et al. (2016) suggested our modern understanding of mental illness came out of

psychotropic discovery, when we began to believe that the absence of biological compounds in

the brain causes mental health issues. While managing a condition like psychosis by correcting a

chemical imbalance is helpful, authors say we cannot conflate a correlation (e.g. people with

symptoms of psychosis experience relief through psychotropics) with causation (e.g. an absence

of compounds in the brain causes psychosis). Though authors urge us to focus on the

precipitating factors that cause mental illness, this faulty correlation may be too deeply

embedded within the field, and could be the reason why we struggle to accurately diagnose and

treat mental health conditions.

Speaking to a deeply troubling inconsistency of mental health diagnoses, in their 2006

study, Aboraya and Rankin pointed out the pervasive issues with reliability (defined as the extent

to which a test or theory yields the same results repeatedly) and validity (defined as the truth of

scientific claims). They described three historical phases of transition in the field and note that

even with meticulous revision of diagnostic criteria through five versions of the DSM, there

continues to be lack of reliability in psychiatric diagnoses.

Aboraya and Rankin (2006) posited the cause of this to be inadequacy in two categories: inconsistency in patient factors and inconsistency in clinician factors. Under patient factors, they list things like psychological state, proxy information for severely ill patients, and atypical presentations of disorders. Under clinician factors, they list interview skills, personal training and school of thought, reliance on observation and lack of depth and clarity in nomenclature (interestingly enough, broader definitions existed in earlier versions of the DSM) (p.44).

Aboraya and Rankin (2006) close out their article by suggesting improvements in the ways clinicians collect data and offer interviews, as well as further development of diagnostic criteria by those in the field. Despite the obvious heavy consequences of inaccurate diagnoses leading to consumption of subsequently prescribed pharmaceuticals, authors offer little commentary on the social implications of their analysis.

Some practitioners in the field have recognized the inaccuracy in only looking at biology when we develop mental health treatments. For example, according to the medical model, it was previously believed a person diagnosed with schizophrenia possessed the biological predisposition to become "psychotic", and that some stressful event or trauma brought that capacity out of them. One clinical tool for tracing social impacts like trauma history is called the ACEs score test, which asks a series of questions to determine a linear causality between presence of significant events in a persons' life and likelihood of future chronic health problems, mental illness, and substance misuse in adulthood (Filetti et al., 1998).

Using the innovative traumagenic neurodevelopment model as a basis—which suggests that stress may cause the development of psychosis symptoms— Read et al. (2014) recently furthered research by demonstrating non-linear, rather than one-directional feedback among ACEs factors and psychosis symptoms. This confirmed the link between childhood trauma and

psychosis, and supported the claim that traumatic events should be understood not as triggers of genetic or internal predisposition toward psychosis, but as causes of psychosis themselves (p.72).

Though it may seem like a technical discrepancy, innovation like this shifts the narrative of who experiences psychosis and why, placing emphasis on how external context has the capacity to deeply affect us internally, rather assuming our internal biology is to blame. Replacing the previously accepted Diathesis Stress Model for schizophrenia, which focused more on biological causes of schizophrenia and its symptoms, the traumagenic neurodevelopment model creates space for more preventative measures for (Longden et. al, 2016, p.25). It could greatly diminish stigma for people in all cases of mental health, because blame is taken away from the person and cause is instead identified in their environment. Theory like this helps further quantify trauma as direct result of systemic inadequacy and challenge normative standards of the oppressive medical model.

Sawrikar and Muir (2018) explored the exponential impact of stigma in Australia from the systems level vantage point, inquiring about the difference in experiences between what they define as "consumers and carers of mental illness" (p.158). This qualitative focus-group study identified key gaps in perspectives of those who are living with various mental health conditions, and the people in their lives from whom they receive significant support.

Sawrikar and Muir (2018) named three outcomes of stigma culture which place an undue burden on families to provide support: lack of readily available knowledge about mental health and prevention; low capacity of general health practitioners to identify and treat mental health symptoms holistically rather than through the medical model; and lack of systems and infrastructure which are accessible, affordable and inclusive. Sawrikar and Muir (2018) stated that such inadequate systems in effect lean on families to provide holistic care, but offer little

"acknowledgment and awareness of the extensive and persistent informal support they provide, creat[ing] a new group of 'consumers' who may not necessarily be mentally ill but who are mentally 'unwell' "(p.174). In turn, this dynamic creates a culture of dependency, resentment and further stigma within family networks, perpetuating greater stress and challenges for families of people with chronic issues.

Authors concluded with recommendations for a dual system of combating stigma, which involves a bottom-up approach of psychoeducation around the unique mental health needs of each consumer at the individual and family level, in conjunction with a top down approach of increasing awareness and access to effective treatment options at a societal level. It's important to name that even within studies specific to countries other than the U.S., researchers struggle to recommend a clear path toward righting the systemic failing of a mental health system to meet the needs of citizens.

We return to the training model mentioned earlier by Ali and Sichel (2016), and look at Metzl and Hansen's (2014) "structural competency" framework which stresses that all medical professionals need awareness of stigma and structural inequality within the healthcare system. Metzl and Hansen (2014) propose this system as a replacement for "cultural competency", which they argued lacks the necessary acknowledgement of systemic oppression. Metzl and Hansen (2014) also posed that an understanding of individual cultural differences between practitioner and client doesn't eliminate the external barriers clients face in complying with treatment, and therefore define structural competency as the following:

"[A] trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication "non-compliance," trauma, psychosis) also represent the downstream implications of a number

of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health" (Metzl & Hansen, 2014, p.128).

This model proposes five skills of competency, including a capacity to recognize constraints outside of the medical encounter, a deeper understanding of how systems create patterns of illness for specific identities, redefining traditionally termed "cultural" barriers as structural, observing and imagining structural transformation, and lastly developing a structural humility. Though the model focuses on the medical versus mental health profession, the implications of broken systems impact on mental health outcomes plays out in the same way, as demonstrated by Read et al. (2014).

Metzl and Hansen (2014) recognized challenges that come with the work of revitalizing entrenched structures of delivery systems. However, they offered that the model of structural competency would not only continue the spirit of empowering patients across intersectionalities which cultural competency has started, but also "[allow] medical education to participate more fully in micro- and macro-level negotiations about structural issues in ways that protect the welfare of medicine writ large" (Metzl & Hansen, 2014, p.132).

Here, the concepts of stigma and global economic markets intersect. Returning to Longden et al. (2016) and their work on the medical paradigm, authors explained why we continue to devote ourselves to a medical model which consistently fails us, rather than transitioning to a more nuanced, non-linear, intersectional and trauma-informed perspective. They described how immense global economies have developed out of managing mental health care, and that highly powerful interests are involved in this discussion: not only wealthy pharmaceutical and medical conglomerates and their beneficiaries, but even political candidates,

educational institutions, public policy systems, and non-traditional medical and self-help

industries (p.26).

Longden et al. (2016) stated: "the medicalization of suffering and difference thrives,

because it sanitizes and simplifies" (p.26). They emphasized the structural allies the mental

health system has, and the desire of these powers to avoid immense logistical restructuring not

only for one country but for the entire world. Instead of facing the inadequacies and potential

fallacies within these systems, Longden et al. (2016) asserted how those with power are deeply

invested in keeping reliance upon the systems already created, so they can continue to benefit

from our broken structures. The authors (Longden et al. 2016) end on a series of suggested

actions on a personal, provider and societal level which mirror the calls made by other

researchers, calling the new generation of practitioners to go "beyond reductionist biological

models and acknowledge the complex influence of psychosocial, political, relational, and

cultural components in which mental health problems are inevitably embedded" (p.29).

Discussion

The range of literature explored in our review confirms a pattern of issues in the existing

mental health system, both in practice and in theory: 1) inadequacy of existing medical systems,

which cannot equitably provide services to those who need it most and 2) a stigmatizing

narrative embedded within the medical model, which places responsibility of treatment on the

client and away from complex systems they are oppressed by. How then, can the field

realistically begin to adapt and shift, given the immense cultural stigma concerning the

understanding of mental health in society?

Firstly, the author of this review suggests the answer lies in focusing on prioritizing

practices which can bypass the medical model of mental health by providing room for more

nuanced, and thus more accurate understanding of human complexity. As an average client attempting to understand your own distress, a "biological" explanation for challenges in mental health may offer initial relief, for it could be liberating to learn your symptoms are not in your control and that tangible pharmaceutical resources are readily available to you.

However, ideologically speaking, "biological" is not so different from "internal", and in this way the stigmatizing paradigm through which we currently ask people to consider their mental health is one in which suffering is implied as of internal origin. Such a message is ripe to produce feelings of deep powerlessness, in which all responsibility falls to you and away from systems of power directly benefiting from your economic and social subjugation. How can we ask people to deeply heal while simultaneously believing their pain is of their own organism's doing?

Expressive arts therapy is a paradigm that transforms the subjective, abstract and ineffable into the tangible, felt and known within the frame of a contained therapeutic encounter, and in theory has the capacity to deny a binary definition of wellness. It's focus on high sensitivity and low-skills practice can more easily offer a space for voices of under-represented and marginalized members to speak to the complexities of their lives, because there are no limitation in types of expression considered "therapeutic". The goal is whether consciously or sub-consciously, clients are safely guided to access the somatically held experience of navigating systems plagued by abusive ideology like racism, sexism, ableism, all in a non-linear language that is not of the system, but of the people.

It's focus on embodiment and attunement honors the unspoken body-centered intelligence, which holds every account of cognitive, emotional, and physical trauma within its nervous system. The impact of being met and witnessed in self-expression, which the profession

has struggled to quantify, is significant exactly because it is evocative, and not rational, mirroring the complexity of our human existence. This discipline is also dynamic in its capacity to be practiced outside of a traditional therapeutic encounter without losing elements of its efficacy, by disseminating directives imbued with expressive arts theory to community arts organizations, across social media and into informal gathering and educational settings.

Secondly, as research begins to confirm that adverse childhood experiences like abuse, neglect and violence increase risk for not only psychosis but various health problems later in life, we must now make a more thorough acknowledgement that forms of context like racial and socioeconomic identity are high risk factors for suffering. Affecting radical change in the field of mental health, as Ali and Sichel (2019) stated, requires the profession to shift focus away from encouraging internal agency within clients, and toward educating on realistic capacity for self-actualization in a systemically oppressed context, and demanding necessary progress within our mental health paradigm by exposing the fallacies in the medical model.

Due to its foundation in the experiential element of the human condition, the work of expressive arts therapy is itself an act of social activism. An authentic engagement in the theory of this discipline requires a reflection on the harmful narratives which result from our collective experience in an oppressed society through the intersectionality of both client and therapist.

Using critical race feminism as a tandem frame, this work must be done not only within the therapeutic encounter, but on a large scale. Practitioners are called to consistently trace individual acts of harm to their systemic roots, and use intersectionality as a tool for systemic inquiry. To justly serve clients, we must illuminate and invalidate implicit bias and harmful narratives within the profession in the service of more inclusive models, theories and applications of care. When following the values of seeking nuance as opposed to binaries, we

actively challenge the structure of white supremacy, predicated upon a rigid pursuit of material

prosperity and wealth of economic, social and political power, because small changes in our

individual clinical actions create collective transformation over time.

       We know systemic racism significantly and disproportionately impacts access to mental

health treatment for BIPOC in the U.S., but the framework by which systemic racism is allowed

to exist harms white people too, because its theory has been replicated in other systems like

systemic classism, systemic ableism, systemic transphobia, systemic xenophobia, etc. Here

critical race feminism helps understand why eliminating racism must be our first goal. Though

historically, holding on to socioeconomic status, resources and power were central to

colonialism, the basis upon which it was decided who had access to coveted resources and thus

better positioned themselves in society was first delineated based on race, not class.

       Oluo (2018), asserted how hatred of BIPOC was never the foundation of racism, but it

allowed for the unequal access to resources that upheld systems of power (p.11). Thus, hundreds

of years later, the core lens we must first use when discussing change in the mental health system

is one that reveals the residual impact of systemic racism, not systemic classism or systemic

ableism. Transformation in any of the offshoot systems is impossible so long as racism is

validated, because they are bound together through their mimicking structures. Collective

liberation from these systems is the only path forward.

       Thirdly, if we wish to change the lives of people as part of the critical race feminism

approach, we must also ask ourselves, who are we creating new systems and ways of being in the

world for? Which cultural norms and standards are we centering? In other words, in which

context does our theory of change arise? The problem is that those with the ability to affect

change in systems are generally those who had access to power in the first place. This means that

those commonly in power bring to their leadership an internalized understanding of what it feels like to move through a society which already serves them.

On average, what we as educated white clinicians lack, is the understanding of what it looks like to carry generations worth of racial oppression in our nervous systems, in our cultural upbringing, and in our DNA. However, because we lack the burden of that understanding and reside in a society ruled by systemic racism, it is our job to make life easier for marginalized folks by not asking them to advocate on their own behalf, which puts them at risk of activating internalized trauma. We also know it is true that being white doesn't equate to unlimited privilege, and that through intersectionality we can examine elements of our own lived experiences where we have suffered. The author challenges white clinicians to step outside of the individualist realm of experience, and instead utilize elements of personal suffering to activate compassionate attunement to the collective struggle that BIPOC folks face every day.

Looking at the makeup of the field of psychology, we see it is highly dominated by white females. According to a study done by the U.S. Census Bureau, in 2013 there was an estimated 45,690 white female psychologists, almost twice as many as their white male counterparts. In contrast, there were only 3,802 Black female psychologists and 3,451 Latinx female psychologists, with a similar pattern of about 5 times as many female to male psychologists (American Psychological Association, 2013).

Though this trend specifically describes psychologists, the same pattern is well recognized across the fields of counseling and therapy. Consequently, white women must recognize that in a sea of people hoping to make a difference in mental health, our voices ring out the loudest, our perspectives are heard most often, and our cultural values are transformed from theory into practice most easily. While this doesn't erase the foundational privilege white

males hold in western society as a whole, it's a significant and sobering fact as to who are the

gatekeepers of possibility.

Speaking to stigma culture, which we see as a huge barrier in both advancement of

mental health treatment options, accurate diagnostic criteria, individual pursuit of treatment and

general social understanding, is predicated on the system of ableism, and is actively supported

through the medical model of mental health. The medical model is outdated, not only because it

measures infinitely complex humans through a simplistic binary, but because the mechanisms

through which we have been calculating psychiatric wellness, prescribing medication and

offering diagnoses are founded upon correlation, not causation.

In fact, we still have very limited scientifically significant understanding of mental

health. Instead, we are finding success in treatments that turn toward complexity and away from

simplicity. For provision of these services, we turn to models like structural competency, which

give us the tools for dynamic imagining of the client before us as a holistic human being

negotiating a series of obstacles day by day. However, there are both practical and logistical

barriers to disrupting a major system of power like the medical model.

One dramatic shift in society as of late is the unparalleled understanding of social justice

across a range of demographics, evidence of which we see in movements like the 2020

presidential election, and Bernie Sanders unprecedented success advocating for radical ideas

termed socialist—quite unthinkable just a decade before. This emergence is influencing

community advocacy and psychoeducation efforts around every type of identity issue, showing

us that a greater number of citizens are no longer satisfied with the America they have been

handed. Aided by a widespread increase in exchange of information due to the internet, and

simultaneous social awakening to inequality in basic resources like health care, our sociopolitical

climate calls us in to go beyond the status quo and to raise the standard for what we envision as possible.

In the field of mental health, this means making services with the capacity for greater inclusion much more accessible despite the structural discrimination within the established medical model. The author suggests that at minimum, this means diversifying traditional mental health offerings by standardizing training for all mental health practitioners with required courses on structural competency and bridging the gap from theory to practice with the use of "attunement and embodiment" concepts from the expressive arts paradigm.

For creative and expressive arts therapists specifically, the author proposes increasing alternative modes of mental health delivery, including leaning into new methods of telehealth and app therapy and creating accessible and safe forms of psychoeducation via social media, which are now possible due to technological advancement. This requires further research regarding the theoretical and ethical implications of providing embodied forms of therapy in non-embodied methods of delivery like video, phone or text therapy. It also implies an evaluation of legal structures around practitioners' scope and liability and how they vary across state lines.

We can also look to non-profit and community arts organizations as stewards in the field of non-traditional models of care. While these systems come with their own sets of struggles, here in Seattle we see groups like Art with Heart, Urban Artworks, and Path with Art successfully offering group arts-education and interventions aimed at healing but without provision of direct mental health care. These groups cultivating community and increase skills-based growth in their clients, mirroring the expressive arts paradigm's belief in the power of transformation through collectivism and creativity. BIPOC and those marginalized through class

and ability are more likely to engage these services as opposed to inpatient/outpatient therapy, because organizations often seek partnerships with local communities on the grassroots level. There is currently limited data on the efficacy of these programs, as organizations struggle alongside expressive arts therapists to demonstrate the value of creative expression.

However, these and other non-traditional methods of delivery lack appropriate methodology for assessment of mental health needs, which can keep those on the margins of mental health acuity in a dangerous middle ground without appropriate services. Deepening our understanding of what scaling these types of programs might look like across the U.S. would require program evaluation of the varied forms of arts delivery methods, and critical assessment of potential risks and limitations. This research does not yet exist. However, if history has taught us anything, it is that structures meant to work on systems levels seem to be highly inefficient. Perhaps scaling work that is effective on grassroots levels into greater impact systems would complicate outcomes and diminish success, and instead diversifying the types of programs available now may allow for a more thorough reach across a breadth of needs and populations.

References

Aboraya, A., Rankin, E., France, C., El-Missiry, A., & John, C. (2006). The Reliability of

   Psychiatric Diagnosis Revisited: The Clinician's Guide to Improve the Reliability of

   Psychiatric Diagnosis. *Psychiatry (Edgmont)*, *3*(1), 41–50.

Ali, A., & Sichel, C. E. (2019). Radicalizing advocacy in service settings: Using structural

   competency to address tensions between social action and psychological practice.

   Psychological Services, 1-8. http://dx.doi.org/10.1037/ser0000382

American Psychology Association (2013). *Statistics on Psychology Professions.*

   https://www.apa.org/workforce/publications/13-demographics/table-7.pdf

Bockoven, J. S. (1976). Moral treatment in America's lunatic asylums. *Hospital & Community*

   Psychiatry, 27(7), 468–470.

Brookfield, S. D. (2005). *The power of critical theory: Liberating adult learning and*

   teaching. San Francisco, CA: Jossey-Bass.

Community Mental Health Act (1961), H.R. 4998— Public Law 87-395.

   https://www.jfklibrary.org/archives/other-resources/legislative-summary/health

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique

   of antidiscrimination doctrine, feminist theory and antiracist politics. *University of*

   Chicago Legal Forum, (1), Article 8.

   http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Estrella, K. (2005). Expressive arts therapy: An integrated arts approach in Malchiodi C. (2005)

   Expressive Therapies. (pp.183-186). Guilford Press.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss,

   M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction

to many of the leading causes of death in adults: The Adverse Childhood Experiences

(ACE) study. *American Journal of Preventive Medicine*, 14, 245-258.

Hadley, S. (2013). Dominant narratives: Complicity and the need for vigilance in the creative

arts therapies. *The Arts in Psychotherapy,* 40, 373-381. doi: 10.1016/j.aip.2013.05.007

Heller, J. (2010). Emerging themes on aspects of social class and the discourse of white

privilege. *Journal of Intercultural Studies*, *31*(1), 111-120.

doi: 10.1080/07256860903477670

Hodgkinson, S., Godoy L., Beers L.S., et al. (2017). Improving mental health access for low-

income children and families in the primary care setting. *Pediatrics*, *139*(1), 1-9.

doi: 10.1542/peds.2015-1175

Hussung, T. (2016). *History of Mental Illness Treatment: Obsolete Practices.* Concordia

University. https://online.csp.edu/blog/psychology/history-of-mental-illness-treatment

Jones, N., Rosen, C., Helm, S., O'Neill, S., Davidson, L., & Shattell, M. (2018). Psychosis in

Public Mental Health: Provider Perspectives on Clinical Relationships and Barriers to the

Improvement of Services. *American Journal of Orthopsychiatry*, *70*(1), 65-79.

doi: 10.1037/ort0000341

Junge, M. B., Alvaarez, J. F., Kellogg, A., & Volker, C. (2009). The art therapist as

social activist: Reflections and visions. *Art Therapy: Journal of the American Art

Therapy Association, 10*(3), 148–155. https://www.journals.elsevier.com/

the- arts-in-psychotherapy .

Kossak, M. (2009). Therapeutic attunement: A transpersonal view of expressive arts therapy. *The

Arts in Psychotherapy*, 36, 13-18. https://www.journals.elsevier.com/thearts-in-

psychotherapy .

Kuhn, T. (1962). *The structure of scientific revolutions.* Third Edition. Chicago: University of

    Chicago Press.

Kwong, M., Tin-Hung, R., & Huang, Y. (2019). A creative pathway to a meaningful life: An

    existential expressive arts group therapy for people living with HIV in Hong Kong. *The*

    Arts in Psychotherapy, 63, 9-17. https://doi.org/10.1016/j.aip.2019.05.004

Levine, S. (1997). Expressive arts therapy: A call for dialogue. *The Arts in Psychotherapy*, *23*(5),

    431-434. https://doi.org/10.1016/S0197-4556(96)00060-3

Longden, E., Read, J., & Dillon, J. (2016). Improving community mental health services: The

    need for a paradigm shift. *The Israel Journal of Psychiatry and Related Sciences*,

    53(1):22-30. https://www.ncbi.nlm.nih.gov/pubmed

Metzl, J.M, & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement

    with stigma and inequality. *Social Science & Medicine,* 103, 126-133.

    https://doi.org/10.1016/j.socscimed.2013.06.032

Moxley, D., & Calligan. H.P. (2015). Positioning the arts for intervention design research in the

    human services. *Evaluation and Planning*, 53, 34-43.

    https://doi.org/10.1016/j.evalprogplan.2015.07.013

National Alliance for Mental Illness. (2019, September). *Mental Health by the Numbers.*

    https://www.nami.org/learn-more/mental-health-by-the-numbers

National Institute on Mental Health. (2019, April). *Statistics: Suicide.*

    https://www.nimh.nih.gov/health/statistics/suicide.shtml

Oluo, I. (2018). *So you want to talk about race.* First edition. New York, NY: Seal Press.

Read, J., Perry, B., Moskowitz, A., & Connolly, J. (2001). The contribution of early traumatic

events to schizophrenia in some patients: A traumagenic neurodevelopmental

model. *Psychiatry: Interpersonal and Biological Processes*, *64*(4), 319-345.

https://doi.org/10.1521/psyc.64.4.319.18602

Sajnani, N. (2012). Response/ability: Imagining a critical race feminist paradigm for the creative

arts therapies. *The Arts in Psychotherapy*, 39, 186–191.

https://doi.org/10.1016/j.aip.2011.12.009

Sawrikar, P. & Muir, K. (2018). Toward a family-oriented treatment approach for consumers and

carers of mental illness. *International Journal Of Mental Health, 47*(2), 158-183.

https://doi.org/10.1080/00207411.2017.1367448

Shohat, E. (2001). Talking visions, talking art, talking politics: Ella Shohat on her

latest book. *Fuse Magazine*, 23, 28–37.

Stiles, W.B., Barkham, M., & Mellor-Car, J. (2008). Effectiveness of cognitive-behavioural,

person-centred, and psychodynamic therapies in UK primary-care routine practice:

Replication in a larger sample. *Psychological Medicine, 38*, 677-688.

Van der Kolk, B. A. (2014). *The body keeps the score: Brain, mind, and body in the healing of

trauma*. New York: Viking.

Young, A.S., & Rabiner, D. (2015). Racial/ethnic differences in parent-reported barriers to

accessing children's health services. *Psychological Services, 12*(3), 267–

273. https://doi.org/10.1037/a0038701

THESIS APPROVAL FORM

Lesley University
Graduate School of Arts & Social Sciences
Expressive Therapies Division
Master of Arts in Clinical Mental Health Counseling: Expressive Arts Therapy, MA

Student's Name: Sofiya Kostareva

Type of Project: Thesis

Title: Subverting the Narrative: Addressing Gaps in the Medical Model of Mental Health Through Expressive Arts and Critical Race Feminism Paradigms

Date of Graduation: May 16, 2020

In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

ThesisAdvisor: