Beyond Resilience:

Blending Wellness and Liberation in the Helping Professions

Isaac Prilleltensky and Ora Prilleltensky

Peabody College of Vanderbilt University

Correspondence should be sent to Isaac Prilleltensky, Department of Human and

Organizational Development, Peabody College, Box 90, Vanderbilt University,

Nashville, TN, 37203, USA. Electronic correspondence may be sent to

Isaac.Prilleltensky@vanderbilt.edu

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 were to follow 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 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 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 natural environment 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 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).

Helpers in the mental health and social work field face a gap between their understanding of unhealthy environments and their ability to do something about them. While the level of critique tends to be quite complex, the level of social justice practice tends to be quite embryonic. Critical psychologists 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. 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 & Larner, 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. They enumerate the barriers to acting, and 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 psycho-political validity as a new measure for the evaluation of our social justice agenda.

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, and 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 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. 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.

Insert Table 1 about Here

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, while 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 a result, we have neglected social justice and support for marginalized communities at our peril.

The current risk in terms of our values is to extol respect for diversity above all, for cultural diversity cannot exist in the absence of social justice. All the values presented in Table 1 are co-dependent and inter-dependent. 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.

Unfair distribution of power has implications not only for how independence is defined (in primarily physical terms), but how it is actually enacted in various medical and rehabilitation settings. Much of the work carried out by counselors, 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 functioning. I, Ora, am reminded of a patient I worked with who had to negotiate with one of his treating therapists that it is pointless for him to attend a breakfast group. A stroke had left this man with significant physical impairments, while 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. 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 in one's life and the role of individuals and groups to challenge systems of inequity and discrimination. Coping without challenging 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 intra-psychic 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 could not 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 (Prilleltensky, 2003). 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). Empowerment does not take place only at the personal level. Relational and collective empowerment support personal empowerment and vice versa (Kiefer, 1984; Lord & Hutchison, 1993). Power equalization must take place at all these levels.

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 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 out 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).

People with disabilities have argued that it is society, rather than the impairment itself, which is the source of their disablement: "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," declared the Union of the Physically Impaired Against Segregation in 1976 (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, many did not attain the necessary skills in order 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 work place. Those who require assistive devices and/or attendant care often come against paternalistic policies designed to retain professional control over resources. Physical barriers have also been a source of exclusion, as 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 (Prilleltensky, in press, 2003, 2004). 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..." 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 daughters' emergent sexuality.

Michael Oliver, a disabled academic in the UK, was one of the first people to talk about the social versus the individual model of disability (1990). 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 UK. 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 the "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 upon 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 wellbeing of people with disabilities (Morris, 1993; Oliver, 1990; Shakespeare, 1998; White, in press). Consider the following quote of a disabled activist in the UK who describes the impact that the social model 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 re-examining 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, the 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 in other 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 sometimes prevent fruitful explorations of similar agendas.

Insularity is a definite risk. We need to apply the call for diversity to our own professional practice. There are diverse fields within the helping professions concerned with social justice and social change. Looking around can help us find wheels that are well oiled, we don't need to reinvent them.

The second question is not less pressing. Psychology cannot afford to ignore critiques of the helping professions and of 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 the helping professions raised by non-psychologists.

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 towards wellness and liberation (Oliver, 1990). If we are to make progress towards social justice, we need to create alliances with the people we wish to help (Nelson, Prilleltensky, & MacGillivary, 2001). Much can be learned from social movements and consumers' movements in their efforts to declassify homosexuality as an abnormality, to obtain access to pubic 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.

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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 promotion of wellness and liberation (Nelson & Prilleltensky, in press). Here we propose ways of melding professional and critical praxis (Prilleltensky, 2001; Prilleltensky & Nelson, 2002; Prilleltensky & Prilleltensky, 2003a, b). Our challenge is to find ways of reconciling the two sets of skills and aims. From the perspective of the professional helper, the critical practitioner wishes to answer 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** of 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 would argue that reconciling these diverse roles would promote the dual goals of wellness and liberation. 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 (Prilleltensky, O., in press a, b, c) 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. Different types of mothering require different types of resources. An expanded notion of motherhood 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 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' 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. Nelson and Prilleltensky (in press), Prilleltensky and Nelson (2002), and Murray, Nelson, Poland, Matycka-Tyndale, Ferris, Lavoie, Cameron, and Prkachin (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:

- 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 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.

As insiders within the health and helping system, psychologists and counselors face many barriers and limitations. While 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. To guide our commitment to these two priorities I proposed the concept of *psychopolitical validity* (Prilleltensky, I., 2003; 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 2 and 3, respectively.

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To understand issues of well-being, oppression, and liberation at the personal, relational, and collective domains, we turn our attention to Table 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 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 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, economic forces and 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, behaviours, 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 3 integrates levels of intervention with key concerns for mental health: wellness, oppression, and liberation. This is a vision of preferred interventions. We would show high degrees of commitment and accountability to the extent that we pursue these

interventions. As a monitoring system, Table 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 referred to our understanding of psychopolitical dynamics of oppression, transformative validity demands changes towards 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, 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 been often advocated for but infrequently acted upon 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).

Conclusion

People affected with physical disabilities and psychosocial problems are better off developing resilience and ways of coping. But resilience must go beyond coping 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. Their own participation in challenging injustice, along with mental health and community workers, 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 urgently needed.

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│    Helper    │              │ Professional │              │    Agent     │
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│ knowledge for│              │     and      │              │  liberation  │
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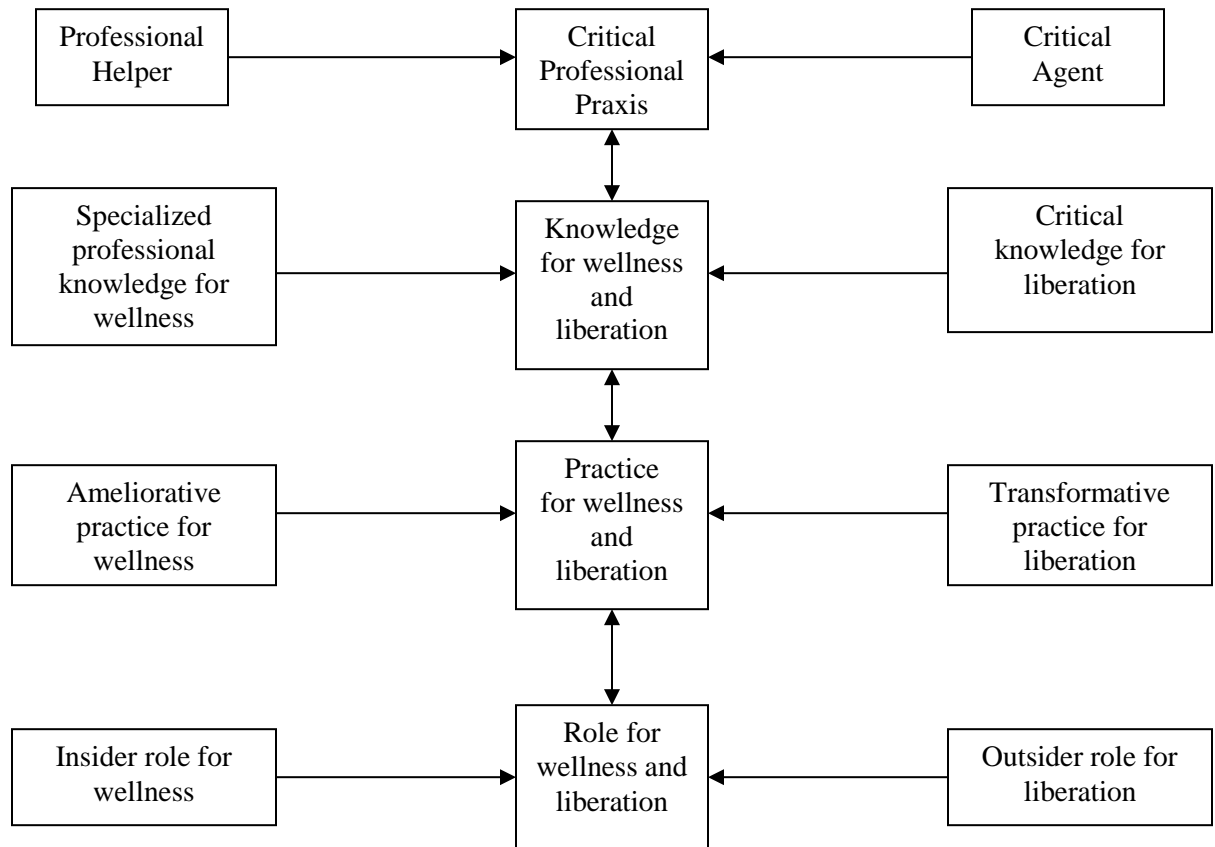
Figure 1

Knowledge, Practice And Roles For Critical Professional Praxis In Mental Health
Practice

Adapted from Prilleltensky & Prilleltensky, 2003 b.

Table 1
Personal, Relational, and Collective Domains of Wellness and Liberation

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

Adapted from Prilleltensky & Nelson, 2002

Table 2

Guidelines for Epistemic Psychopolitical Validity

Concerns	Domains		
	Collective	Relational	Personal
Wellness	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

Adapted from I. Prilleltensky, in press.

Table 3

Guidelines for Transformational Psychopolitical Validity

Concerns	Domains		
	Collective	Relational	Personal
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

Adapted from I. Prilleltensky, in press.