Mental health in the urban black community: a sociological approach

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MENTAL HEALTH IN THE URBAN BLACK COMMUNITY:
A SOCIOLOGICAL APPROACH

A THESIS
SUBMITTED TO THE FACULTY OF THE DEPARTMENT OF SOCIOLOGY
ATLANTA UNIVERSITY IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS

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CHAPTER I

INTRODUCTION

The increasing concern about Urban Community mental health in the
United States is evidenced by the considerable resources and manpower
that have been mobilized for community mental health programs in recent
years. The main objectives of these programs are as follows:

Improving the mental health of community residents,
reducing the number of persons who suffer from
mental disorders; reducing the risk that residents
will be prone to mental disorders, and reducing pre-
ventable stress.¹

To accomplish these goals in the black urban community, mental health
professionals must recognize that there are differences between poor
communities and poor black communities.

One of the major differences is that because of the nation's socio-
economic mobility patterns and racial discrimination, blacks are often
forced to remain in the ghettos. Poor whites, we have greater access
to the labor market, can escape from their dismal surroundings far
more easily.

¹Report of the National Advisory Commission on Civil Disorders (New
Further, the National Advisory Commission on Civil Disorders points out the following facts about health in black communities:

The residents of the racial ghettos are significantly less healthy than most other Americans. They suffer from higher mortality rates, higher incidence of major disease, and lower availability and experience higher admission rates to mental hospitals.\(^1\)

The inequities in the administration of justice, long experienced by blacks, have been well documented. However, overriding all other differences between black and white communities is the practice of racism against blacks on the personal and institutional level.

Although discussions about mental disorders in the black community usually begin with the illustrations of the pathologies found there, one rarely hears explanations about why these pathologies exist.

Traditional analysis of the black community would lead one to believe that black people are inherently deficient in some way. But whites have set the standards by which blacks are measured. By placing numerous stumbling blocks and often insurmountable barriers in the path of blacks, whites have made it almost impossible for them to measure up to these standards.\(^2\)

This creates tremendous stress in the black community as a whole and often is the source of mental disorders.

\(^1\)Report of the National Advisory Commission on Civil Disorders (New York, 1968), pp. 269-270.
STATEMENT OF THE PROBLEM

This research focus is on the environmental, economic and cultural stresses and the powerlessness that exists in the black communities of most major American cities from the standpoint of mental health.

Social scientists are predicting that technological change and all of the vagaries of a large city are possibly producing pressures that cause strains in personalities. Black people, inner city stresses and mental health programs are examined and emphasized for the forthright futurance of the mental health of black people, as these factors are germane to the goals of mental health programs in black communities.

Although helping community residents increase their capacity to solve their own problems, is a legitimate goal of any community mental health program helping reduce preventable stress in the community is equally legitimate.\(^1\)

Environmental problems are viewed differently in white and black communities. Many whites are disturbed about the destruction of natural resources on a national, regional and local level and the effect of that de-

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struction on their recreational facilities. Blacks tend to view the environmental situation differently. Nathan Hare suggests that:

Most blacks are troubled by environmental factors that affect their immediate survival, dilapidated and overcrowded housing, roaches, rats, noise, and industrial fallout from factories adjacent to their communities.\(^1\)

Most studies over the years have provided data on how conditions in the ghettos contribute to stress. For example, Mary Sarvis describes the effects of the slum environmental as follows:

Families are crowded into inadequate space, and the lack of privacy is marked. Children are exposed early to sexual and aggressive scenes. Street life is vivid, group-oriented and relatively unrestrained. Families tend to be driven into one or two extremes; they either surrender to this over stimulating chaos, or they try to isolate themselves and their children from it, either solution tends to promote their child's lack of personal identity or security.\(^2\)

In the now classic 1939 study of the incident of mental disorder in Chicago, Faris and Dunham found that the "occurrence of schizophrenia was greatest in the city's dilapidated, crowded tenement areas."\(^3\)

---


E. Franklin Frazier in his study of the Negro in America makes the following observation relative to the ecological arrangement:

Overcrowding has severe social and psychological consequences. Under such conditions, a person's opportunities for self-perception, interpersonal relationships, and even his mental health are often seriously affected.¹

As long as black people are forced to live in ghettos, further manifestations of deviant behavior resulting from substandard living conditions will be inevitable.

Racial discrimination in the job market has very serious implications for mental disorders as measured by the society at large.

Erickson states that:

Work dignifies by providing a living dollar as well as a challenge to competence; without both, opportunity is slavery perpetuated.²

Drucker points out that:

Social effectiveness, citizenship, indeed even self-respect depends on access to a job. Without a job, a man in industrial society cannot possibly be socially effective.³

The ramifications of economic realities must be considered when treatment plans for black patients suffering from mental disorders are developed. More important however, energies should be directed toward altering the economic system that reinforces mental disorders in black communities. A system that survives and functions on powerlessness among blacks.

In white terms, powerlessness often means that black people are lazy and therefore, incapable of marshalling their own resources to break the shackles of poverty. Scherl and English offer the following definition of powerlessness as it is used in this paper:

The overriding social concomitant of poverty is the absence of power, by powerlessness, we refer specifically to the inability to control or alter significantly one's life situation and the forces impinging upon it. The personal concomitants of poverty include an inner sense of helplessness, hopelessness.¹

Mental health professionals treating mental disorders in the urban black community must attempt to distinguish between powerlessness that originates within the individual and powerlessness that is imposed on the

individual from without. If that powerlessness is derived from within, individual therapy techniques may prove to be effective. However, if the client's despair is derived from his inability to get a response from an impossible system, then there is a moral obligation or so it would seem, on the part of the professional to help change that system.

The Black child, like all children, learns how to function in his own culture. His language is the legitimate form of communication in his immediate surroundings.¹

His diet, music, religious expression and the life, are different from those of other ethnic groups. Furthermore, the behavior patterns he learns enable him to survive in an environment that is often hostile and complex.

The black youngster knows how to deal effectively with bill collectors, building superintendents, corner grocery stores, hippies, pimps, whores, sickness and death. They know how to jive school counselors, principals, welfare workers, juvenile authorities, and in doing so display a lot of psychological cleverness and originality.²

When the black child enters school, the white controlled system
tries to negate all he has learned. At the same time, however, it sys-
tematically cuts off his avenues for self-expression and deprives him of
a positive self-image. When the child does poorly on culturally biased
examinations, he is often labeled as suffering from some type of mental
disorder and therefore, is incapable of learning. Hurley points out that
in cases of this nature:

The school system, rather than hold the teachers
accountable, assume that the pathology of the
mental disorder lies within the child.¹

The Autobiography of Malcolm X provides a vivid illustration of how
the school system views blacks. When Malcolm told his eighth grade
teacher that he wanted to become a lawyer, she gave him the following
advice:

Malcolm, one of life's first needs is for us to be
realistic; a lawyer, that's no realistic goal for
a nigger, you are good with your hands, making
things. Why don't you plan to be a carpenter?²

¹Oliver L. Hurley. "Special Education in the Inner City". Paper present-
ed before the Conference on Special Education Programs for the Mentally
Retarded (Lake Arrowhead, California, March 7-10, 1971).
²Malcolm X and Alex Haley. The Autobiography of Malcolm X (New York:
This kind of advice is still given to many black people, regardless of their potential.

The environmental, economic and cultural problems, and the powerlessness in black communities discussed in this statement of the problem, represents only a few of the many factors that cause acute stress which often leads to mental disorders in the urban black communities.
CRITIQUE OF THE LITERATURE

Much of the earlier literature attributes many of the blacks social and psychological ills to his self-hatred and resultant self-destructive impulses.

Noted psychiatrist Dr. Alvin F. Poussaint in an article entitled, "The Psychology of a Minority Group with Implications for Social Action," challenges this self-hatred thesis as being of less importance in the psychic development of black people than the aggression-rage constellation. The author presents a historical and social-psychological analysis of this phenomenon, as well as the more traditional methods of sublimination.

Abram Kardiner and Lionel Ovesey, The Mark of Oppression, very vividly examines self-hatred in terms of rage. Their findings indicate that a black person with all the self-love and self-confidence in the world, could not express it in a system so brutally and suppressive of

self-assertion. Since appropriate rage at such emasculation can be expressed directly only at a great rise, the Negro has repressed it and suppressed it, but only at great cost to his psychic development.

Lee Rainwater, in "Crucible of Identity: The Negro Lower-Class Family," analyzes the black sub-culture in terms of identity. The significant findings indicate that most black people are affected by hypocrisy, they are too inexperienced to comprehend and by gross disparity between the ideals they are taught and the reality they see. They are further made desperate by having little or no voice in matters that vitally affect their lives.

Kurt Lewin, Resolving Social Conflicts, provides an early (1948) frame of reference for the subsequent self-hate concept. A concept disputed by many latter day social scientists. However, his marginal man concept is still referred to when examining the caste like status of minority groups.

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Hylan Lewis, "Culture, Class and Family Life Among Low-Income Urban Negroes," Employment, Race and Poverty, portrays the black family in positive terms, different from white middle-class models. This exceptional article uses field material from a study conducted in Washington, D.C. The accumulated data, including interviews with low-income black urban parents, presents a picture of variations, complexion, and aspirations for their children that range from deep concern to disinterest. However, the greater portion of these parents employ positive means within their limited conditions and exhibit a willingness to sacrifice for their children's interests.

Herman Gottesfeld, The Critical Issues of Community Mental Health, examines the growth process of community mental health. Using the case study method, the author functions as a participant observes.

Part one of the book, describes the many crisis, often in dramatic detail, part two discusses the problems of the administration and staff; part three reviews interaction between institution and community; and part four applies some of the lessons learned to the general problems of community mental health programs in urban ghettos.

Gerald Caplan, *An Approach to Mental Disorder*, presents not only the literature of mental disorder, but the probing critique of method and meaning, through the problems of diagnosis and research techniques. Thorough coverage is given to schizophrenia as the most extensively studied and prototypical disorder. There are fewer available data on affective psychoses and psychopathic disorders. Although these conditions are amply covered, they are discussed in less depth than schizophrenia.

Dr. June J. Christmas, "Psychosocial Rehabilitation in Economically Deprived Communities" is a reflection of an exciting series of innovations and, above all, a series of demonstrations that show psychiatric difficulties to be treatable and preventable in many instances and capable of being lived within other instances.

This paper should receive the attention of all who are involved in community health programs, as well as of those who are involved in the more traditional approaches to the management of emotional disorders.

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Erik H. Erickson, in "The Concepts of Identity in Race Relations," raises some pertinent questions about concepts of personality and positive elements within the black community as commonly presented in the literature. One of the significant contributions made by Erickson in this article, is the recognition of cultural components in the black community that contribute to positive identity but are in direct contrast with white identity.

Malcolm X and Alex Haley, The Autobiography of Malcolm X provides a theoretical framework for analysis and interpretation of the black experience as a developmental process. This rare insight into black life has seldom been expressed with such clarity.

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MAJOR CONCEPTS AND THEORIES

It should be clearly stated, at the beginning, that the problem or the situation in which minorities find themselves in regard to mental health, is quite complex and variable. The general mental health issue, for minorities, is the extent to which mental illness or institutionalization for minority group members is above average. In addition, however, there are a variety of sub-issues which must be analyzed and researched if the appropriate programs are to be developed. For the purpose of dealing with these issues in meaningful ways, this writer makes the following hypothesis.

(1) That a major cause of the mental health problems of black people are attributable to economic, social, institutional and environmental stresses that fall mainly on black people.

(2) That prejudice and racism accounts for excessive negative self-esteem and often serious mental illness.

(3) That many of the mental health problems of blacks are intimately lined with various repressive and discriminatory aspects of the majority group.
That prejudice and discrimination are psychologically economically damaging to both the minority and the majority group.

These are a few of the sub-issues that must be investigated, in this writer's opinion, in order to come to grips with the mental health implications of the profound racial and social revolution that the country is currently undergoing.

This study is limited primarily to the aforementioned concepts. The range of factors involved in mental health are too involved, various, and complex to venture further.
TYPES OF DATA AND THEIR AVAILABILITY

The data for this study were collected from various organization records and publications; medical and social science journals, and books and articles relating to the subject matter. This represents a fairly well standardized procedure developed by sociological researchers for obtaining information of this nature. The data represents material elicited from this research, and is designed to interpret and review such status variables deemed necessary to describe the salient characteristics of mental health among blacks.

In this study, the researcher has tried to avoid relying on personal impressions while reviewing the various types of data and their accessibility. The study is limited to existing empirical findings.
METHODOLOGY

Data for this study were obtained by using the information gathered from personal interviews in addition to the data collected from research journals, articles, and books relating to the subject. Prior to this major study, the writer visited each of the community mental health centers on the Lower East Side of New York City. During these visits, center directors, along with other key mental health personnel, were interviewed. These interviews were recorded as personal observations for future references.

The mental health centers representing hospitals, settlements, schools and social service agencies on the Lower East Side, were formed under the auspices of L. E. N. A. (Lower East Side Neighborhood Association). Centers must either be physically located within the Mental Health Communities defined geographic limits (Lower East Side, North-14th Street, South-Brooklyn Bridge, West-Broadway, East-East River), or offer extensive service to residents of this area. All are either licensed approved, or funded by the New York State Department of Mental Hygiene.
During the period from September, 1972-June, 1973, the investigator served as Supervisor of a special project, (Project Recycle), and received special permission from the director of L. E. N. A. to gather data from existing mental health records in an attempt to isolate primary cause and effect of mental disorder in the urban black community.

The first step was to identify the clients presently undergoing treatment, and to state the problem or condition under which this service is addressed. Included in the statement, to the extent possible, the number and characteristics of the individuals affected.

Research findings indicate that accumulated stress without sufficient external and internal resources to combat its (stress) affect on the individual, family and/or group, is a major step toward Mental Disorder. Therefore, the presence of poverty, oppression and emotional deprivation, with all of its ramifications; i.e., unemployment, inadequate housing, inadequate education, family relationship breakdown, and dysfunctional behavior makes it virtually impossible for an individual or family to deal with extreme stress.

During the previously mentioned time period, the researcher had continuous contact with mental health practitioners, psychologists, sociologists, psychiatrists, social workers and administrators. Outreach
workers and community organizers were required to submit weekly reports of their findings. Thus, a knowledge of the stress factors and other variables that often lead to mental disorders were available on a day-to-day basis for evaluation and interpretation by superiors.

In this study, it is recognized that training for a special project is part of over-all supervisory responsibility for staff development and should in no way reflect personal impressions of various agencies.

Data were collected from the following Mental Health Centers:

(1) Gouverneur Hospital
   9 Gouverneur Slip
   New York, N.Y. 10002

(2) The Educational Alliance
   197 East Broadway
   New York, N.Y. 10002

(3) Victory Guild Psychiatric Consultation Service
    of the University Settlement
    184 Elridge Street
    New York, N.Y. 10002

(4) Mental Hygiene Clinic
    Beckman Downtown Hospital
    1701 Williams Street
    New York, N.Y. 10002

(5) Mental Hygiene Clinic
    Beth Israel Medical Center
    10 Nathan D. Perlman Place
    New York, N.Y.
(6) Catholic Charities
Family Service
530 Grand Street
New York, N.Y. 10038

(7) Hamilton-Madison House
50 Madison Street
New York, N.Y. 10038

(8) Henry St. Settlement, Mental
Hygiene Clinic
40 Montgomery Street
New York, N.Y.

(9) Lower Eastside Narcotics Addictions, Inc.
165 East Broadway
New York, N.Y. 10002

(10) Mobilization for Youth
214 East 2nd Street
New York, N.Y. 10002

(11) New York Clinic for Mental Health
150 Fifth Avenue - (20th St.)
New York, N.Y.

(12) New York Infirmary
Social Service Department
321 East 15th Street
New York, N.Y. 10003

(13) Postgraduate Center for Mental Health
124 East 28th Street
New York, N.Y. 10016
CHAPTER II

SELF-ESTEEM AND MENTAL HEALTH

The self, as used in this research, involves "the individual person as the object of his own perception". This definition includes both the content of what is known and one's evaluation of this content. If one accepts the idea of the self image as an historical resultant of social interaction with others, then low self-esteem must be closely linked with problems in interpersonal relationships. A person with low self-esteem tends to feel that others hold negative opinions of him, whereas low self-evaluation indicates feelings of deprivation and threat by the social environment, which suggests that low self-evaluation is an important precondition for mental disorder.

Research in this area indicates conceptualized self-esteem as contributing directly to mental disorder, or have at least associated it with susceptibility to mental disorder.

EARLY APPROACHES TO BLACK SELF-HATRED

Self-hatred seems to be a psychopathological phenomenon. However, modern sociology and psychology show that many psychological phenomenon are but an expression of a social situation in which the individual finds himself. It is in other words a social-psychological phenomenon, even though it usually influences deeply the total personality. The self-hatred concept is not new, however, the interpretations vary considerably. As early as 1948, Kurt Lewin pointed out that self-hatred in a phenomenon which is present in many underprivileged groups, when he stated that:

One of the better known and most extreme cases of self-hatred can be found among American Negroes. Negroes distinguish within their group four or five strata according to skin shade, the lighter the skin, the higher the strata. This discrimination among themselves goes so far that a girl with a light skin may refuse to marry a man with a darker skin. An element of self-hatred which is less strong but still clearly distinguishable may also be found among the second generation of other immigrants to this country.¹

This self-hatred concept lays the foundation for Lewin's Marginal Man Theory. Self-hatred, uncertainty and instability can create psychological difficulties.

¹ Kurt Lewin, Resolving Social Conflicts (New York: Harper and Brothers, 1948) p. 189
In practically every underprivileged group, a number of people will be found who, although regarded by the privileged majority as not belonging to them, feel themselves as not really belonging to the underprivileged minority. They are people who belong neither here nor there, people who are in the position of what sociologist call marginal men. Lewin seemingly feels that the self-hatred feelings in these so called marginal men are due more or less to the permanent state of conflict in which they find themselves. As Lewin points out:

The frequency of marginal persons in an underprivileged group is likely to increase the more the difference between the privileged and underprivileged groups decrease, with the resulting paradox that the betterment of the group might increase the uncertainty and tension of the individual.

Lewin further elaborates when he states that:

Those marginal men and women are in somewhat the same position as an adolescent who is no longer a child, and certainly does not want to be a child any longer, but who knows at the same time that he is not really accepted as a grown-up. This uncertainty about the ground on which he stands and the group to which he belongs often makes the adolescent aggressive, over-sensitive and tending to go to extremes, over critical of others and himself.

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1 Ibid., p. 180
2 Ibid., p. 181
Figure I diagrams behavior based on Kurt Lewin's concept of the marginal man. This concept essentially explains that, not the belonging to many groups is the cause of mental and emotional conflict, but rather the conflict is caused by an uncertainty of belongingness generated by self-hate.

In Figure I, the person (P) is shown as not being a member of either the majority group (MA) or the minority group (MI) to the extent where he is clear and confident about his views and personal relations to either side. He is therefore, compelled to remain in a rather vague and uncertain, but permanent inner conflict.
THE PERSON (P) STANDING ON THE BOUNDARY BETWEEN THE MINORITY GROUP (MI) AND THE MAJORITY GROUP (MA)

FIGURE I

THE MARGINAL MAN THEORY

THE PERSON (P) STANDING ON THE BOUNDARY BETWEEN THE MINORITY GROUP (MI) AND THE MAJORITY GROUP (MA)

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Research indicates and verifies that most mental health professionals generally agree that self-hatred if it does indeed exist, is an attenuated form of rage, and is the emotion toward those who inspire fear and rage. The difficult problem for those are constantly subject to frustration in how to contain this emotion and prevent its expression. Abram Kardiner and Lionel Ovesey explain the psychodynamics of rage thusly:

The most immediate effect of rage is, therefore, to set up a fear of its consequences. Fear and rage become almost interchangeable. When the manifestations of rage are continually suppressed, ultimately the individual may cease to be aware of the emotion. In some subjects, the only manifestations of rage may be fear.¹

They further state that,

The techniques for disposing of rage are varied. The simplest disposition is to suppress it and replace it with another emotional attitude, submission or compliance. The greater the rage, the more object the submission. Thus scraping and bowing compliance and ingratiating may actually be indicators of suppressed rage and substained hatred. Rage can be kept under control but replaced with a substained feeling, resentment. It may be kept under control, but ineffectively, and show itself in a passive manner. It may be kept under sustained control for long periods, and then become explosive. Rage may show itself in subtle forms of ingratiating for purposes of exploitation. It may finally be denied altogether and replaced by an entirely different kind of expression, like laughter, gaiety or flippancy.²


² Ibid., pp. 304-305.
Kardiner and Ovesey found that the low most common end products of sustained attempts to contain and control aggression, were self-esteem and depression, which are the results of the continuous failure of a form of self-assertion.
In considering the effects of the family on mental health, it must be considered who the individual believes himself to be and to be becoming. In early childhood years, identity is a family bond since the child's identity is his identity vis a vis other members of the family. As the child grows older, he incorporated into his sense of who he is and is becoming, his experiences outside the family, but always influenced by the interpretation and evaluations of those experiences that the family gives. Lee Rainwater, an observer of lower-class families and value systems supports this proposition: with the following observations:

From the child's point of view, the household is the world; his experiences as he moves out of it into the larger world are always interpreted in terms of his particular experience within the home. The painful experiences which a child in the Negro slum culture are always interpreted in terms of his particular experience within the home. The painful experiences which a child in the Negro slum culture has are, therefore interpreted as in some sense a reflection of this family world. The impact of the system of victimization is transmitted through the family; the child cannot be expected to have the sophistication an outside observer has for seeing exactly where the villains are. From the child's point of view, if he is hungry, it is his parent's fault; if he experiences frustrations in the streets or in the school, it is his parents fault; if the world seems incomprehensible to him, it is his parents fault; if people are aggressive or destructive toward each other it is his parents fault, not that of a system of race relations.

In another culture, this might not be the case. However, the effects of the caste system brings home through a chain cause and effect all of the victimization processes in such way that it is often difficult even for adults in the system to see the pain and mental anguish they feel at the moment and the structured patterns of the caste system. Ideally, in a society, as children grow up and are formed by their elders into suitable members of the society, they should gain increasingly a sense of competence and ability to master the behavioral environment their particular world presents. However, this does not prove to be the case in the urban black ghetto culture, growing up involves an ever increasing appreciation of one's shortcomings, and of the impossibility of finding a self-sufficient and gratifying way of living.

Much has been written about the black man's psychic reactions to being a member of an oppressed minority in a white man's land. As witnessed by the previous psychological nuances discussed thus far in this chapter by Kurt Lewin, Abram Kardiner, Lionel Ovesey and Lee Rainwater. The position of the black man is unique among minority groups in America because he alone bears the scars of a slave heritage and wears the indelible mark of oppression, his dark skin.
The system of slavery in its original form and as its remnants exist today, had three (3) dramatic consequences for the black man's psyche. It generated in him 1) self-hatred and negative self-esteem; 2) suppressed aggression and rage; and 3) dependency and non-assertiveness. Although these manifestations are analytically distinguishable, they are not discrete phenomena, being interdependent and interrelated on many different levels.

Let us look briefly at the genesis and initial consequences of racism and examine black people responses to it from a historical perspective as examined and analyzed by Dr. Alvin Poussaint.

The castration of Afro-Americans and the resulting problems of negative self-image, suppressed aggression, and dependency started more than 350 years ago when black men, women and children were wrenched from their native Africa, stripped bare both physically and psychologically and placed in an alien white land. They thus came to occupy the most degraded of human conditions, that of a slave: a piece of property, a non-person. The plantation system implanted and fostered the growth of a helplessness and subserviency in the minds of Negroes that made them dependent upon the goodwill and paternalism of the white man. The more acquiescent the slave was, the more he was rewarded within the plantation culture. This practice forced the suppression of felt retaliation rage and aggression in black men and women. Those who bowed and scraped for the white boss and denied their aggressive feelings were promoted to "house nigger" and "good nigger." Thus within this system, it became a virtue for the black man to be docile and non-assertive. "Uncle Toms" are examples of these conditioned virtues.¹

Consequently, in order to retain the most menial of jobs and keep from starving, black people quickly learned servible responses. Thus, from the days of slavery to the present, passivity and the resultant dependency became a necessary survival technique. The intensity of the white man's psychological need that the black be shaped in the image of this projected mental sickness was such as to inspire the whole system of organized discrimination, segregation, and to a large part, the exclusion of blacks from society.

White racists through the centuries have perpetrated violence on those blacks who demonstrate aggressiveness or insubordination.

As Dr. John D. Reid states:

Negro mothers learned to instruct their young children to behave as say yes sir and no sir when the white man talks to you.  

Similarly, various forms of religious worship in the black community have fostered passivity in blacks and encouraged them to look to an after-life for eventual salvation and happiness.

In addition to demanding non-aggression and subservience, whites also inculcated in the black low self-esteem and self-hatred. As Dr. Alvin Poussaint states:

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1 John D. Reid, Atlanta University, Atlanta, Georgia Lecture Notes: Class: Sociology of the Ghetto, November, 1974.
Whites made certain that any wares allotted to the Negro were inferior. The Caucasian American socialized the black man to internalize and believe the many deprecating things which were said about him. They encouraged and rewarded behavior and attitudes in Negroes that substantiated these indicting stereotypes.¹

In this way, many blacks were conditioned to believe, Yes, I am inferior. The most tragic and yet predictable part of all of this structuring, is that the black has come to form his self-image and self-concept on the basis of what white racist have prescribed. These aspects of the black man's socialization in an oppressive system have serious consequences on his psychological development. Through contact with such institutionalized symbols of caste inferiority as segregated schools, neighborhoods, and jobs and more indirect negative indicators such as the reactions of his own family, he gradually become aware of the social and psychological implications of his racial membership. He is likely to see himself as an object of scorn and disparagement, unwelcome in a white high caste society, and unworthy of love and affection. From that time early in life the entire personality and style of interaction with the environment often becomes molded and shaped in a warped, self-hating, and self-denigrating way. Sometimes this self-hatred can take on very subtle manifestations. Dr. Alvin Poussaint discusses this concept in terms of competition:

¹Ibid., p. 33.
Competition, for instance, which may bring success, may also bring failure. Thus, the efforts which may bring success to a black man are often made even when the opportunity exists. This is no doubt for two (2) reasons: First, the anxiety that accompanies growth and change is avoided if a new failure is not risked; therefore a try is not made. Second, the steady state of failure represented by non-achievement (and defined by someone other than yourself) rather than by an unsuccessful trail, is what Negroes have come to know and expect, and so they feel safer (less psychologically discomforted) with the more familiar. Furthermore, it has often meant survival to black men to deny the possession of brains, thoughts, and feelings, thus making it difficult to move from a position of passivity to one of activity and to acknowledge heretofore forbidden feelings and behavior as now safe, legitimate, and acceptable.¹

Research findings indicate that in psychiatric practice, it is a generally accepted principle that a chronic repressed rage will eventually lead to a low self-esteem depression, emotional disorder and rage.

The availability of job is especially crucial for the black man to maintain mental health in his struggle for dignity. Not only do jobs give men a sense of importance and self-worth, they may also be a channel for the appropriate release of aggression. As in sublimation and displacement, they may allow black men to express the assertiveness that has been so long damned up.

¹ Ibid., pp. 37-38.
Almost every clinical study of psychopathology among blacks indicate that the black who is not identified with other members of his group, is relatively more prone to manifest various forms of mental illness. Because this phenomenon cannot be conceptualized in terms of a quantitative scale, the data will be used to explore the manifestations of this behavior in the population, rather than for rigorous testing of this hypothesis.

The original question was posed in the form: Does the Negro like being a Negro? The answer based partially on the now classic study by Kenneth B. Clark, conducted this study in Racial Identification and Preference in Negro Children. Several researchers tended to interpret Clark's findings as indicative of self-hate. Prohausky and Newton give a vivid example of this train of thought:

The Negro child's choice of dolls or playmates can be viewed not only as a preference for whites, but also as an emphatic rejection of one's own racial group.  

In an effort to clarify his findings, Clark in a later book notes that:

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A child cannot learn what racial group he belongs to without being involved in the larger pattern of emotions, conflicts, and desires which are part of his growing knowledge of what society thinks about his race.¹

For the black child, these judgments operate to establish his own racial group as inferior to white people.

The point which much of this research attempts to establish is that the experiences of blacks amounts mainly to an unending source of conflict, which detrimentally affects self-conceptions. Rainwater gave even greater importance to the family experience,

In growing up, the Negro slum child learns what he cannot do. He learns about the blocks and barriers to his mastery of his environment, and he learns most of all the futility of trying.²

Rainwater concludes by defining the urban Negro family as the "crucible of Identity".³

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REFERENCE GROUP BEHAVIOR AND MENTAL DISORDER

Reference group concepts as used in this study must be clarified at the onset. Although there is some overlapping in the research literature in the application of this concept, some important differences are present. These differences contribute to the ambiguity of generalizations emerging from such studies. Shibutani delineated three (3) separate usages of the term reference group, and they are used as such in this study.

(1) It may refer to that group which serves as the individual's criterion in making comparisons, particularly evaluations concerning his own status of self-image.

(2) It may designate that group from which the individual wishes to gain or maintain acceptance.

(3) The term may also refer to that group whose perspectives and norms provide the individual with an orienting framework for structuring his own perceptual field.¹

Although Shibutani's distinctions are conceptually clear and important to bear in mind when designing relevant research, these three different usages seem to be logically related and possibly empirically linked in ongoing social behavior. To put it another way, if an individual employs a reference group as a basis for self-evaluation,

does not this same group then structure his perceptual field? Similarly, if a reference group serves as a basis for self-evaluation and provides the individual with a normative structure, it seems logical that he also, if only in fantasy, wishes to gain admittance to this group.

It seems that the use of a reference group as an anchor point enabling the individual to make judgments concerning his own achievements and self-image, is most relevant to his sense of self-esteem and ultimately to his state of mental health. Given two persons of identical objectively defined status, the individual who evaluates himself by the standards of a relatively higher status reference group, may be less satisfied with his own status and thus, more prone to various manifestations of maladjustments and psychopathology.

This chain of thinking has appeared frequently in the research literature, as Hyman points out,

People choose reference groups, or reference individuals occupying a status relatively close to their own. This tendency can be attributed to proximity to the individual in life situations, or as a result of objective facts which facilitate such comparison.¹

Festinger, et al., further points out in support of this point, that,

Similar or proximal status choices are a result of the pressure toward uniformity which may exist in a group.\(^2\)

In the context of the study it is assumed that, because of their objectively range of social interaction with others of similar status, and because of the need to maintain feelings of competence, most people do tend to select reference groups at, or close to, their own positions.

Parker and Kleiner in discussing reference groups, state that:

When an individual is below his reference group on a scale of status positions, he is characterized by a negative discrepancy, if his own position is above that of his reference group, he has a positive discrepancy.\(^1\)

Up to this point, the theme of this discussion suggests that if we compare people of equal status, those with relatively high reference groups (negative discrepancies) will be more prone to self-devaluation and mental illness. The hypothesis presented in this chapter incorporates the idea of a direct relationship between degree of negative discrepancy


from reference group and severity of mental illness. The more negatively
discrepant, the greater the severity of the mental disorder. If an individ-
ual does not have significant others (reference group) by which to evaluate
his own achievements and abilities, the estimation of his position relative
to others can be very unstable. According to Festinger,

The individual suffering from a mental disorder
and lacking a social base for evaluation, will
place himself further above or below some vague
reference point than the individual in the commu-
nity who is not socially isolated.¹

It is then possible that the mentally ill person places himself above
his reference group to bolster his self-esteem, or selects a reference
group above his own position in order to derive vicarious pleasure
through identification with prominent individuals.

Data shows that there is a direct relationship between reference
group behavior and mental disorder, also there is a relationship be-
tween the severity of illness and the degree of negative discrepancy
from reference group, thus confirming the original hypothesis.

OCCUPATIONAL STATUS AND MENTAL HEALTH

It is very possible that the stress imposed by economic roles and in turn, the presence or lack of protection and support from other sources of stress afforded by one's occupation and subcultural group, may contribute to the differential onset of mental disorder in any human population. Clark points out that,

Studies of mental disorders by occupation generally indicate that those in the less skilled and lower-status occupations tend to exhibit a high rate of major mental disorders, particularly the psychoses.¹

These studies have been based primarily upon first admissions to mental hospitals, usually publicly supported, while other inquiries substantiating this result have been based upon prevalence date instead of incidence rates. In both instances, skepticism may be voiced about the validity of these findings, in that a high risk of bias exists toward over-representation of those in the lower-income occupations hospitalized in state institutions and other hospitals known to provide chronically ill persons.

Clark's conclusions are strongly refuted by Benjamin Passamanick, currently Associate Commissioner, New York State Department of Mental Hygiene. Dr. Passamanick and a team of researchers offers data that contrasts sharply with that generally found on the prevalence of mental disorders among the higher occupational status classes. They offer that,

Once the lower classes came to the hospitals for treatment or care, they were more likely to remain there, but the frequency with which they initially became ill was only slightly greater than that of the higher occupational status patients.¹

Using for the first time, evidence of persons receiving treatment either in clinics or from private psychiatrists, this study found the highest rates of hospitalization for mental disorders among the upper occupational and social strata. Based on this data, the following conclusions therefore, seem warranted.

The incidence of mental disorders was found to be higher in this study for certain prestige occupations, such as those in the professional category, than previous studies, based only upon first admissions to mental hospitals, have indicated.

This is demonstrated by the high rate of mental disorders found among those so engaged. These disturbances are more likely to be of the acute type which can be effectively treated by psychiatrists in private practice and in private clinics. Furthermore, prevalence rates, contrasted with incidence studies will tend to underrepresent this high status group and to overenumerate the mentally ill population obtaining custodial care in public institutions.
BEHAVIOR DETERMINED BY SUBJECTIVE SOCIAL STATUS

The white professional researcher in many cases, should be held responsible for the creation and refinement of the social status conditioning techniques employed to establish and maintain dependent and acquiescent behavior in black people. The role which black people play in perpetuating the conditioning process is also significant. Dominant emphasis appears to be placed not on what whites have done to blacks, but on why blacks permit whites to do what they do. This change of emphasis would seemingly have profound implications for theory and research in black behavior.

Dr. June J. Christmas touches on this problem,

A social caste system for blacks, together with inner psychic despair, tend to lock black people into a self-fulfilling prophecy of failure.¹

The Sterling County follow-up study also shows that,

The ability to secure emotional support from others and to plan objectively for the future,

are the most important factors in developing mental health and preventing mental disorder.\textsuperscript{2}

For practical purposes, social status in this paper will utilize three (3) different measures: occupation, income and education. The literature regarding the relationship between social status and mental disorder is characterized not only by contradictory findings, E. E. Hyde and Kingsley, 1944; Kaplan, Reed and Richardson, 1956, but also, by what appears to be a failure to investigate in a systematic fashion the reasons for observed relationships between these variables. A notable exception seems to be Langner and Michael, these authors explained that,

\begin{quote}
The inverse relationship between status and mental disorder in a community population is related stress factors that are independently associated with psychopathology.\textsuperscript{1}
\end{quote}

However, careful analysis of the relationship between stress factors and social status positions failed somehow to yield an explanation for the decrease in mental illness rates with increasing status levels. In addition, status-associated factors which would explain high or low rates of

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mental disorder have not yet been identified.

This writer tends to disagree with the majority of the data in this area, and offers that there is a relationship between social status and mental disorder in the urban black family. First off, the total picture must be looked at, and I feel most researchers fail to do so. A portrayal of the urban black family in positive terms, different from white-middle class models, is too often the exception rather than the rule in journal reports of white social scientists. The greater portion of low-income black parents employ positive means within their limited conditions, and exhibit a willingness to sacrifice for their children to achieve an acceptable social status.

In support of this hypothesis, Hylan Lewis offers a proposition that should be strongly considered in evaluating the dynamics of the total picture of low-income black families, in terms of sacrifices to achieve greater social status.

(1) The amount and the implications of the diversity among Negroes in low-income urban families, are too frequently overlooked or underrated in popular and scientific thinking.

(2) Negro family behavior, and especially those with low-income, is marked by a shifting back and forth between, and a compartmentalizing of select-
ed aspects of poverty and deprivation and of adequacy and affluence.

(3) Much low-income family behavior has a strongly pragmatic cast, essentially non-class, non-cultural or transcending class and culture, as currently used in its derivations.¹

This evidence suggests that we take into consideration the economic pressures of late twentieth-century urban living upon blacks and the preference for recognizable status goals in the greater society. There are also indications of pressures both inside and outside the family that operate on some parents which could diminish their confidence in their ability. Which suggests that there is a complex nature of relationships between behavior and conditions which could conceivably lead to over-burden, confusion and possibly the development of mental disorder while attempting to achieve greater social status.

CHAPTER III

MENTAL HEALTH AND ECONOMIC DEPRIVATION

We are witnessing a tremendous revolution in mental health with one of the primary aims first to bypass, and finally to eliminate the asylum approach to the treatment of emotional disorders. Concurrently, there has developed the realization that the State can no longer confine itself to providing care only for the psychotic, that in fact, all mental disorders are a public responsibility. The concern of society for mental health in the community at large, is the background against which community psychiatry has emerged and set the stage for federal and state legislation.

Most basic of all, is the idea that the focus must be on the total population. The needs of one group may differ widely from those of another so that the mental health will necessarily vary widely according to the demography of the respective sub-populations for whom they are intended. But the overall mission of programs should be the composite needs of the total population. This intent may be contrasted with the present situation, which is characterized by gross maldistribution of services and denial of the needs of large segments of the population.
The waste of human resources in the inner cities of this nation is appalling. Generations of black children grow from malnourished and poorly educated childhood, to unemployed, unskilled adulthood, often without the inner strength to cope successfully with their troubled environment, or the wisdom to see its true causes. Many flee from their unsuccessful efforts to cope with a troubled reality into the unreality of mental disorder, drug addiction, or the aimless existence of the alcoholic street corner society. Others succumb to generational dependency induced by a restrictive labor market, a demeaning welfare system, and an economic and social structure dependent on racial discrimination, scarcity, and limited opportunities for meaningful emotional gratification. As Dr. Donald Schwartz points out in his 1972 Assessment of Community mental health:

Rates of unemployment, underemployment, and failure to complete high school, are typically highest in inner cities. An inadequate school system induces underachievement, miseducation, and the dropout or pushout, while failing to instill motivation, teach skills, or require task orientation. Substandard housing, narcotics, addiction, alcoholism, poor nutrition, and medical disabilities, are commonplace. With the press of urban migration from the south, thousands of persons move into inner cities each year, unaccustomed to urban living, skilled in ways that cannot be utilized in the city, and lacking in basic literacy.1

Yet, for reasons which practitioners and researchers have yet to explore to any great degree, many black men and women carry on their lives without succumbing to family disruption, alcoholism, drug dependency, or mental disorder, despite inadequate necessities and ineffective human services. Evidence of the strength of black survival becomes a relative victory, however, when measured against human loss.

Dr. June J. Christmas gives a very vivid portrayal of human loss when she states:

Human loss reveals itself in many ways. One of the most viable and healthy social roles a man can play is that of worker, wage earner, and head of family. But when he lacks marketable skills, it is extremely difficult for him to assume a socially constructive role within his family and community. When a medical or emotional disability forces a black man in an inner city ghetto into the position of non-worker, he may move from his former position of marginal existence in a situation of underemployment or casual work, or as a hustler, to a role as non-worker. His self-concept as a black man, already devalued by the wider society becomes even lower. When physical or mental disorder had led him to seek medical or psychiatric care at his community hospital, his recovery is interpreted with by the lack of a job, the lack of money, and the lack of self-pride as a man who cannot only be, but do. Indeed, deficiencies in a social and vocational rehabilitation services, limit the effectiveness of the medical or psychiatric treatment which the hospital can and does attempt to provide, thus underscoring the need for rehabilitation as a complement to treatment and prevention.¹

In inner cities, the course of returning to a socially productive role after illness is not only stressful and difficult, but is intrinsically interwoven both with pressing social conditions and with psychological coping abilities. The provision of rehabilitation services is difficult, however, not only because the appropriate tools to handle the related tasks of treatment and rehabilitation have not been developed, by and large, but because coordinated services, talking social, vocational, and psychological factors into account and using those tools that have been developed, are also lacking. The lack of rehabilitative services for the psychosocially disabled illustrates this point. Central city admission rates to public psychiatric hospitals are typically among the highest in each city. In this regard, Dr. Christmas points out that:

In black inner cities, these rates are not a true index of either prevalence or incidence of mental illness among black people, since they reflect the complex, interrelationships of racial discrimination, groups acceptability of deviancy, or lack thereof, of subgroups culture. Nevertheless, an unmet need exists for the development of rehabilitation services in inner cities for the large number of persons discharged each year from psychiatric hospitals. They are thrust out, unready for independent living, bearing the burden of institutionalization, the stigma attached to mental illness, and the loss through disuse, of whatever work skills they may once have had. ¹

PHILOSOPHY OF PSYCHOSOCIAL REHABILITATION

Because of the factors affecting particularly those who are both socially and economically disadvantaged and physically or mentally disabled, are so interwoven, intricate, and complex no single-faceted rehabilitative approach is appropriate to meet the needs. In addition to a multifocused emphasis, the situation requires, moreover, a different conceptualization both of the problem and of the solution. One approach that has proved effective in the social and vocational rehabilitation of persons with psychiatric disorders is that of psychosocial rehabilitation.

This approach was developed by the Harlem Hospital Center, Department of Psychiatry, Division of Rehabilitation Services, and has been implemented in programs conducted in Harlem Rehabilitation Center, its community based facility, located in the heart of the black inner city.¹

The psychosocial approach to rehabilitation addressed itself not only to individual educational and vocational potential and to skills development but also to economic, social, physical, and psychological factors that serve to enhance or deter the rehabilitative process.

¹Ibid., p. 93.
Psychosocial rehabilitation is characterized by the use of multiple, comprehensive, coordinated, interdisciplinary inventions directed toward aiding individuals to achieve productive, social, psychological, health, educational, and vocational roles within the limit of their capacities and potentialities, with recognition of their disabilities. The range of these interventions includes, but is not limited to therapists, activities, services, assistance, education, training, self-development, self-help and individual and group action. According to Dr. June J. Christmas, psychosocial rehabilitation is based on a number of underlying assumptions:

The first assumption places high value on the humanist orientation. Men and women are valued for their existence and for their efforts toward self-identity, recovery and actualization. Potential for personal growth is envisioned not only for recipients of service, but for the helper as well whose needs for fulfillment may be satisfied in part, by work well done. For a black inner city community, such a programmatic application of humanism has a special meaning, particularly when it is conceived as relating to improvement in human services.¹

In the social context of the black inner city, existing within a wider social system where racist practices lead to social and economic deprivation and political powerlessness for most blacks, the challenge of developing affective social and vocational rehabilitation services in the humanist framework is formidable. The difficulties and frustrations inherent in its implementation are numerous. In varying degrees, the worlds of black men and women in inner cities demonstrate some of the features characteristic of the larger society. Black men are affected in many ways. Unemployed, uneducated, and unwanted, they are deprived of goods and services, crowded in slums and ghettos, beset with a sense of marginality, and treated as less than marginal. Levine and Kantor describe psychosocial rehabilitation as a process,

Considering the marginality implicit in being black in a racist, white society; the marginality and restrictions resulting from poverty and a devalued imposed social position; and the marginality. Powerlessness, and anomie experienced as men and women recover from mental disorder.\(^1\)

Based on the intricate relationship between the need for individual change and social change, it seeks to mobilize the strength within the

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individual, the group and the community.

Research indicates that a second major assumption is that man and society are interrelated and interdependent. Thus, the corollary exists that the social, economic, physical and psychological aspects of individuals lives are interrelated. This relationship is particularly significant for persons who occupy positions of low are marginal social status, who experience continuing deprivation, or who occupy a devalued imposed social position such as mental patients, physically disabled people, poor people, and members of racial minorities such as blacks. Complicating social, economic, and political factors influence the course of psychiatric rehabilitation. Even when they are not a hindrance, their impact is considerable.

The framework of a social systems formulations assumes a belief in the malleability of personality and the alterability of conditions of the environment. Social systems of education, health, social welfare, and other social institutions are viewed as having a major role in contributing to the development of new social environment which in turn are restrictive to or facilitative of human development. Within this context, human services and social action are closely intertwined.

Much has been written and discussed around the idea that the dynamic developmental view of the nature of man is integrally linked with the
primacy of emphasis on change. Dr. June Christmas is one of the foremost advocates of this idea and explains the link in this manner:

These assumptions take into account man's past and present experiences; his view of his many selves, public, private, idealized image, the good me, the bad me, the self as seen by significant others; his intrapsychic world, his real world, his fantasy world, his hopes and aspirations; his relationships with others and with his environment; his conflicts, fears, defenses, and adaptive mechanisms; his need for autonomy; his dependence on meaningful relationships. They are not seen as fixed and unalterable, but, for each individual subject to varying degrees of modification through the vicissitudes of life experiences and through planned change experiences such as human service interventions, either of which may be therapeutic and growth-enhancing, or antitherapeutic and growth-reducing.¹

Rehabilitation services that accept this view of man, seek to foster and develop numerous positive change experiences, to increase psychological strengths and adaptive mechanisms, and to utilize environmental stress to aid individuals in their ability to cope successfully.

In looking at the concept of imposed social position, another underlying assumption, Dr. Eugene Pattison states that:

The development of the individual and of his potentialities can be assessed only in terms of the opportunities afforded him by the environment. Assessment of a given individual's development must be made only in terms of the degree to which he has been able to utilize the opportunity afforded by environment.

¹Ibid., p. 165.
The degree to which the individual's imposed social position has operated disadvantageously in precluding a chance for development, must be assessed and weighed.\textsuperscript{2}

For black men in America, a devalued imposed social position is the rule. Psychiatric illness, and socially unacceptable disorders such as alcoholism and drug addiction add an additional negative value. Poverty is the third burden borne by the typical inner city rehabilitant. Consequently, in assessing outcome and progress through a rehabilitative course, all of these factors are to be considered.

To be effective in rehabilitating inner city residents, both psychologically and socially, the psychosocial philosophies discussed thus far cannot be implemented effectively outside of the local community in a traditional dominant culture bound mode, by staff unacquainted with ghetto culture, resources, and strengths. It must be related to other services provided by the human services delivery system in a manner that ensues continuity of care and enhances rather than frustrates their availability, use and effectiveness.

PSYCHOSOCIAL REHABILITATION SERVICES

A survey of the mental health centers from which specific data is used in this paper indicates that in terms of services, the orientation framework is basically uniform. The elements essential to rehabilitation programs developed in keeping with the orientation are social, therapeutic, educational, vocational, and environmental. Each is social, in that human relationships are essential to its implementation.

In the social aspects, individual and group relationships are directed toward socialization, resocialization, and social learning. In the therapeutic features, the emphasis is upon therapeutic relationships, social learning, resolution of intrapsychic conflict, and interpersonal functioning. The educational emphasis focuses also on social learning as well as the skills development and acquisition of knowledge. The vocational element relates to skills development at a higher level, and to the learning of new social roles. The environmental emphasis relates to control over decisions affecting one's life, control of the environment, the development of potential for constructive action in the social context, and the increasing of life options and choices.
Within the framework of staff and patient members/clients acting as change agents in various social systems, group forces, goals, sanctions, leadership, norms, identification, and support, are used to mobilize the change potential in each individual and group.

This orientation also emphasizes dynamic social transactions directed toward restoring a previous state of social equilibrium or hopefully, assisting in moving toward a higher level of integration, toward learning more adaptive behavior and more constructive social roles, and toward acquiring an increased ability to relate to the familial and social environments.
PROBLEMS AND PROCESS

In the development of programs in psychosocial rehabilitation, there is acceptance of the responsibility to be not only in, but of the black community. This approach attempts within its own limitations to contribute to constructive individual and social change by the implementation of services and activities that may lead to alternatives to the continuing waste of human resources. But the path toward change is far from easy. Nor does it depend on simplistic solutions.

As Dr. June Christmas states:

The complicating factors that aid or interfere with the implementation of psychosocial rehabilitation, such unfortunate outcomes as the abandonment of progressional responsibility; the view of community participation as a panacea; retreat from a total service approach to a limited treatment emphasis; involvement with interdisciplinary rivalries rather than with the definition of the unique and generic qualities in each discipline; and the disillusionment that comes when social action yields short-term results that are emotionally gratifying, but gainfully disappointingly.¹

The writer suggests that other problems in addition to the ones previously mentioned, would grow out of the unique experience of black men

¹Ibid., p. 173.
within this country, influenced by the historical determinants of present day black life, the social reality, values and norms of that life, and the psychological, social, and economic effects of racism; poverty, segregation, discrimination, and deprivation.

In conclusion, evidence indicates that with each rehabilitative approach, the question must be raised as to whether this service will assist the individual toward a move constructive and potent role in family and in society. Yet, the effectiveness of service must be evaluated in terms of the total opportunity structure. If the wider society must be evaluated in terms of the total opportunity structure. If the wider society is so structured that it requires racism and poverty, high unemployment and restrictive labor unions, individuals gains in psychological strength, skills, and self-esteem accomplished through rehabilitation programs may be of little avail. The movement of disadvantaged persons into positions of greater social competence and power, requires action directed beyond individuals to wider social institutions, to alter them so that they can better meet human needs.
CHAPTER IV

SUMMARY AND CONCLUSIONS

Studies on mental disorders have suggested that a greater proportion of lower-class persons suffer from mental illness than higher status individuals. The methodology generally used by researchers in this area has been epidemiological, with hospitalization the most frequently used approximation or index of severe mental disorder. There is a good deal of evidence that many factors other than degree of illness influence whether one is hospitalized or not. Proximity to mental hospitals, labeling processes in the community, attitudes toward mental disorder, public versus private resources and agencies, alternatives available to upper stratum individuals, and outpatient services are some of the variables operative. Another factor frequently overlooked is that in treatment, persons whose backgrounds are grossly divergent from that of the psychiatrist (e.g., lower-class persons) tend to be seen by him as sicker than those whose attitudes and behavior are closer to his own outlook. Consequently, studies of true prevalence must deal with biases in
clinical classification due to subculture perspective, just as studies of treated prevalence must deal with biases in community and professional response.

In regard to black self-esteem, it must be recognized that cultural components in the black community, contribute to positive identity but are in direct contrast with identity. This matter assumes even greater importance when one realizes that interpretations of identity, self-concept, and self-esteem in black people are based on instruments developed by and for the white majority. The fact that instruments (MMPI, THURSTONE, etc.) used, are not objective lends unwarranted validity to the data drawn from them, since the role patterns used for categorizing these personality traits are drawn from white experiences and the majority frame of reference. Even when it is acknowledged by the researcher that experiences and cultural perceptions differ in black and white communities, conclusions are drawn that indicate no awareness of this reality. As a result, black manners of dress, walking, and socializing, black aspirations, black leisure-time activities, etc., are assessed as latent manifestations of some abnormality (mental), instead of functional adaptations to the cultural milieu that has evolved from the circumstances and opportunities available to ghetto dwellers. This rephrases and com-
pletely negates the common assumption that blacks, having been forced to function as an inferior in a society that places little value on him as a person and continually reinforces this negative image, has internalized these concepts of himself to such a degree that a positive self-concept is practically impossible.

In consideration of mental disorders as the deviate phenomenon, the findings were supported by the perception of a more open opportunity structure and higher goal striving stress among the downwardly mobile and high-status upwardly mobile population, compared to their non-mobile status peers.

Findings further indicate that mental health areas to be emphasized include causes and methods of combating prejudice, discrimination, stereotypes and racism, as there is a definite link between these areas and sound mental health.

Finally, community mental health centers must take special cognizance of the needs of those whose position in our society subjects them undue stress merely by reason of their status, while simultaneously limiting their access to resources which can assist them to enter the mainstream of American life.
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