Making The Most With The Time You've Got:
Eight (or so) "Myths" and Real Experiences In Human Service Systems

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Individuals, families, and communities involved in human service systems can get inducted into "myths" that even human service professionals believe. Lived experience, however, offers a challenge to these taken-for-granted beliefs. This presentation examined limitations inherent in many assumptions and explored more useful ways of thinking about people, problems, and solutions.

Preface

In the context of this presentation, "myth" was understood to mean *stories that organize systems of power*. This definition is meant to honor the contributions certain stories make to many cultures' ways of understanding life processes at the same time that it renders visible the socially constructed nature of professional ideas masquerading as truth.

In keeping with the ethical commitments informing this presentation, I invited participants to share their own lived experience in relation to the professional "myths" we explored, rather than receive the information as docile bodies, passively waiting to be

filled up with expert knowledge. They agreed to allow me to record their responses and include them in this paper.

Introduction

When engaging with human service systems, many individuals and families learn that their ways of experiencing themselves, the world, and their relationship to the world are somehow flawed or invalid. They then embark on a transformative journey that replaces their previous way of being with one claiming support from objective, neutral, and scientifically-supported facts. In essence, people learn that their knowledge about themselves is secondary to certain other people's privileged knowledge about them.

At the same time, people interested in working within mental health, juvenile justice, child welfare, education, and other human service systems often find that their natural proclivity to help others gets subverted by established policies, norms, and "professional" understandings. This can leave them feeling like they are not as helpful as they thought they would be and not working with the passion that brought them into the field.

Human service work is currently undergoing a progressive re-visioning, however, based on the premises that *all people have strengths*, *building on strengths makes more sense than focusing on deficits*, and *there are multiple ways of being in the world* (Swartz, 2004a). Participants in the presentation explored some taken-for-granted notions in the human service field and considered alternatives to assumptions that are often regarded as facts or truth.

Some of the "Myths"

Below is a selection of "myths" we talked about and questions we raised in relation to their privileged status. Participant contributions are noted in quotations. I have made minor changes—very minor—so their thoughts make sense in a paper format.

There are factual, unbiased, and objective theories that describe human behavior and development better than people's own experience.

- To what extent are people of color included in the pool of "subjects" studied that establishes "normal" human behavior and development? How about diverse genders and gender identities? Sexualities? Economic situations? Cultures? Spiritual traditions? Abilities? Wouldn't the context in which research takes place be relevant in relation to the author's personal life and family experiences, sources of funding, and time in history?

"We get that in education sometimes. I'm just thinking of when I took my human development classes. They say: this makes you do this, this makes you do this, this makes you do this. That doesn't always happen. For example, they say babies roll over at 4 months, my baby rolled over at 3 weeks. You can't determine guidelines for how people will act behaviorally."

"To believe otherwise would make life so much harder because you wouldn't know what to do with people...you wouldn't have a diagnosis so you couldn't treat them [laughter]."

Problems are located inside people.

- The dominance of a naturalistic and medical model of understanding human experiences has led to internalization of problems (Madigan, 1996). The target for change, then, has to be an individual person rather than, for example, a history of social injustice. How does locating problems inside people lead to pathologization of people's identities? How might a problem identity limit people's opportunities for growth and change? Alternatively, if we acted *as if* problems were located outside of people…

"Well then you can take those problems and turn them around."

"What you are doing is trying to take the shame and blame away from the person, as if they were having this problem on purpose."

"It gives the person more energy to resolve the problem. I mean if you're looking at *yourself* you're closed and if you're looking at *something else* you have more energy to go after it, you're moving forward."

Workers can be and should be neutral.

- Nineteenth and 20th Century notions of geographic nationalism have informed modern constructions of "boundaries" for professionals (Foucault, 1980). Yet human service workers are *always* engaged in a process of supporting people's current

experience of their lives (i.e., the status quo) or supporting alternative experiences. What possibilities for therapeutic connection are closed down by the ideal of a disengaged worker?

"I'm not sure how you can. I don't know how one can be neutral."

"Unfortunately, the 'care coordinators' in our program would say that they work with the family but they don't need to know them or become close to them."

Diagnoses are purely descriptions of clinical pathology.

- This disregards the real effects of historical diagnoses such as drapetomania, the tendency for African-American slaves to run from slave-owners; negritude, the tendency for African-Americans to have different colored skin—for which the only cure was to become white;[*] and homosexuality, which has only been absent from the *Diagnostic and Statistical Manual of Mental Disorders* for one generation(American Psychiatric Association, 1968). "Transvestic fetishism" and "gender identity disorder" persevere as mental illness diagnoses (American Psychiatric Association, 2000) despite significant progress gay, lesbian, bisexual, and transgender communities have made towards achieving social and political legitimacy.

"Culture" is defined by one's ethnicity.

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[*] This affliction was diagnosed by Benjamin Rush, who signed the Declaration of Independence and has been enshrined on the seal of the American Psychiatric Association (Jackson, 2002).

- How is it that so many constructions of "cultural competency" have come to be focused on race or ethnicity and make use of general and global prescriptions for how certain groups of people behave? In Terry Cross's (2004) keynote address at the *2002 Building on Family Strengths* conference, he noted the role that culture plays in "shaping who we are, how we make decisions, how we solve problems, how we conceive of the world around us, how we feel, how we have fun, and how we join together as families" (p. 4).

"I just found out today that I am a 'colored' person," [from a Native Hawai'ian].

"Culture is your life."

"How do 'white' people fit in? What is their culture?"

"I went into the hotel hair salon—the beauty supply store—and I was looking for something to put into my hair, and I couldn't find the products that I use. But the display was pretty, it just didn't have the products I use."

"I worked in the field of adoption and yes, I think that there are common cultural and ethnic experiences, but I think if you are a service provider and you go into it thinking this or that will always happen then you've already been prejudiced towards your client. When I worked in adoption there were a lot of women I worked with where I had to really work against the stereotype that Latino and African-American people do not

relinquish their children–they'll go through the process but they'll change their minds. And I had to always worry about how I went in to make sure that I wasn't projecting a stereotype like: this is wasting my time because you're going to change your mind. There were a couple women whose greatest concern about white women adopting their children was that they wouldn't be able to do their hair."

People's history of deficits, missed milestones, and failures are more important in doing an assessment than their strengths.

- While agency assessment forms are increasingly leaving space for "strengths," this part of the document is often overshadowed by the dominance of deficit-oriented information. What if assessments were thought of as interventions themselves, instead of a baseline from which to develop intervention strategies (Swartz, 2004b)? If at least an equal amount of time was spent in conversation about strengths, how might people see themselves as more skilled in responding to life events? How might we go beyond understanding strength as what someone is good at, and move toward rich descriptions of strength in relation to qualities, skills, abilities, dreams, hopes, values, and achievements?

"We grow from our strengths. We don't grow from our weaknesses. We don't build a stronger person out of what they do wrong, we build a stronger person out of what they do right."

"There don't seem to be any funding streams that work to build on people's strengths."

People should be identified by their diagnosis.

- At a training I attended on the technique known as Eye Movement Desensitization and Reprocessing (EMDR), the trainer referred to a presumed common experience amongst the professionals in attendance along the lines of, "We all know how difficult it is to work with borderline personality disorders." I thought to myself, "Now I've worked with people who have been given the diagnosis of 'borderline personality disorder,' but I don't recall ever working with the 'borderline personality disorder' itself." Someone diagnosed with cancer *is not cancer*. Someone struggling with Anorexia *is not Anorexia*. Why then do we refer to a child as "*being* ADHD"? Why do we call a young person "*a* truant," or an adult "*a* depressive" (Swartz, 2004b)?

"You can't say that someone with Asperger's, like me, is the same as someone else on the autistic spectrum."

"I'd prefer to just be a person."

"It just cuts you down when you are called a case."

"Our children who are in placement or who are incarcerated identify themselves as the labels that have been given to them. Why would we even bother to label someone when they have the types of challenges that brought them into care? We have other challenges

too, like we have gas, we've got colds, you know. We've got other things and we don't sit around and tell everybody 'I'm a cold case.'"

What's really important is psychological make-up, emotions, thoughts, and/or behavior.

- Each of these is the central focus of a different therapeutic tradition that has held a dominant position at one time or another in the last century. Each tradition has claimed its own construct as essential. But, as one participant said…

"We don't know what's really important. Maybe it's different for everybody."

Conclusion

Participants in this conference presentation wondered together what might become possible if services were grounded in alternative sets of professional stories. How might "clients" find services more useful? Would agencies and programs consider their work more effective? Maybe the experience of "empowerment" would be better facilitated? Might visits become more consistent and reliable? Perhaps workers would find themselves under the influence of stress less frequently and more connected to their original purposes for choosing this line of work?

Through exploring limitations of privileged professional assumptions and the possibilities that result from alternative understandings, individuals and families who seek services are able to step into a strong position of expertise in relation to their own lives. They are then able to partner with human service workers in joint efforts to establish clear preferences

for living, develop strategies for achieving these life preferences, and enlist support in re-connecting with local communities.

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