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Critical Psychology Foundations for the Promotion of Mental Health

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Abstract. The aim of this paper is to apply the conceptual and practical resources of critical psychology for the promotion of mental health. The paper consists of three main sections. The first section, dealing with foundations, presents the moral values that form the core of critical psychology, as well as the epistemological tenets that inform its practice. The second section reviews conceptual resources such as conceptions of the good life and the good society, as well as professional definitions of mental health and applied ethics. A review of practical tools for implementing the values of critical psychology complements the discussion on conceptual resources. The final part of the paper concerns the application of critical psychology principles in the practice of school/educational, community, and clinical psychology.

Key words: values, practice, mental health, school, clinical, community

> I agree with the tenets of critical psychology, but how do I put them into practice? Critical psychology makes sense, but what are its implications for clinical psychology? I feel that my work as a school psychologist reinforces an oppressive institution - how can critical psychology help?

These are legitimate questions that critical psychologists face. Implied in them is the call for praxis: for articulating the practical application of critical theories. This paper is concerned with this challenge. As such, it is an attempt to translate the moral, epistemological, and conceptual foundations of the field into practice. Following a review of critical psychology`s main tenets I illustrate their applicability in the areas of school/educational, clinical, and community psychology.

Critical psychology concerns itself with society as much as with psychology. Indeed, it is critical of society as much as it is critical of psychology. Critical psychology locates itself at the nexus of society and the profession of psychology. This movement is premised on four basic assumptions: (a) that the societal status quo contributes to the oppression of large segments of the population, (b) that psychology upholds the societal status quo, (c) that society can be transformed to promote meaningful lives and social justice, and (d) that psychology can contribute to the creation of more just and meaningful ways of living. If we accept these premises, we are not only critical psychologists but, most importantly, critical citizens. In our inseparable roles as critical psychologists and critical citizens, we are concerned with the lack of social justice and how psychology masks social injustice, we are perturbed by the lack of caring and compassion for the disadvantaged and by psychology`s indifference to them, and we are disturbed by the deterioration in the quality of life of millions of people and by psychology`s apathy towards them. In our inseparable roles as agents of social and professional change, we should strive to create a psychology that works for, and not

against the oppressed (Braginsky and Braginsky, 1974; Fox and Prilleltensky, 1997; Ibáñez and Íñiguez, 1997; Martín Baró, 1994; Parker and Spears, 1996, Sullivan, 1984; Tolman, 1994).

Foundations of Critical Psychology

Moral Foundations

The moral foundations of critical psychology derive from an integration of the voices of community members, moral and political philosophers, social researchers, and practical philosophers. The values of critical psychology should reflect what people in position of disadvantage need and want. Values should be grounded in the context of the daily living realities and subjectivity of the people with whom we wish to establish bonds of solidarity. But the values expressed by community members themselves require moral and political scrutiny, for even though they are an expression of what people wish, some social groups have been known to wish upon others reprehensible things. Hence, the need for interrogation of what people want, regardless of their social location of privilege or disadvantage. Much like wealth does not confer moral superiority, disadvantage does not grant righteousness.

Critical psychology needs the tools of moral and political philosophy to inspect the ethical foundations of different social values. In addition, it needs to rely on social research because it explores what values people endorse and why. Finally, critical psychology depends on practical philosophy because it is the application of values in particular contexts. Practical philosophers strive to promote the good society by implementing sound social values. Practical philosophers can be considered all the citizens, professionals and social agents who struggle to put into practice the social values prescribed by moral philosophers and validated by social scientists as meeting the needs of a particular population. These social agents have invaluable knowledge about the contextual challenges involved in fostering the good society (Halberstam, 1993; Kane, 1998; Singer, 1993; Toulmin and Gustavsen, 1996).

The values I propose for critical psychology derive from these complementary sources. I hope these diverse and complementary resources manage to avoid narrow visions of social values that are based either on de-contextualized philosophical abstractions or on political interests devoid of ethical justification.

No single list of values can be comprehensive enough to reflect the prerequisites for the good or just life, or the good or just society. We are, by necessity and by nature, limited in what we can say about desired values at any point in time. Our social location, our personal horizon, and our own subjectivity impose restrictions in what we can propose (Burman et al., 1996; Richardson and Fowers, 1998; Henriques, Hollway, Urwin, Venn, and Walkerdine, 1984; Gordo López and Linaza; 1996). The best we can do is take into account the values prescribed by community members, researchers, philosophers, and critical theorists and apply them judiciously for the benefit of those who suffer from social injustice. This type of analysis has led me to identify three types of inter-related and complementary values (Prilleltensky, 1997).

Personal Values. These are values that serve the needs of the individual. Self-determination and personal health represent principles that advance the well-being of the private citizen. Self-determination or autonomy refer to the ability of the individual to pursue chosen goals without excessive frustration; while personal health is a state of physical and emotional well-being that is intrinsically beneficial and extrinsically instrumental in pursuing self-determination.

Social Values. Social values complement individual aims, for the attainment of personal objectives requires the presence of social resources. Distributive justice, or the fair and equitable allocation of bargaining powers, resources, and obligations in society, is a prime example of a social value. Another social value is support for societal structures that advance the well being of the entire population. Among others, we can readily mention public services, like health and education, that attend to the needs of the entire population. Sense of community and solidarity is yet another social value that is needed to pursue both the good private life and the good society.

Mediating Values. Individual aims need to be harmonized with social aims. Mediating values such as collaboration and democratic participation ensure that private and collective goals be achieved in tandem and not at the expense of one another (Habermas, 1990). Surely too much self-determination is bound to conflict with social justice. When self-determination degenerates into individualism, it is important to invoke values that restrain the pursuit of hedonistic objectives that come at the expense of other people. Respect for human diversity is another mediating value. This principle seeks coherence and harmony without violating the identity of minorities (Fowers and Richardson, 1996; Taylor, 1992; Young, 1990).

Good and just societies cannot thrive in the absence of any of these three groups of values. The absence of social values leads to the individualism we are all too accustomed to in the west, whereas the absence of personal rights is conducive to dissatisfaction with collective regimes. A most delicate balance between personal and collective values is needed to promote a society in which the good and just life is not counter-indicated with the good and just society. This is why it is imperative to pay attention to the mediating values and processes that are supposed to bring a measure of peaceful co-existence among groups with varied interests.

In summary, the moral foundations of critical psychology rest upon personal, social, and mediating values informed by grounded knowledge of what people need and want, and by philosophical analyses of these wishes. What we have is a dual dialectic between the personal and the social and between subjective desires and dispassionate justification of values. Indulging in one extreme of either dialectic will result in a skewed and incomplete picture of values.

Epistemological Foundations

Unlike positivist conceptions of social and behavioural sciences which regard knowledge as the accumulation of objective facts devoid of personal and political interests, critical psychology acknowledges the inevitable role that subjectivity and power play in research. Although some researchers wish psychology could render `neutral empirical

and theoretical truth,` (Kendler, 1993: 1046), such ideal is unattainable. The very terms we use to frame the subject matter are socially constructed (Ibáñez, 1996). This is not to say that all research is equivalent to personal predilections, but rather that scientific work is embedded in a complex web of professional and political circumstances that make it impossible to claim supreme and detached objectivity. Critical psychology does not relinquish the pursuit of clarity and distinction between investigators` subjectivity and data gathered in research; it simply asserts that we should be cognizant of the forces limiting our ability to claim truth, for the very definition of what is truth is culturally predetermined. Researchers cannot transcend their cultural horizons - their cognitive frameworks are shaped by the particular training privileged at a specific historical moment. As a result of this understanding, critical psychologists assume a more modest stand with respect to knowledge claims, a stand that admits the social construction of scientific statements.

The rigid division between facts and values, heralded by positivists as a major achievement of modern science, prevented social researchers from even acknowledging the presence of values in their work. Critical psychologists seek to obtain knowledge that is sensitive to the personal, political, and cultural contexts in which data are gathered and interpreted. The result of the critical stance is not to renounce the search for valid knowledge, but rather to attain a more sophisticated perception of what is knowledge and how it is bound with power and history (Serrano, 1996). Others have elucidated the methodological pluralism needed to approximate this epistemological standard (Burman and Parker, 1993; Kidder and Fine, 1997; Gordo López and Linaza; 1996; Parker, 1992; Richardson and Fowers, 1998).

Once we accept that research cannot be value-free, the question remains to what end is knowledge to be used. Should knowledge be pursued for its own sake, or should it be subservient to explicit moral and political goals. I submit that critical research should be used at the service of the oppressed. This rather radical position maintains that resources should be used not just to satisfy academic curiosity but rather to help people in need. Critical knowledge is to serve people, not to play some modern or postmodern game devoid of political objectives. This is how critical psychology differs from traditional and some postmodern approaches to science, in its explicit pursuit of knowledge for social justice (Prilleltensky and Gonick, 1994).

What I propose for critical psychology is a committed epistemology. Science has been a tool for domination; the time has come to use knowledge for liberation (Bulhan, 1985; Martín Baró, 1994; Montero, 1992).

Resources for Critical Psychology

Conceptual Resources

Critical psychology is founded on a series of social and disciplinary postulates. Clarity with respect to these basic concepts should facilitate the implementation of the values discussed earlier. Critical psychology differs from mainstream psychology in its conception of the good or just life, the good or just society, and the societal status quo (Parker and Spears, 1996; Prilleltensky, 1994).

Mainstream psychology`s view of the good life is based on individualism and acceptance of the capitalist ideal of the consuming citizen (Sampson, 1983; Sarason, 1981). Consumerism, hedonism, and the pursuit of wealth is the ideal life promoted by the media, an ideal reinforced by psychologists. Critical psychologists would advance a conception of the good and just life that is based on reciprocal self-determination. That is, a vision of the individual citizen striving to attain personal goals in consideration of the needs of others and of the community as a whole. This concept is predicated on a good or just society based on mutuality, democracy, and distributive justice. This is in stark contrast to regnant notions that the good society *is* the capitalist society, the social organization that lets the market (i.e., the powerful corporations) decide who is to prosper and who is to suffer, who is to benefit from globalization and who is to lose a job because of it (Korten, 1995; McQuaig, 1998).

Critical psychologists oppose the societal status quo because it singularly promotes personal values, and only for a privileged few. The powerful are not invested in promoting either social or mediating values, but only personal values, and only for themselves. The societal status quo, in its present form, is fundamentally inimical to the promotion of values espoused by critical psychologists.

Explicit professional practices and assumptions help to further define the field of critical psychology. In critical psychology, mental health problems are framed in holistic terms that take into account the psychological, social, and economic circumstances surrounding the person`s life (Hare-Mustin and Marecek, 1997; Prilleltensky, 1994). Mental health problems are examined in light of social and interpersonal factors oppressing and disempowering the individual.

Critical psychology interventions strive to equalize power in a person`s life and in society as a whole. Psychology is to pursue justice in the person`s life and in societal structures at the same time. The role of power and disadvantage in micro and macro social contexts is taken very seriously. Restoring a measure of personal control is seen as paramount in the ascendancy of personal dignity and self-respect (DeVaris, 1994; Mack, 1994).

This professional view of mental health problems is vastly different from mainstream conceptions that look for and successfully locate pathology within the person or within the family (D. Cohen, 1990; 1994; Pilgrim, 1992). The search for personal deficits culminates, naturally, in person-centred interventions devoid of attention to power structures. These strategies lead, in turn, to victim-blaming definitions.

While critical psychologists acknowledge the biological sources of various forms of psychological suffering (Research and Education Association, 1995), they oppose the exclusive use of psychotropic medications to treat them. The organism responds to external conditions. Alleviating social sources of anguish must complement biochemical treatment. Caution should be exercised to engage in neither biological nor sociological reductionism.

Critical psychology advocates for the active participation of clients in the helping process; not just in following a prescribed treatment, but in the very definition of their

needs and formulation of action plans. The helper is expected to truly collaborate with the user of services and not just impart expert advice. Power is to be shared and not arrogated by the professional or delegated to him or her by the client (Prilleltensky and Nelson, 1997).

Professional ethics is a critical arena for critical psychology (Brown, 1997). In my view, recipients of services should contribute to the very definition of what constitutes ethical behaviour in the helping relationship. Applied ethics should be transparent to the client and not shrouded in professional jargon. Dominant conceptions of professional ethics serve first and foremost the interests of the professional. The current language of applied ethics does not leave room for challenging authority of for allowing the voice of the client to be heard (Prilleltensky, Rossiter, and Walsh-Bowers, 1996).

In summary, critical psychologists differ markedly from mainstream psychologists with respect to notions of the good life, the good society, the societal status quo, the nature of diagnosis and treatment, the role of the client, the role of the helper, and professional ethics. These parameters form a conceptual kit for the psychologist wishing to practice the values of critical psychology.

Practical Resources

Practical resources are methods and vehicles for the implementation of values. I will review in this section a range of strategies developed by feminist and community psychologists, radical educators, community developers and others invested in value-based practice.

The value of client self-determination is put into practice with the help of participatory techniques. Either in therapy, counselling, or community research and interventions, participatory techniques can elicit from service users their needs, expectations, fears, and wishes (Nelson, Ochocka, Griffin, and Lord, in press). Asking for client input is not a one shot deal. As needs and expectations change over time, consumers should be given a chance to express their opinions throughout their involvement with psychologists. The professional is to create a climate of safety in which the client should feel comfortable to agree or disagree with the helper. Social norms around professionals are such that clients may censor themselves from expressing their real needs, verbalizing instead what they think the therapist wants to hear, thereby achieving the goal of being a `good client.` The helper should be alert to the possibility of the client distorting his or her sentiments in order to acquiesce with the professional. This is why participatory techniques do not amount to much unless the client feels that she or he can trust the helper.

The idea of consulting consumers about the direction of the helping relationship is equivalent to the ethical mandate of obtaining informed consent. As therapy progresses, changes take place in the client and in the therapeutic relationship itself, and the helper should obtain renewed permission from the client to delve into certain topics or to propose a new course of action. It is good practice to consult with the client often about his or her satisfaction with the course of events. This is a useful step in granting helpees a measure of control over the therapeutic alliance.

Affording client self-determination is closely linked to the implementation of collaboration and democratic participation. Professionals are used to being in control of the helping encounter. Sharing power is not something professionals readily can or want to do (Pilgrim, 1992; Spinelli, 1994). Either in therapeutic or self-help settings, professionals semi-automatically assume control of the situation (Constantino and Nelson, 1995). The role of resource person requires more humility and less imposition on the part of the `expert.` This unpretentious stance humanizes and demystifies the helping encounter. Such depowering of the professional does not mean that he or she have nothing to offer, or that they should become invisible for the other to become visible; it simply means that the power differential between professional and lay person, preset by cultural norms, can be bridged by practicing humility (MacGillivary, Nelson, and Prilleltensky, 1998).

Caring and compassion are shown by expressing empathy, by listening non-judgmentally, and by expressing support. Attending to the sorrow of clients or community members requires that we do not jump to actions before clients are ready. We need to stick with the pain and suffering, and we need to be able to identify with the anguish. Premature movement toward action of any kind may curtail opportunities for grieving.

Respect for human diversity embodies the practice of the three values mentioned above: affording clients more control over the helping relationship, collaborating with them in setting goals, and attending to their suffering. Respecting diversity can be advanced by minimizing preconceptions concerning what is good for a client or group. Granting them an opportunity to define for themselves who they are and what they need is of inestimable benefit. This value calls for a momentary suspension of judgment to allow diverse people to articulate their diverse needs. Suspending judgment does not come easily to professionals who are supposed to be in the driver`s seat and expected to tell others how to live their lives. Some professionals no doubt do this very well, others continuously presume to know what is right for the other (Constantino and Nelson, 1995; Halleck, 1971; Sutherland, 1992; Spinelli, 1994).

Promoting the value of health requires that we attend to the many facets of a client`s life, not just to his or her psyche. Cognitive and affective processes are the primary domain of psychologists, but for community members, these aspects of their lives are only a portion of who they are. Psychological problems tend to be reified into categories such as personality disorders, character flaws, or thought disturbances (D. Cohen, 1990, 1994). However prevalent these problems might be, they do not exist on their own, nor do they come out of thin air; they are connected to people`s social support, employment status, housing conditions, history of discrimination and overall personal and political power (C. Cohen, 1993, 1997). Enhancing mental health means also enhancing physical, economic, and social health. Community reintegration of persons with psychiatric disabilities requires a total health approach. Successful projects extend community-based supports in non-stigmatizing ways, offer housing and employment and afford clients maximal input into decisions affecting their lives (Carling, 1995).

Furthermore, promoting complete health means promoting social justice, for there cannot be health in the absence of justice. Insofar as justice means the fair and equitable

allocation of resources and obligations in society, and health cannot be achieved without economic and social resources, there cannot be health unless there is justice. In the same vein, there cannot be caring and compassion unless there is justice, for we care not just about the emotions of clients but also about their living conditions and total quality of life (Neubauer, 1997).

Working for social justice is the most foreign concept for mental health professionals (C. Cohen, 1997; Mack, 1994). Most of them can see how to advance autonomy and caring and compassion, even some measure of collaboration, but when it comes to social justice, mental health workers are at a loss. This is not because of a lack of models, but because of a perennial, pervasive, and unjustified separation between their role as citizens and their role as professionals. Social justice, we are told, belongs in the private life of the psychiatrist or psychologist, not in their professional role. Such separation, I submit, creates artificial boundaries between our work as critical citizens and our job as critical professionals.

Building coalitions with grass roots organizations, mobilizing communities, joining social justice movements, and getting involved in social action with psychiatric consumer/survivors are but some of the actions that promote justice (MacGillivary, Nelson, and Prilleltensky, 1998). The first step in joining social justice efforts is to understand that we cannot advance the well being of clients in our professional life without promoting fairness in our civic life. Patients and clients continue being citizens after they leave our consulting room. In fact, they are citizens most of the time, and patients only some of the time. Whereas only some of the time they benefit from professional attention, most of the time they require a just society.

Feminist and radical educators have done much to show the linkages between the personal, the professional, and the political (Hernandez, 1997). Political education and consciousness raising with respect to oppressive social forces is critical for client wellness and for social justice. Freire has demonstrated the liberating effects of political education (Freire, 1975, 1994, 1997; Macedo, 1994; McLaren and Lankshear, 1994), whereas feminist and other therapists have shown the empowering effects of deblaming people and deflecting problems to where they belong: in the social domain (Hare-Mustin and Marecek, 1997). Hence, working for social justice enables citizens to see more clearly the source of their suffering, helps them deblame themselves, and promotes fairness at a large scale (Waldegrave, 1990).

Critical Psychology and Mental Health

Oppression has political as well as psychological roots and consequences (Prilleltensky and Gonick, 1996). Oppression contributes to mental health problems in the form of depression, suicidal ideation, learned helplessness, surplus powerlessness, emotional isolation, and other difficulties. Although the link between oppressive societal conditions and psychological health may seem obvious to us now, this has not always been the case. Historically, psychology and psychiatry ascribed mental health problems to internal mechanisms that were thought to be quite independent from the social circumstances in which the person lived. Intrapsychic reductionism prevailed in the mental health professions for several decades, with adverse consequences for consumers of

psychological services. The mental health professions lapsed into what Jacoby (1975) aptly called `social amnesia.` The internal overshadowed the external (Bulhan, 1985, Chesler, 1989; Ingleby, 1981; Nahem, 1981).

A critical history of abnormal psychology reveals three distinct approaches. The *asocial* approach locates the origins of mental health problems in personal defects deriving from either organic or psychological sources (Albee, 1981; Braginsky and Braginsky, 1976; C. Cohen, 1993a, 1993b; D. Cohen, 1990, 1994; Foucault, 1954/1987, 1961/1967; 1985; Hare-Mustin and Marecek, 1997; Ingleby, 1981; Rose, Lewontin, and Kamin, 1984). C. Cohen (1993b) has labelled this trend the biomedicalization of psychiatry. This orientation largely neglects the role of social, political, and economic factors in the genesis and perpetuation of mental health problems, with the untoward effect of blaming victims of social injustice for their own misfortune. As Wineman put it, `to blame the problems of those who are most severely affected by destructive conditions primarily on the deficits of `character disorder` or `pathology` of individuals is a classic case of blaming the victim` (1984, pp. 44-45). In its relentless pursuit of private pathologies, psychology colluded with political conservatives in offering person-centred explanations of social malaise (Pilgrim, 1992). Human suffering occasioned by rampant social injustice and discrimination was creatively ascribed to either biological or psychological inferiority.

The *microsocial* approach calls attention to the interpersonal dynamics involved in the creation and perpetuation of mental health problems. Oppressive structures and practices present in families, schools, places of employment, hospitals and other settings can have detrimental mental health effects. Theories of labelling and family therapy have explained how structures of domination can contribute, directly or indirectly, to feelings of self-doubt, alienation, and inferiority (Prilleltensky, 1994). A critical approach to mental health must take into account the political and psychological repression that often take place in families and organizations. Thus, the microsocial orientation has facilitated a slightly more comprehensive social view of mental health. Although the contributors to this approach have varied greatly in their political ideologies (Sedgwick, 1982; Vatz and Weinberg, 1983), they have all helped in shaking the foundations of the asocial approach.

The *macrosocial* approach is characterized by attention to social, economic, cultural, and political factors. Poverty, exploitation, social isolation, and discrimination, in all of its debilitating forms, have a tremendous impact on the mental health of the population (Albee, 1986; Chesler, 1989; Mirowsky and Ross, 1989). Although community psychology and psychiatry have done much to advance this orientation, their contribution to mental health is somewhat limited by their professional and disciplinary boundaries. Attempts to improve mental health are constrained by narrow conceptions of what is proper for a professional to do. It is proper to do research on risk factors predisposing vulnerable children to psychological problems; it is not proper, or within the realm of the profession, to launch political campaigns to advocate on behalf of the disadvantaged. It is proper to promote social support groups for the isolated and the unemployed; but it is not proper, or within the purview of the discipline, to publicly oppose corporations gutting towns of their source of livelihood and their sense of community (C. Cohen, 1998).

Applications of Critical Psychology: Tenets for the Promotion of Mental Health

The purpose of this section is to suggest means of applying critical psychology tenets to clinical, school, and community psychology. This effort may help bridge the gap between critical psychology theory and action.

School/Eductional Psychology

Much like the rest of psychology, school and educational psychology adhere to deficit and asocial models of mental health. Problem behavior is typically explained in intrapsychic terms that neglect the role of environmental factors in the genesis and perpetuation of children`s difficulties (Breggin and Breggin, 1994). This is why much-needed primary prevention programs have been slow in developing. The primary prevention role of the school psychologist, Alpert argued, `occurs only in our discussion of roles and in our value system, not in the real world` (1985: 1118). This state of affairs led Zins and Forman to argue that `despite the growing interest in prevention and mental health promotion, most school psychologists spend minimal time in such activities on a day-to-day basis` (1988: 539). The situation has not changed much since Zins and Forman offered their grim assessment (Weissberg and Elias, 1993).

In spite of enormous evidence pointing to the social causes of children`s psychological distress (Basic Behavioral Science Task Force of the National Advisory Mental Health Council, 1996; Garbarino, 1992; McLoyd, 1998; Weissberg, Gullotta, Hampton, Ryan, and Adams, 1997), most therapeutic and diagnostic efforts are directed toward the individual child. Not only is there a proclivity to be reactive as opposed to proactive, but once problems are detected there is an inclination to treat the single child and neglect sorely needed environmental changes (Johnston, 1990; Witt and Martens, 1988).

Not unlike most fields of applied psychology, school and educational psychology adopt the defect model. Kovaleski (1988) noted that `this model holds that children with school problems have discrete disorders that are internal to the child` (p. 479). This state of affairs was accurately portrayed by Kaplan and Kaplan (1985), who asserted that school psychologists ignore `the social context and...proceed to locate emotional disturbance...and learning problems *within* the child...the impact of environmental conditions, other people, and societal values remain in the background` (p. 323). This reasoning is pervasive in case-centred consultations, where `the position is still taken...that the problem lies in the child or with the child`s behavior` (Witt and Martens, 1988: 213), and in special education, where most models assume that `the problem of not learning is within the students` (Heshusius, 1989: 406).

These practices contradict the holistic view of mental health advanced by critical psychology. Furthermore, they promote a blame-the-victim orientation that ascribes fault primarily to the child. The child is often victimized by referrals which frequently arrive with three distinct but unspoken assumptions:

> (a) that there is something `wrong with the child,` (b) that the psychologist can find whatever is wrong with the child, and (c) that the clinician can recommend either special education placement or treatment. Conspicuously absent from

> many referrals is the expectation to modify certain aspects of the child`s human or educational environment. Simply put, the referral reads: `change the child or place him or her elsewhere; don`t change us.` (Prilleltensky, 1994: 152)

In light of these practices, it is incumbent upon the critical psychologist to push for assessments that incorporate an evaluation of the total learning and living environment of the child. Comprehensive definitions of health need to replace intrapsychic conceptions of wellness, and social and educational interventions need to supersede the single focus on `fixing the child.` Systemic approaches reframe mental health in ecological terms. There are exemplars of whole school initiatives that focus on early identification and treatment of academic difficulties, support for families, provision of child care, and other services which seek to enhance health, and not just react to crises (Weissberg and Elias, 1993; Zigler, Finn-Stevenson, and Stern, 1997). While not always totally congruent with a critical psychology agenda, these models offer critical psychologists more humanistic and empowering ways of practice.

Not to be forgotten is the child`s lack of power in an adult-driven institution. Children`s powerlessness is to be addressed by advocating for their rights instead of colluding with adults in applying labels and making children acquiesce.

For critical psychologists working in schools, there is not a shortage of challenges. The key challenges are to move etiological reasoning from asocial to macrosocial paradigms, and to shift the locus of intervention from the single individual child to the whole environment (Prilleltensky, Peirson, and Nelson, 1997).

Clinical Psychology

For critical psychologists working in clinical settings, there is not a shortage of challenges either. The primary obstacle lies in transforming reactive, deficit-oriented, and expert-driven approaches to proactive, strength-based, and collaborative practices.

Most therapeutic approaches reflect more concern for the values of autonomy, caring, empathy and personal health than for ideals of diversity, community, and social justice. Lakin (1991) observed that the argument that `modern Western psychotherapy reflects an emphasis on individual rather than communitarian values is undoubtedly correct` (p. 51). He stated that `most of the more familiar therapy orientations in our society reflect values of individual freedom of choice, of self-fulfilment, of personal achievement, and of emotional growth and expression in preference to the ideals of collective responsibility` (p. 51). More recently Doherty (1995) expressed the same view: `therapists since the time of Freud have overemphasized individual self-interest, giving short shrift to family and community responsibilities` (p. 7). Sarason (1996) summarized the message of traditional therapists to clients as follows: `you should give priority to your needs, your goals, your uniqueness, your potentials, to break the chains that fetter and plague you` (p. 43). Sarason (1996) went on to elaborate the adverse consequences of these messages: `as is almost always the case when individualism is highly prized, the sense of belonging and having obligations to the collectivities to which you belong takes second place` (p. 43).

The corollary of these trends is that the value of social justice is positioned at the background of our priorities. The pursuit of justice need not come at the expense of autonomy though. Personal values are as important as social justice. But the problem is that in our society values are out of balance, out of context, and out of control. Values are out of balance because self-interest, with the tacit approval of psychology, takes primacy over almost all other values (Sarason, 1981). Values are out of context because in the current historical moment people yearn for more solidarity and sense of community, but culture makers continue to produce images of personal elevation as the ultimate achievement in life. Finally, values are out of control because individualism is rampant and nearly uncontrollable, with greed and competition at an all time high in the West (McQuaig, 1998; Saul, 1995).

What is the critical psychologist to do vis á vis these distortions in values? The moral imperative, Bakan wrote in 1966, is `to try to mitigate agency with communion` (p. 14). In clinical psychology this effort should take place both within the therapeutic settings and outside of it. Doherty is one of the few who claimed that psychotherapy `has the resources to contribute to the formation of a new cultural ideal in which personal fulfilment will be seen as part of a seamless web of interpersonal and community bonds that nurture us and create obligations we cannot ignore` (p. 20). He advocated for an enriched moral dialogue that places obligations to others as a central concern in therapy. His book offers useful suggestions for practicing in ways that honor personal as well as collective values.

Practitioners at the Dulwich Centre in New Zealand have brought justice to the forefront of therapeutic work (Waldegrave, 1990). Much like feminist therapists do (Brown, 1994; Marecek and Hare-Mustin, 1991; Watson and Williams, 1992), their approach explicitly links the mental health of clients with experiences of social injustice. The values of critical psychology are congruent with these two approaches. Like them, critical psychologists strive to promote autonomy together with justice, diversity along with collaboration, and personal health as much as community health.

The principle of self-determination seeks to afford clients a voice, foster personal strengths, and allow clients a measure of control over the helping process. To do so, helpers create a safe space, facilitate a listening environment, and pay respect to the dignity and integrity of the person seeking help. By enacting the tenet of collaboration and participation, critical psychologists create partnerships with community members, allow an informed choice of intervention and demystify expertise (Mair, 1992). They achieve that by fostering client ownership over the therapeutic encounter and by paying attention to the intersubjective processes occurring between helper and helpee. Social justice is addressed by dealing with inequities present within and without the therapeutic relationship, by de-blaming victims, and by rectifying power imbalances in the clients` life and in society as a whole. The value of diversity, in turn, affirms the unique identity of clients and is instrumental in bridging across cultures. This is facilitated by listening without prejudice and by making no hasty assumptions concerning what is in the best interest of the client. The ideal of health is promoted by comprehensive and ecological definitions of wellness, and by addressing systemic barriers impeding the attainment of higher levels of personal and collective well-being.

None of these values can be actualized without attending to social oppression, poverty, and discrimination. Fusing personal and collective ideals with the help of mediating values requires constant attention to both the psychological and sociological realms of life.

Community Psychology

A branch of psychology explicitly concerned with the impact of the social environment on mental health is community psychology. Whereas mainstream psychology offers interventions aimed at individuals, community psychologists direct their efforts at social systems like schools, self-help groups, and community organizations. In contrast to traditional applied psychology, community psychology focuses on people`s strengths rather than deficiencies. Community psychologists envision the helping process as one in which professionals and citizens collaborate in defining problems and solutions, as opposed to one in which the expert`s role is to impart erudite advice. Community psychologists (Prilleltensky and Nelson, 1997), along with feminist psychologists (Wilkinson, 1997), are very outspoken with respect to the need to invoke social justice to improve mental health. But the rhetoric has a hard time getting translated into action.

Not surprisingly, seeing how social injustice diminishes mental health is easier than bringing about social justice to improve health and welfare. Like many well-meaning citizens, community psychologists are stuck in trying to reform, as opposed to transform, societal structures of oppression. The urgent need to ameliorate the living conditions of those who suffer has overshadowed the long-term prospect of changing society more radically for the benefit of present and future generations. This is unfortunate, for without a serious transformation of structures of oppression and inequality, avoidable pain and sorrow will never subside.

To bring the values of critical psychology into community psychology, we need to understand the latter's *modus operandi*. Social and preventive interventions can be plotted along a continuum of social change. Ameliorative efforts help victims of injustice, illness, and abuse, without challenging the societal status quo; while reformist initiatives adopt a more active role in perfecting existing institutions - an effort is made to make social structures work better for people. Transformative interventions, on the other hand, go beyond humanizing existing structures. Transformative interventions seek to bring about lasting change in line with the ideals of social justice.

Most community programs are ameliorative or reformist at best; they fall short of radical social critique (Albee, 1996; Albee and Perry, 1995). Most preventive interventions follow a reformist focus and promote organizational changes to better serve the needs of clients. Community agencies are restructured to offer improved services; clients are given a say in how to run the agencies. These are important but insufficient efforts, for they invoke self-determination and collaboration but neglect social justice. Albee (1986, 1996; Albee, Joffe, and Dusenbury, 1988) has reminded us that by neglecting this value we ignore the `causes of the causes` of much human suffering, for without an even distribution of social goods, other basic needs and rights cannot be fulfilled.

Despite its commitment to the fair and equitable allocation of resources, community psychology has paid negligible attention to issues such as poverty and anti-poverty movements, grassroots organizing, political mobilization, human rights, and sustainable economic development. Prilleltensky and Nelson (1997) have outlined a few avenues for the pursuit of social justice in community psychology. Such an agenda would entail `(a) connections between the personal and the political; (b) connections among constituents who are involved in, and affected by, social change; and (c) connections among the micro, meso, and macro levels` (p. 178).

Women`s realization that their personal suffering is related to their oppression in the home (micro level), school, and workplace (meso level); and to their discrimination in social and economic policies (macro level), led them to form social justice movements (Cohen, Jones, and Tronto, 1997). Although women`s struggle is far from over, it provides a positive example of the type of social justice agenda that community psychology needs to pursue. Initiatives of this kind can be expanded to solidarity work with psychiatric/consumer survivors, labor unions, anti-poverty organizations, advocacy coalitions for people with disabilities, anti-racist organizations and worker cooperatives (MacGillivary, Nelson, and Prilleltensky, 1998). Involvement in transformative, macro-level projects of this sort will put social justice at the forefront of community psychology`s concerns.

Partnerships with social movements should have explicit outcome goals. Social justice achievements should be seen in changes in public policy, in better distribution of resources through progressive taxation, in material improvement in the lives of the disadvantaged, in heightened political awareness, and in women`s increased control of political institutions (**Balcazar, Mathews, Francisco, Fawcett, and Seekins,** 1994; Bunch, 1987; Nelson, 1994).

Conclusion: Towards a Macrosociopolitical Approach

A macrosociopolitical approach goes beyond the identification of environmental sources of suffering and oppression; it strives to engage in social and political action to eradicate sources of domination and unnecessary psychological pain. This is the void that critical psychology needs to fill. As critical citizens and professionals, critical psychologists need to avoid single focus explanations of mental health problems and appreciate the multidimensional nature of psychological suffering. But in addition to embracing a comprehensive understanding of psychological anguish, critical psychologists need to engage in political actions that honor the indivisible commitment to improving society, psychology, and mental health at the same time. To further this challenge I propose three directions for action.

Politicize the Public

Currently, when psychologists become involved in the political process it is mainly through legislative mechanisms such as parliamentary committees studying mental health issues. Psychologists present briefs and research findings informing legislators about the latest behavioural science studies. This form of influencing public policy has to be complemented by politicizing the public to be more vocal about expressing its needs and

more forceful about demanding action. Long term solutions can derive only from serious efforts that alter the distribution of goods and resources in society.

Create Partnerships for Solidarity with the Oppressed

Calls to include professionals from other disciplines is heard far more often than the need to involve community members themselves in solving their problems. I submit that we need to work together with community members suffering discrimination and oppression and learn from them how best to ally ourselves with their aims. Professional helpers, who usually belong to the middle class and are quite protected from social ills, need to be educated about the plight of consumer/survivors of the mental health system, disadvantaged children, minorities, and the homeless.

Engage in Systemic Political Thinking and Action

While concentration of efforts on a single issue, such as community reintegration, helps gather momentum for much needed reforms, critical psychologists should be mindful not to create fragmentary solutions to systemic problems. More money for one cause or another can alleviate temporarily the suffering of one segment of the population, but we should keep in mind that comprehensive solutions require systemic changes. In fact, many governments pit one interest group against another, thereby weakening the opportunities for coalition building among oppressed groups.

In the case of poverty, it is evident that the problem won`t be resolved by more training programs but by fundamental changes in the tax system and in the distribution of societal resources (Korten, 1995; McQuaig, 1998). We could focus on public health campaigns to enhance the wellness of children, but unless these efforts are accompanied by resources, the outcome may be negligible at best, and cynical at worst. As Halpern (1988) pointed out in discussing such a project: `efforts to reduce the incidence and management of diarrhea in infants through parent education in simple health care practices were constrained by the fact that many families had limited access to uncontaminated water` (p. 257).

The challenge for critical psychologists is to integrate these guidelines into practice. The assimilation of these recommendations requires clarity with respect to the values, concepts, and methods that form the foundations of critical psychology. Otherwise, we may engage in actions that appear helpful but that do not really reflect the moral, epistemological, and political bases of critical psychology.

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