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## BEYOND RESILIENCE

*Blending Wellness and Liberation in the  
Helping Professions*

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Resilience typically implies the ability to cope with family and social adversity (Prilleltensky, Nelson, & Peirson, 2001). Although the adversity is deplored by helping professionals, they usually limit themselves to working with the family and consider the social problems to be beyond their scope. If all of us followed this reasoning, nobody in the helping professions would enact practices that challenge injustice. Instead, we would resign ourselves to deal with the victims of injustice, hoping to steel our clients before the next blow. But an increasing number of helpers are growing uncomfortable with the idea that all they can do is react to environmental assaults—they want to prevent them. Furthermore, they want to redefine resilience as the ability to not only cope with conditions related to adversity and injustice but also to challenge their very existence.

Indeed, helping professionals are struggling to promote a social justice agenda. Counselors,

psychologists, and social workers realize that their caring work is constantly undermined by conditions of injustice. At least for helpers working with marginalized populations, the injustice encountered by their clients has the power to undermine their caring work. Youth workers, for example, frequently do their utmost to empower young people and to instill in them a sense of control, only to realize early in the course of counseling that the environment in which marginalized youth live is much more powerful than the most sophisticated psychological intervention.

A growing number of professionals understand that caring in the proximal sense is insufficient in the absence of caring in the distal sense. Proximal caring is expressed within the confines of the counseling session, whereas distal caring is manifested in work to promote justice in the community. Without the latter, the former has meager chances of success. Without

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distal caring, in the form of challenging and changing unjust environments, proximal caring remains a humane but somewhat inadequate answer to the plight of the poor and the disadvantaged. Research has repeatedly demonstrated the effects of noxious environments on mental health (Carr & Sloan, 2003; McCubbin, Labonte, Sullivan, & Dallaire, 2003). From this perspective, promoting resilience has much to do with promoting social justice.

Helpers in the mental health field face a gap between their understanding of unhealthy environments and their ability to do something about them. Whereas the level of critique tends to be quite complex, the level of social justice practice tends to be quite embryonic. Critical psychologists, like other groups of critically oriented helping professionals in allied fields of practice, have been creating alternatives that go beyond the status quo and its critique. In this chapter, we introduce some lessons from critical psychology, a movement that promotes wellness and liberation *at the same time*. Here we recommend several steps for blending caring work with justice work in efforts to mitigate the risks that confront marginalized populations. To illustrate the application of these recommendations, we will discuss them in the context of people with physical disabilities.

There is commonality in the critique of counseling psychology put forth by Vera and Speight (2003) and Lewis, Lewis, Daniels, and D'Andrea (2003), of social work put forth by Mullaly (2002), and of psychology put forth by critical psychologists (Nelson & Prilleltensky, in press; Pare & Lerner, in press; Prilleltensky & Nelson, 2002; Sloan, 2000). Vera and Speight (2003) synthesize the shortcomings of an approach that pays lip service to cultural diversity and social justice but falls short of articulating emancipatory ways to practice. They enumerate the barriers to acting, not just thinking, justly. They point out that multicultural competencies must go beyond the recognition of oppression: A caring and competent practitioner ought to enact alternatives that not only identify but also, and primarily, reduce oppression.

Helping professionals have differing degrees of critical awareness. Some of them are indifferent to how their profession promotes the societal status quo. Others, in turn, are painfully aware

of how their professions blame victims for their misfortune. However mindful, the latter group is at a loss when it comes to creating alternatives. In the case of counseling, Vera and Speight perform an invaluable service for those who may be unfamiliar with psychology's support for an unjust state of affairs (Prilleltensky, 1994). They adroitly summarize the unwitting alliance between counseling psychology and the societal status quo. In this chapter, we heed their call for aligning our practice as helping professionals with the principles of social justice. We believe that progress can be made by (a) stressing the synergy of diverse values, (b) stressing the synergy between wellness and liberation, (c) learning from existing critiques within psychology and other fields, (d) promoting role reconciliation between the helping professional as healer and agent of change, and (e) adopting psychopolitical validity as a new measure for the evaluation of our social justice agenda. These five initiatives to make psychological interventions more influential in the sphere of social justice set the conditions for a broader and more contextually relevant environment in which wellness can take hold. As we will show, the roots of wellness (and resilience) are firmly anchored in the ground of socially just communities and processes.

### INTERDEPENDENT VALUES

No single value is comprehensive enough to address the entire range of human needs. Therefore, we judge values such as social justice, caring and compassion, and cultural diversity on their synergistic qualities, not on their isolated merits (James & Prilleltensky, 2002; Prilleltensky, 2001). Vera and Speight (2003) correctly point out that multicultural competence without social justice is insufficient. Table 6.1 organizes human needs and values into three separate spheres of wellness and liberation: personal, relational, and collective. If we concentrate solely on relational values such as cultural diversity and democratic participation, we run the risk of neglecting both personal and collective needs. Similarly, the historical focus of psychology on self-determination and health meant that little or no attention was paid to democratic participation,

cultural diversity, sense of community, or social justice (Fox & Prilleltensky, 1997). Vera and Speight are justifiably alarmed that if we concentrate on celebrating diversity without attending to power inequality and social injustice, we will undermine wellness and liberation, for they cannot exist but in the synergy created by the composite of values.

Historically, there is a propensity to concentrate on single values. Such proclivity is largely determined by dominant political and cultural ideologies. During conservative times, personal values of self-determination tend to be extolled, whereas principles of equality and justice come to the fore during progressive eras (Levine & Levine, 1992). It is our job to diagnose the mood of the times and realize what values we're missing from the equation. There is little doubt that psychology has absorbed the zeitgeist of the last three decades and concentrated on individual remedies for social maladies (Albee, 1990; Cushman, 1990; Fox & Prilleltensky, 1997; Prilleltensky, 1994; Sampson, 1983; Sarason, 1981). As Boyden and Mann show in Chapter 1, the preponderance of resilience research and theory that is focused more on the psychological development of individuals than on the social and cultural context in which individuals live exemplifies this trend. As a result, we have neglected social justice and support for marginalized communities at our peril.

However, there is also the current risk because our values extol respect for diversity above all else, even though cultural diversity cannot exist in the absence of social justice. All the values presented in Table 6.1 are codependent and interdependent. Extreme reliance on a single value undermines the existence of that very value, for it cannot thrive in the absence of others. We must be forever vigilant about what values are being privileged and what values are being ignored. There cannot be justice in the absence of compassion, and there cannot be compassion in the absence of justice. Striking a balance among values for personal, relational, and collective wellness and liberation is our most pressing task as professionals and citizens.

The values of self-determination, and social justice in particular, have been severely undermined for many people with disabilities. So long as the problems they encounter in their

daily living are attributed to the impairment itself, efforts to enhance wellness are conceptualized and enacted at the individual level alone. Those who require assistance with daily living often have to fight for control over what services they will receive, their mode of delivery, and who will assist them with the most intimate self-care tasks. The inability to carry out physical tasks unassisted is often taken as deficiency in the ability to make important decisions about one's life. Combined, such threats to control threaten individuals' capacities to overcome the multiple adversities they face coping with a disability, threatening their capacity to experience themselves as both resilient (for overcoming adversity) and well (for sustaining a quality of life).

Unfair distribution of power has implications not only for how independence is defined (in primarily physical terms) but for how it is actually enacted in various medical and rehabilitation settings. Much of the work carried out by counselors and occupational and physical therapists is focused on patients' ability to independently carry out activities of daily living or to come to terms with their inability to do so. Whereas most people would prefer to be as independent as they can in self-care, it is critical that this is not regarded as necessary for autonomous adult or child functioning. I, Ora, am reminded of a patient I worked with who had to negotiate with one of his treating therapists to convince the therapist that it was pointless for the patient to attend a breakfast group that had as its goal to make him capable of preparing his own morning meal. A stroke had left this man with significant physical impairments, although his cognitive functioning remained relatively intact. It was very clear to him that he would not be attending to his own breakfast at home given the time and energy that this required of him. Given the emphasis placed on physical rehabilitation, convincing his therapist of this was no easy task. The therapist insisted the man needed to learn this skill, overlooking the man's capacity to make judgments on his own course of rehabilitation. Making such decisions on behalf of others is what truly robs people of dignity and control over their lives.

Resilience stems, in part, from the capacity and opportunity to understand the role of adversity

**Table 6.1** Personal, Relational, and Collective Domains of Wellness and Liberation

<i>Domains</i>	<i>Wellness and Liberation</i>		
	<i>Personal</i>		<i>Collective</i>
	<i>Relational</i>	<i>Personal</i>	<i>Collective</i>
<b>Values</b>	Respect for human diversity	Health	Social justice
<b>Definition</b>	<p>Promotion of fair processes whereby children and adults can have meaningful input into decisions affecting their lives</p> <p>Promotion of people's ability to define themselves individually and collectively and to resist political, ideological, and cultural domination</p> <p>Protection of physical and emotional health and resistance to unhealthy personal, relational, and societal forces</p>	<p>Self-determination and personal growth</p> <p>Promotion of ability of children and adults to pursue chosen goals in life without undue oppression</p>	<p>Support for community structures</p> <p>Promotion of vital community structures that facilitate the pursuit of personal and communal goals</p> <p>Promotion of fair and equitable allocation of bargaining powers, obligations, and resources in society; and resistance to forces of exploitation and domination</p>
<b>Needs addressed</b>	<p>Identity, dignity, self-respect, self-esteem, acceptance</p> <p>Participation, involvement, and mutual responsibility</p>	<p>Mastery, control, self-efficacy, voice, choice, skills, growth and autonomy</p> <p>Emotional and physical well-being</p>	<p>Sense of community, cohesion, formal support</p> <p>Economic security, shelter, clothing, nutrition, access to vital health and social services</p>

SOURCE: Adapted from Prilleltensky and Nelson (2002).

in one's life and the role of individuals and groups to challenge systems of inequity and discrimination. Coping without challenging these systems may result in accepting the unacceptable.

## WELLNESS AND LIBERATION

The helping professions have traditionally concerned themselves with wellness, health, and well-being. Under the aegis of the medical model, psychology and psychiatry conceptualized problems in living in intrapsychic terms. *Mental health*, *wellness*, and most recently, *positive psychology* became choice metaphors. They all conjure images of people enjoying life, worry free and healthy. This is a most worthy goal, which we fully support. But as with any single value, wellness cannot stand by itself. Unless it is supported by fairness and equality, it is bound to fall. An extensive body of research documents the ill effects of inequality and disempowerment on health and wellness (Kawachi, Kennedy, & Wilkinson, 1999; Kim, Millen, Irwin, & Gersham, 2000; Marmot, 1999). The impact of poverty, marginalization, exclusion, exploitation, and injustice is just as deleterious on the body as it is on the soul (I. Prilleltensky, 2003a). To ignore this evidence is to pretend that our psychological interventions can be potent enough to undo the damage of structural inequality—inequality often expressed in deficient health services and employment opportunities for the poor. We can afford to be humbler. Our psychological interventions are not that powerful.

Wellness is a positive state of affairs, brought about by the simultaneous satisfaction of personal, relational, and collective needs. To meet these needs, we have to attend to power dynamics operating at micro, meso, and macro levels of analysis (Nelson & Prilleltensky, in press). Thus, wellness is intricately linked to empowerment. Empowerment, in turn, does not take place only at the personal level. Relational and collective empowerment support personal empowerment and vice versa (Kieffer, 1984; Lord & Hutchison, 1993). Power equalization must take place at all these levels if wellness is to be a resource available to those

marginalized by disability and other concurrent risk factors.

Liberation needs wellness as much as wellness needs liberation from oppressive forces. Liberation, like freedom, has two aims: liberation from and liberation to (Fromm, 1960). Whereas the former strives to eliminate oppression and abuse at the personal, relational, and collective levels, the latter seeks to pursue wellness for self and others.

People with disabilities have long struggled to attain wellness and liberation at the same time. They have claimed that disability is not a personal tragedy that requires medical solutions but, rather, a social issue requiring social intervention. They have decried the medical model of disability that regarded the problem as residing solely within the disabled individual. The focus on bodily abnormality meant that medically driven solutions were called for. Treatment was designed, implemented, and evaluated by a host of professionals, with the disabled individual having little input regarding the process. What could not be cured had to be rehabilitated, and what could not be rehabilitated had to be accepted. Psychological theories focused on the need to adjust to one's misfortune and make the best of a tragic and limited life. Those who did not despair despite their disability were often perceived as being in a state of denial (Oliver, 1996; Olkin, 1999) or, more positively, resilient, to use the word in the shallowest of ways.

People with disabilities have argued that it is society, rather than the impairment itself, that is the source of their disablement. The Union of the Physically Impaired Against Segregation in 1976 declared:

In our view, it is society which disables physically impaired people. Disability is . . . imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society. (Barton, 1998, p. 56)

Proponents of this alternative social model of disability have demonstrated the multiple ways in which people with disabilities are socially and economically disadvantaged. Being historically excluded from mainstream schooling,

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many did not attain the necessary skills to further their education and make them competitive within the job market. Some encounter discriminatory attitudes and a lack of willingness to make simple accommodations within the workplace. Those who require assistive devices, attendant care, or both often come up against paternalistic policies designed to retain professional control over resources. Physical barriers have also been a source of exclusion; public spaces were historically designed with able-bodied people in mind. A shortage of affordable accessible housing and inaccessible public transportation further marginalize people with disabilities (Barton, 1998; Morris, 1993; Olkin, 1999; Oliver, 1996).

In Ora's research on women with physical disabilities and motherhood, most participants reported that they did not envision that they would lead a life similar to nondisabled peers (O. Prilleltensky, 2003, 2004a, 2004b). One participant who spent most of her childhood in an institution described the difficulty in imagining an adult life beyond that setting: "You didn't see kids there leaving, or getting married, or having kids . . . they just left and you never heard from them again" (O. Prilleltensky, 1998, p. 118). At the time of the participants' birth some four decades ago, most of their parents were encouraged to institutionalize them (although few did), were told to expect little in the way of progress and growth, and were generally painted a grim picture of life with a disability. Not surprisingly, few parents expected that their children would lead typical adult lives and some ignored or actively discouraged their daughters' emergent sexuality.

Oliver (1990), a disabled academic in the United Kingdom, was one of the first people to talk about the social versus the individual model of disability. Along with other disability activists, he argued that the very term *disability* is about exclusion and disadvantage. For example, Oliver suggested an alternative format to a disability survey conducted by the Office of Population Census and Surveys (OPCS) in the United Kingdom. Whereas the standard version focuses on the impairment as the source of limitation, Oliver's version shifts the focus to disabling barriers and attitudes. Consider the following examples:

OPCS: "Can you tell me what is wrong with you?"

Oliver: "Can you tell me what is wrong with society?"

OPCS: "Do you have a scar, blemish, or deformity which limits your daily activities?"

Oliver: "Do other people's reactions to any scar, blemish, or deformity you may have limit your daily activities?"

OPCS: "Does your health problem/disability make it difficult for you to travel by bus?"

Oliver: "Are there any transport or financial problems which prevent you from going out as often or as far as you would like?"

The political action and struggle of disabled people around the world has resulted in significant progress. No longer willing to put up with inadequate resources and professional control, people with disabilities have collectively fought for economic, legislative, and social gains. In the United States, the formation of "independent living movements" in the 1960s and 1970s has been associated with greater individual autonomy as well as more political and economic freedom (White, in press).

The legislation of the American with Disabilities Act in 1990 has ensured that many of the aforementioned gains are not contingent on people's goodwill but are enforceable by law. For example, it is illegal to discriminate against a worker based on disability status, to hold a civic gathering at an inaccessible venue, or to fail to accommodate the needs of a disabled patient at a health clinic.

Although there is still a long way to go, there is little doubt that these practical gains in legislation, economic resources, and social participation, do go a long way toward the enhancement of wellness. Furthermore, the new focus on disabling societal barriers and systematic powerlessness has done much to improve the self-esteem and well-being of people with disabilities (Morris, 1993; Oliver, 1990; Shakespeare, 1998; White, in press). Combined, these changes go a long way toward creating the conditions in which people with disabilities can achieve health. These structural changes

contribute to an individual's being seen by others and himself or herself as resilient. Consider the following quote of a disabled activist in the United Kingdom who describes the impact that the social model of disability has had on her life:

My life has two phases: before the social model of disability, and after it. Discovering this way of thinking about my experiences was the proverbial raft in stormy seas. . . . For years now this social model has enabled me to confront, survive, and even surmount countless situations of exclusion and discrimination. . . . It has played a central role in promoting disabled people's individual self-worth, collective identity, and political organization. I don't think it is an exaggeration to say that the social model has saved lives. (Crow, 1996, pp. 206–207)

It is worth reexamining the concept of resilience in light of the empowering experiences of persons with disabilities. The claim can be made that Crow and other activists became more resilient precisely because they challenged the status quo and not because they learned how to cope with it. In fact, related research on empowerment demonstrates that participating in social actions enhances sense of control, a key component of resilience and mental health (Kieffer, 1984; Prilleltensky, Nelson, & Peirson, 2001).

### INSULARITY AND ACTION

Helping professionals cannot afford to ignore critiques such as this that are occurring in a number of related fields. The field of critical psychology has been struggling with how to promote a social justice agenda in ways that parallel the concerns raised by Vera and Speight (2003) in counseling and by Mullaly (2002) in social work (Fox & Prilleltensky, 1997; Prilleltensky & Nelson, 2002; Sloan, 2000). Prilleltensky and Nelson (2002), for instance, proposed means of promoting a social justice agenda in psychology. They made specific recommendations for working critically in school, health, counseling, clinical, work, and community settings. Community psychology has also been highly influential in fostering social change, prevention, cultural diversity, and

empowerment for the last four decades (Nelson & Prilleltensky, in press; Newbrough, 1992, 1995; Prilleltensky, 2001; Rappaport, 1987). Disciplinary boundaries and the insularity that results sometimes prevent fruitful explorations of similar agendas.

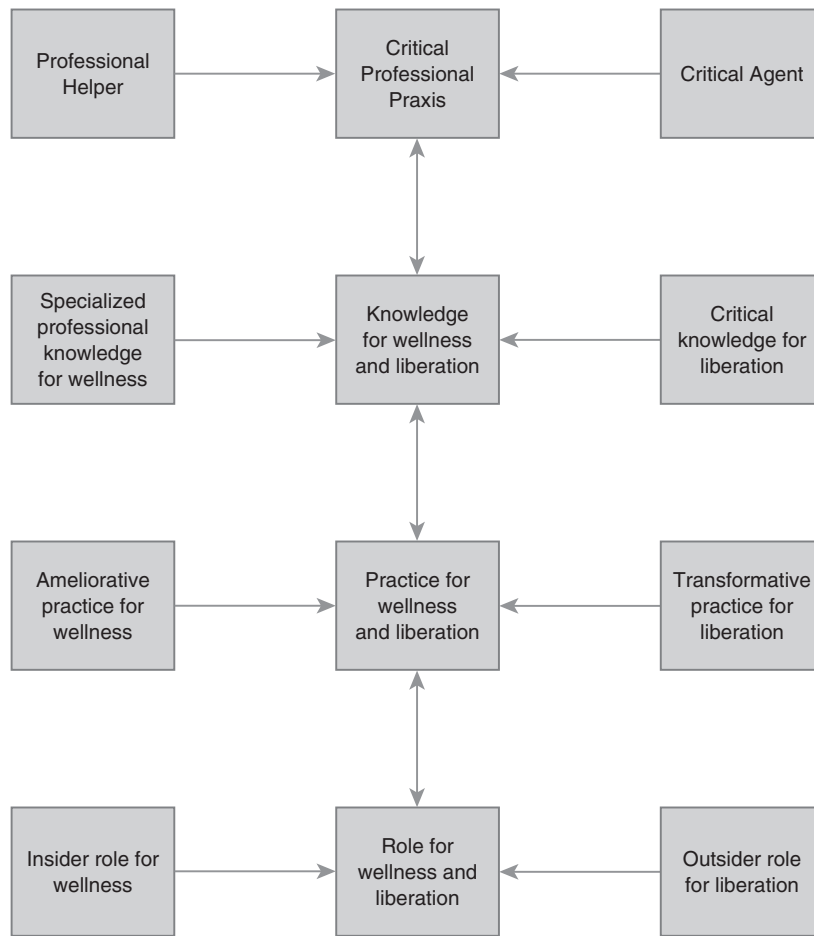
Psychology in particular cannot afford to ignore critiques of the helping professions and the societal status quo mounted by people with disabilities (Oliver, 1990), by consumer/survivors of the psychiatric system (Nelson, Lord, & Ochocka, 2001), by sexual minorities (Kitzinger, 1997), and by other disciplines (Fox & Prilleltensky, 1997). As psychologists, our ability to see beyond our own psychological glasses is limited. Just as we need to expand our definitions of wellness to incorporate other cultural perspectives, we need to listen to critiques of psychology raised by nonpsychologists.

But the problem of insularity goes beyond critique: It affects action as well. We should heed Audre Lorde's dictum: "The master's tools will never dismantle the master's house." People with disabilities did not achieve the rights they did because of professionals. Often, it is in spite of professionals that people with disabilities and other marginalized groups make progress toward wellness and liberation (Oliver, 1990). If we are to make progress toward social justice, we need to create alliances with the people we wish to help (Nelson, Prilleltensky, & MacGillivray, 2001). Much can be learned from social movements and consumers' movements in their efforts to declassify homosexuality as an abnormality, to obtain access to public buildings and transportation, or to overcome the stigma of mental illness (Nelson & Prilleltensky, in press). These actions, we claim, will not materialize until counselors reconcile their roles as healers with their role as change agents.

### ROLE RECONCILIATION

If helpers respond to the call for action, as we hope they do, they will pretty soon face a dilemma: how to reconcile their various roles as professional helpers on one hand and agents of social change on the other. Hitherto, we have not articulated how these two sets of knowledge, practices, and roles work in synergy for the

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**Figure 6.1** Knowledge, Practice, and Roles for critical professional Praxis in Mental Health Practice

SOURCE: Adapted from Prilleltensky and Prilleltensky (2003b).

promotion of wellness and liberation. Here we propose ways of melding professional and critical praxis (Prilleltensky, 2001; Prilleltensky & Nelson, 2002; Prilleltensky & Prilleltensky, 2003a, 2003b). Our challenge is to find ways of reconciling the two sets of skills and aims. From the perspective of the *professional helper*, whether a psychologist, social worker, or other helping professional, being a critical practitioner means seeking answers to three important questions:

1. How does our special *knowledge of wellness* inform our social justice work?
2. How does our *ameliorative practice* inform our transformative practice?

3. How does our *insider role* as wellness promoter in the helping system inform our outsider role as social critic?

From the perspective of the *social change agent*, the critical practitioner needs to address the following issues:

1. How does our knowledge of inequality and injustice inform our counseling work?
2. How does our *transformative practice* in society inform our ameliorative work in the helping system?
3. How does our *outsider role* as social critic inform or relate to our insider role?



We argue that reconciling these diverse roles would promote the dual goals of wellness and liberation, both equally important contributions to the resilience experienced by individuals and their communities. Whereas the former is the primary domain of the professional helper, the latter is the main concern of the critical change agent (Nelson & Prilleltensky, in press). Ora's work on women with disabilities and motherhood (O. Prilleltensky, 2004a, 2004b) provides some practical examples of this reconciliation of roles. For example, the professional helper informed by a critical perspective can encourage girls and young women with disabilities to explore the impact of negative societal messages pertaining to sexuality and disability. This process of conscientization can result in de-blaming and may also lay the foundation for taking a stand against oppression. At the same time, transformative work in the community can be directed at changing restrictive and oppressive concepts of female sexuality and motherhood. Narrow conceptions of motherhood limit the scope of available resources for women who are confronted with the adversity associated with having a disability. Better, we think, to understand that different types of mothering require different types of resources. An expanded notion of motherhood (to include women with disabilities) would naturally lead to a wider definition of acceptable resources.

Wellness and liberation exist in a dialectical relationship. Without liberation, many oppressed people cannot experience wellness, and without wellness, there is no superordinate goal for liberation. Our objective is to blend the two so that our various roles and skills attend to emancipation and quality of life at the same time. Figure 6.1 describes the amalgamation of knowledge, practices, and roles of the professional helper on one hand and the critical agents of change on the other.

The argument can be made that professional helpers cannot research or know in-depth all aspects of wellness and liberation. We agree that interdisciplinary research and action is vital. But it is entirely possible to have interdisciplinary research and action that supports the status quo. This is why we need critical knowledge of how power and inequality play a role in counseling and mental health (Habermas, 1971). If we were

to stay at the level of individual wellness alone and were not to consider the impact of inequality, disadvantage, and oppression or were to leave these political domains to others, we would not be as effective as we might in our individual work because we would obviate the role of power in mental health. There is a need to incorporate critical insights into our daily working routine.

The type of knowledge we pursue has been well articulated by Aristotle and recently revived by Flyvbjerg (2001). *Phronesis* is the type of practical knowledge that combines scientific understanding with political wisdom. It is an applied type of knowledge that seeks understanding in context—contexts that are perpetually suffused by power differentials and inequality. What we seek, in Habermas's words, is knowledge for emancipation.

With respect to practice, we need to articulate how the various roles would be manifested in the actual day-to-day practice of helpers and community workers. Prilleltensky and Nelson (2002) and Murray et al. (2001) have proposed ways of blending the transformative role with the ameliorative task. For us, transformation refers to system change, whereas amelioration refers to individual or reformist change that leaves the sources of the problem unaffected. There are in fact many ways to advance the transformative impulse and critical knowledge in the helping professions (Prilleltensky & Prilleltensky, 2003b). Some potential avenues include the following:

- Creating awareness among colleagues about how power differentials get enacted in interactions with clients seeking counseling
- Forming research and action groups in the workplace to explore how practices may be more empowering of clients
- Increasing political literacy of community members to empower them to scrutinize the practices of helping professionals
- Establishing practices that enable participation of clients, patients, and community members in the management of human services
- Connecting with poor communities and partnering with them in raising the level of public health, advocating for more resources, protesting tobacco advertising, boycotting sexist advertising and others.

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As insiders within the health and helping system, psychologists and other professionals face many barriers and limitations. Although they may be aware of many oppressive policies and practices, they may be constrained in their ability to act. Outside critics, in turn, may feel free to point to shortcomings but may not have the inside knowledge of how systems work or why some practices that may seem unnecessary from the outside may be well justified from the inside.

Whereas the pull for the professional helper is for amelioration, wellness, and the prevention of institutional unrest, the pull for the critical change agent is for transformation, liberation, and disruption of unjust practices. For critical professional praxis to emerge, these two roles need to exist in tension and synergy, not in opposition. If wellness and liberation are to emerge, we need specialized knowledge as much as political knowledge, ameliorative therapies as much as social change, and people working inside the system as much as people confronting it.

### PSYCHOPOLITICAL VALIDITY

How can we make sure that our research and action live up to the ideals presented by Vera and Speight (2003), Mullaly (2002), Prilleltensky and Nelson (2002), and others? This is a question of importance to critical practitioners concerned with the promotion of social justice in the mental health field. To address this concern, I, Isaac, have recently suggested the introduction of *psychopolitical validity* as a tool for the promotion of wellness and liberation (I. Prilleltensky, 2003b, in press).

This type of validity is built on two complementary sets of factors, psychological and political: hence, *psychopolitical*. This combination refers to the psychological and political influences that interact to promote wellness, perpetuate oppression, or generate resistance and liberation. Psychopolitical factors help explain suffering and well-being. At the same time, this combination of terms denotes the need to attend to both sets of factors in our efforts to change individuals, groups, and societies. As a result, we propose two types of psychopolitical validity:

(a) epistemic and (b) transformational. Whereas the former refers to using psychology and politics in understanding social phenomena, the latter calls on both sets of factors to make lasting social changes.

We pay equal attention to psychological and political factors. Psychological factors refer to the subjective life of the person, informed by power dynamics operating at the personal, interpersonal, family, group, and cultural levels. Political factors, in turn, refer to the collective experience of individuals and groups, informed by power dynamics and conflicts of interest at the interpersonal, family, group, community, and societal levels. In both sets of factors, we emphasize the role of power in the subjective or collective experience of people and groups.

Psychopolitical validity, then, derives from the concurrent consideration and interaction of power dynamics in psychological and political domains at various levels of analyses. Hence, we can talk about psychopolitical validity when these conditions are met. When this type of analysis is applied to research, we talk about *epistemic psychopolitical validity*. When it is applied to social interventions, we talk about *transformational psychopolitical validity*. To illustrate these concepts, we refer you to Tables 6.2 and 6.3, respectively.

To understand issues of well-being, oppression, and liberation at the personal, relational, and collective domains, we turn our attention to Table 6.2. Each cell in the table refers to issues of power and their manifestation in political and psychological spheres. Needless to say, this table is not exhaustive or inclusive of all fields in the helping professions. Rather, it concentrates on the priorities of wellness and liberation, two issues we regard as crucial.

Table 6.2 may be used to guide our commitment to emancipatory research. Furthermore, it may be used as an accountability device. We can monitor the extent to which we study the priority areas described in the table. In a sense, these guidelines serve the function of a vision—a vision of what type of research we need to pursue.

Epistemic validity depends on the incorporation of knowledge on oppression into all research and action in mental health. This means accounting for power dynamics operating at

**Table 6.2** Guidelines for Epistemic Psychopolitical Validity

<i>Concerns</i>	<i>Domains</i>		
	<i>Collective</i>	<i>Relational</i>	<i>Personal</i>
Well-being	Accounts for role of political and economic power in economic prosperity and in creation of social justice institutions.	Studies the role of power in creating and sustaining egalitarian relationships, social cohesion, social support, respect for diversity, and democratic participation in communities, groups, and families.	Studies role of psychological and political power in achieving self-determination, empowerment, health, personal growth, meaning, and spirituality.
Oppression	Explores role of globalization, colonization, and exploitation in suffering of nations and communities.	Examines the role of political and psychological power in exclusion and discrimination based on class, gender, age, race, education, and ability. Studies conditions leading to lack of support, horizontal violence, and fragmentation within oppressed groups.	Studies role of powerlessness in learned helplessness, hopelessness, self-deprecation, internalized oppression, shame, mental health problems, and addictions.
Liberation	Deconstructs ideological norms that lead to acquiescence and studies effective psychopolitical factors in resistance.	Studies acts of solidarity and compassion with others who suffer from oppression,	Examines sources of strength, resilience, solidarity, and development of activism and leadership.

SOURCE: Adapted from I. Prilleltensky (in press).

psychological and political levels in efforts to understand phenomena of interest. The following questions might guide the pursuit of epistemic psychopolitical validity:

1. Is there an understanding of the impact of global, political, and economic forces on the issue at hand?
2. Is there an understanding of how global, political, and economic forces as well as social norms influence the perceptions and experiences of individuals and groups affected by the issue at hand?
3. Is there an understanding of how the cognitions, behaviors, experiences, feelings, and perceptions of individuals, groups, and entire communities perpetuate or transform the forces and dynamics affecting the issue at hand?
4. Is there an appreciation of how interactions between political and psychological power at the personal, relational, and collective levels affect the phenomena of interest?

Table 6.3 integrates levels of intervention with key concerns for mental health: well-being, oppression, and liberation. This is a vision of

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**Table 6.3** Guidelines for Transformational Psychopolitical Validity

<i>Concerns</i>	<i>Domains</i>		
	<i>Collective</i>	<i>Relational</i>	<i>Personal</i>
Well-being	Contributes to institutions that support emancipation, human development, peace, protection of environment, and social justice.	Contributes to power equalization in relationships and communities. Enriches awareness of subjective and psychological forces preventing solidarity. Builds trust, connection, and participation in groups that support social cohesion and social justice.	Supports personal empowerment, sociopolitical development, leadership training, and solidarity. Contributes to personal and social responsibility and awareness of subjective forces preventing commitment to justice and personal depowerment when in position of privilege.
Oppression	Opposes economic colonialism and denial of cultural rights. Decries and resists role of own reference group or nation in oppression of others.	Contributes to struggle against in-group and out-group domination and discrimination, sexism, and norms of violence. Builds awareness of own prejudice and participation in horizontal violence.	Helps to prevent acting out of own oppression on others. Builds awareness of internalized oppression and role of dominant ideology in victim blaming. Contributes to personal depowerment of people in position of privilege.
Liberation	Supports networks of resistance and social change movements. Contributes to structural depowerment of privileged people.	Supports resistance against objectification of others. Develops processes of mutual accountability.	Helps to resist complacency and collusion with exploitative system. Contributes to struggle to recover personal and political identity.

SOURCE: Adapted from I. Prilleltensky (in press).

preferred interventions. We would show high degrees of commitment and accountability to the extent that we pursue these interventions. As a monitoring system, Table 6.3 helps to keep track of our actions. Are we intervening primarily at the personal level? Do we focus too much on oppression to the neglect of liberation and well-being? Have we neglected the collective domain?

Whereas epistemic validity refers to our understanding of psychopolitical dynamics of oppression, transformative validity demands changes toward liberation at personal, interpersonal, and

structural domains. The following questions attend to transformative validity:

1. Do interventions promote psychopolitical literacy?
2. Do interventions educate participants on the timing, components, targets, and dynamics of best strategic actions to overcome oppression?
3. Do interventions empower participants to take action to address political inequities and social injustice within their relationships, settings,

communities, and states and at the international level?

4. Do interventions promote solidarity and strategic alliances and coalitions with groups facing similar issues?
5. Do interventions account for the subjectivity and psychological limitations of the agents of change?

Explicit political aims have often been advocated for but infrequently acted on in mental health. Transformative validity may serve to remind us that political literacy and social change have to be part of all interventions. We seek not only to ameliorate social conditions but also to alter the configurations of power that deprive citizens of their rights (Prilleltensky & Nelson, 2002). In so doing, we create the conditions for resilience to be nurtured and to flourish. Our worry is that we too easily psychologize the successful growth of individuals, those with or without disabilities. We have failed to investigate the conditions—social, political, and structural—that must necessarily exist to support wellness and resilience. Using the benchmarks of epistemic and transformative psychopolitical validity, we believe, offers the field of mental health (researchers and practitioners alike) a way in which to conceptually broaden the scope of their work to account for a nonindividualizing health discourse. That discourse has been thus far lukewarm to a more contextual understanding of health phenomena.

## CONCLUSION

People affected with physical disabilities and psychosocial problems are better off when they demonstrate resilience as evidenced by successful ways of coping. But resilience must go beyond being a phrase limited to understanding how individuals cope with adversity. It must entail a challenge to the very structures that create disadvantage, discrimination, and oppression. This is not to pile more responsibilities on people who already experience challenges in their lives. Rather, it is a call to action for people with and without disabilities and for those who advocate with them for a more caring and just

society to create the conditions for resilience to be experienced. Their own participation, along with mental health and community workers, in challenging injustice can do much to enhance resilience. Professionals cannot stand back and hope that personal resilience will emerge from their therapeutic interventions alone. Community change, not just personal change; political change, not just psychological change; and justice, not just caring, are all urgently needed.

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