CULTURAL ASSUMPTIONS, SOCIAL JUSTICE, AND MENTAL HEALTH: CHALLENGING THE STATUS QUO

Isaac Prilleltensky

While transnational corporations and powerful governments glorify the accomplishments of capitalism toward the end of the millennium (Dobbin, 1998), an ever increasing mass of people continues to suffer from injustice (Ransom, 1999) and mental health problems (Kramer, 1992). While public relations firms assist financial empires and world leaders to solidify their domination over most of the world=s resources (Stauber & Rampton, 1995), suffering and disease proliferate because of lack of access to basic needs such as food, clothing, shelter, and medicine (Korten, 1995). While a few people become richer every year, more and more people become poorer and live in abject poverty (Ransom, 1999).

The architects of public opinion and the guardians of the status quo rely heavily on the creation and procreation of cultural assumptions that secure the hegemonic domination of power elites over most of the unsuspecting public (Rose, 1999). The public has come to accept the ideology of individualism, the invisible hand of the market, and the philosophy of competition as the new mantras of the twentieth century (Saul, 1995). Certain cultural assumptions about the good life and the good society and about social problems and solutions circumscribe the horizon of possibilities concerning what type of society we have, and what type of community we could devise for ourselves. Hegemonic notions regarding Athe nature@ of human beings limit our ability to imagine how societies might be improved.

This chapter is concerned with the role of certain cultural assumptions in mental health and social justice. The chapter has two main objectives, a descriptive and a prescriptive one. The first objective is to describe a model that explains the influence of cultural assumptions on distributive justice and mental health. The second aim is to prescribe certain steps for challenging cultural presuppositions that undermine both social justice and mental health. First, I present an overview of the model. Following that I apply the model to the current state of affairs in Western societies. The third and final section offers ways of challenging the status quo.

Overview of the Model

The model consists of four main modules: cultural assumptions, social justice, resources, and mental health. Cultural assumptions influence mental health directly and indirectly. I will claim below that cultural assumptions exert a direct influence on mental health via societal and psychological discourses, and indirect influence via conceptions of social justice. Notions of social justice have an impact on the allocation of resources in society, a phenomenon with notable consequences for the mental health of the population. In short, certain cultural norms and discourses have a negative impact on the mental health of the population. These norms affect also the predominant conceptions of social justice, which, in turn, determine the distribution of resources in society, a key factor in the promotion of mental health. I explain below the different components of the model and how they interact with each other.

Cultural Assumptions

Cultural assumptions are the predominant conceptions about individuals and society that are almost taken for granted in a particular context. These are largely unquestioned presuppositions about what is proper, what is desirable, what is the nature of human beings, what is a problem, and what is possible in society. Cultural assumptions create and limit discourses about how human beings should interact with each other, about how they should make a living, about welfare, dependency, health, and safety. These assumptions penetrate daily conversations through newspaper reports, speeches by politicians, commentators, movies and television.

Cultural assumptions respond to group interests; they are not formed in a vacuum. They serve the needs of those invested in perpetuating the societal status quo (Macedo, 1994). My usage of cultural assumptions here is reminiscent of Gramsci=s concept of hegemony. The phenomenon of consent and conformity achieved by persuasion and cultural assumptions rather than force is what Gramsci (1971) called cultural Ahegemony.@ This concept is well summarized by Boggs (1976): ABy hegemony Gramsci meant the permeation throughout civil society of an entire system of values, attitudes, beliefs, morality, etc. that is in one way or another supportive of the established order and the class interests that dominate it@ (p. 39). So successful is the hegemonic project in many societies that individuals need not be externally controlled to fit into the prescribed mould; they regulate themselves. As Rose (1999) put it:

Disciplinary techniques and moralizing injunctions as to health, hygiene and civility are no longer required; the project of responsible citizenship has been fused with individuals= projects for themselves. What began as a social norm here ends as a personal desire. Individuals act upon themselves and their families in terms of the languages, values and techniques made available to them by professions, disseminated through the
apparatuses of the mass media (p. 88).

Cultural assumptions supportive of the societal status quo are spread throughout society in multiple ways. In this chapter I am concerned ı**rily with dissemination of hegemonic notions through societal and psychological discourses.**

***Societal Discourses*. Cultural assumptions and hegemonic notions shape the contours of societal discourse about the good life and the good society. I use these two terms here because they embody many assumptions about popular conceptions of psychology, politics, sociology, and mental health. People hold implicit or explicit versions of the good life. Is the good life fostered by the accumulation of material possessions or by an ascetic life style? Do we find meaning in the spiritual enrichment found in close friendships or in incessant work? Do we value individualism and competition or sharing and collectivism? Each society prescribes and proscribes certain modes of thought and conduct through the media. An ever increasing and sophisticated army of opinion makers helps in the process. As we shall see below, prevalent conceptions of the good society and the good life have serious and rather deleterious effects on the mental health of the powerless and the oppressed (Prilleltensky & Gonick, 1996).**

***Psychological Discourses*. Without a doubt psychological discourse has penetrated almost every facet of life: the bedroom, the school, the hospital, the workplace, the family, the government (Prilleltensky, 1994). Psychological advice is sought to solve innumerable problems and psychologists dutifully respond to the call. But psychologists do not just answer the call to solve problems created by others. They themselves contribute to the very creation of social problems through an extensive lexicon of assessment, diagnosis, classification, treatment, rehabilitation, normalcy, deviancy, adjustment, and the like. The tools used by psychologists to define and solve problems contribute to cultural assumptions about the good and normal life. Melucci (1996) points out that the professionals entrusted with helping others activate a Achain reaction of diagnosis-therapy-new diagnosis which perpetuates our dependence on the experts. These processes tend to generate a widespread self-labelling process through which we internalize the criteria used in the external definition of our condition@ (p. 85).**

Societal discourses concerning the good life and the good society, as much as psychological discourses regarding problem definition and problem solutions, convey cultural assumptions about what is acceptable and unacceptable in society. In combination, they exert a powerful impact on mental health and social justice. If our prevalent notions of the good life is a life of competition and personal achievement, we should not be surprised that alienation, isolation, mindless consumerism and lack of compassion characterize the social condition (Kohn, 1986; Sloan, 1996).

Distributive Justice

The way we define problems dictates the way we solve them. If we define justice as giving people what they deserve based on their merit, and if merit derives from education and opportunities in life, then we reward only those who had a chance to advance themselves.

Concepts of social justice include procedural, retributive and distributive justice (Tyler, Boeckman, Smith, & Huo,

1997). Here I concentrate on distributive justice because it has direct implications for the allocation of resources in society, a phenomenon with multiple consequences for mental health (Zill, Moore, Wolpow Smith, Stief, & Coiro, 1995).

Distributive justice may be defined as the fair and equitable allocation of bargaining powers, resources, and obligations in society (Miller, 1978). Resources can be distributed according to various criteria, such as need, merit, or equality. It can be argued that under conditions of equality of opportunity, the principle of merit may apply. But an argument can be made that, under conditions of inequality, need is the more appropriate criterion. In other words, the social context determines to a large extent the most appropriate criterion. In a case where there are jobs for everyone, and all persons have adequate training to perform these jobs, it can be argued that people who work harder or who contribute more to the common good may be rewarded more than others. But if we live in a society where there are not enough jobs, and the jobs available are only for those who have a certain training, there are many people who remain unemployed despite their intentions to join the labour force. In such a case, it would be more adequate to distribute societal resources according to need in order to procure basic necessities for those cannot provide for themselves.

Many societies adopt a mixed model of individual and social responsibility (Eichler, 1997). However, in many others, injustice is perpetuated by distributing resources almost exclusively according to merit, in gross disregard for the social needs of marginalized groups (George & Wilding, 1976; Miller, 1978). Distributive justice calls for the re-allocation of resources in order to attain a balance between the goods and opportunities of all social groups. Without an even distribution of social goods, other basic needs and rights such as health and self-determination cannot be fulfilled.

Notions of the good life and the good society, as well as definitions of personal problems, impinge on our conceptions of social justice. Our conceptions of distributive justice contribute, in turn, to the allocation of resources in society, a key determinant of mental health.

Resources

Resources can be material or psychological aids in the procurement of physical and emotional wellness. Material resources include food, clothing, shelter, and health care. Psychological resources include a secure attachment, social support, self-efficacy, nurturing relationships, social skills, and the like. Research has shown that access to both material and psychological resources can contribute significantly to the promotion of mental health (Prilleltensky, Nelson & Peirson, 1999).

Access to resources is determined, to a large extent, by the model of justice employed in society. More and more Western societies are shying away from models of social responsibility that call upon the state to provide welfare for those who cannot provide for themselves (Griffin Cohen, 1997). Models of social or individual responsibility are dictated, in turn, by predominant cultural assumptions about the good life and the good society, about the worthy and unworthy citizen. These conceptions have an ultimate impact on mental health.

Mental Health

Mental health can be defined as a state of psychological wellness characterized by the satisfactory fulfilment of basic human needs (Prilleltensky, Nelson, & Peirson, 1999). Some of the basic needs for mental health include a sense of mastery, control, and self-efficacy; emotional support and secure attachment; cognitive stimulation; sense of community and

belonging; respect for personal identity and dignity, and others (Basic Behavioral Science Task Force, 1996a, 1996b).

Individuals experience mental health and the fulfilment of basic needs depending on the resources available to families and communities (McLoyd, 1998). For some families, lack of food and money to pay the rent are major sources of stress. For others, this is not a problem at all. For those who lack basic resources, society=s cultural assumptions about the poor are very important because these ideas can determine to what extent governments will supply basic necessities for the needy.

In summary, cultural assumptions exert a direct influence on mental health through definitions of the good life and the good society and through psychological definitions and solutions to problems. Notions of the good life derived from competition and individualism lead to social isolation and psychological stress. When these problems are defined in individualistic terms, the person is viewed as responsible for her or his suffering. But cultural assumptions also exert an indirect influence on mental health via society=s definitions of social justice. The way we frame justice determines how we allocate resources, and the way we allocate resources has a direct impact on the mental health of the poor and the vulnerable (McLoyd, 1998). We turn now to an examination of how the model explains the actual state of affairs with regards to mental health and social justice.

Actual State of Affairs

In this section, I will describe the current relationship between cultural assumptions, social justice, resources, and mental health in Western societies. I am most familiar with the North American context, but from readings and personal research I know that the situation is somewhat similar in other industrialized countries as well (Prilleltensky, Laurendeau, Chamberland, & Peirson, 1999). I will analyze now the state of affairs with regard to each one of the factors involved in the model. Following that I will show how they interact to produce powerful effects on the mental health of the population.

Cultural Assumptions

As noted in the overview of the model, cultural assumptions about what is acceptable and unacceptable in society are both created and promulgated by societal and psychological discourses. I will examine each one of these discourses in turn.

***Societal Discourses*. Predominant notions of what is the good life and the good society are enormously influenced by the culture of consumerism, hedonism, and individualism. It is no exaggeration to claim that advertising serves as the main guide of behavior for vast number of consumers who direct their lives according to the latest fashions and corporate dictates (Sloan, 1996). What to wear, where to dine, what car to drive, what credit card to use, what movie star to emulate, what politician to gossip about; all these aspects of life are managed by public relations firm specializing in impression management and marketing of artificially created needs (Stauber & Rampton, 1995).**

For products to sell, producers need consumers who worry about how they look, what they drive, and where they shop. In short, they need people who adulate themselves. They need a culture of individualism where the self becomes the main preoccupation of consumers. Rather than citizens, they need consumers (Rose, 1999). The ideology of consumerism goes hand in hand with individualism. The person is the center of the world.

But the cultural assumptions of the market assault us in other ways as well. The marketers bombard the market with unhealthy products that distort our sense of well-being and that produce addictive behaviors. Under the banner of personal choice and responsible consumption, corporations invade our public space with images of violence, drugs for hyperactive children, and with a diet industry that leads to eating disorders. The cultural assumption that consumers are adults who can choose to watch or consume whatever they like provides a rationale for selling bogus diet products, tobacco, and for broadcasting thousands of violent and rape scenes on television.

The ideological creation of the self-contained individual serves not only economic but political purposes as well (Cushman, 1990). From an economic point of view, the person as consumer is the fuel that drives the capitalist engine. From a political point of view, the individual is constructed as the source of both self-fulfilment and suffering. Success is attributed to personal merit, and misery to personal failure (Sarason, 1981). When problems befall an individual, it is primarily his or her personal responsibility to survive. They are on their own. The dominant cultural assumptions are that people are to help themselves, as if we are all the product of Apersonal@ merit, disconnected from the help of others, or unaffected by opportunities (or lack thereof) afforded us by privilege or deprivation. Hence, when suffering occurs, it is not at the political system that we turn our gaze, but rather inwards, toward an exploration of personal deficits. Thus, the culture of individualism does not only create suffering by fomenting fragmentation and competition, but it also leaves individuals to their own devices to overcome stress and pain.

***Psychological Discourses*. Mainstream psychology=s view of the good life is also based on individualism and tacit acceptance, if not outright promotion, of the consuming citizen (Sampson, 1983; Sarason, 1981). Mainstream psychology successfully looks for and locates pathology within the individual or within the family (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 (Prilleltensky, 1994). Psychological problems tend to be reified into categories such as personality disorders, character flaws, or thought disturbances (Cohen, 1990, 1994). However prevalent mental health problems might be, they do not exist on their own, nor do they come out of thin air. Instead, they are connected to people=s social support, employment status, housing conditions, history of discrimination and overall personal and political power (Cohen, 1993, 1997; Mack, 1994; Prilleltensky, 1999a).**

Working for social justice is the most foreign concept for mental health professionals (Albee, 1986; Cohen, 1997; Mack, 1994). Most of them can see how to advance autonomy and caring, even some measure of collaboration, but when it comes to social justice, mental health workers are at a loss. This is not because of lack of models, but rather 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 of the psychologist, not in their professional role. In the end, psychologists adopt and propagate a discourse that locates pathology within individuals, that produces victim-blaming, and that diverts attention from issues of social justice because it reduces social problems to issues of personal struggle (Fox, 1997).

In combination, societal and psychological discourses strengthen cultural assumptions regarding individualism, consumerism, and political illiteracy. Cultural assumptions regarding the good society revolve around individuals, not collectives. Thus, we lack a discourse that examines social dilemmas in communitarian terms. It all starts and ends with atomized individuals removed from social contexts (Cushman, 1990; Sampson, 1999).

Distributive Justice

The spin doctors of globalization seem to have successfully erased the language of social justice from popular vocabulary (Leonard, 1997). Enormous and unprecedented gaps between the rich and the poor are described in technical, economic, and bureaucratic terms completely devoid of political connotations (Allahar & Côté, 1998). Somehow we have lost the language of social justice. Instead, we have gained the idolatry of econometrics and the consensual discourse of globalization. Words like exploitation, domination, and oppression are nowhere to be found in popular media, as if they vanished with the Berlin wall. Problems of profound injustice that are quintessentially the subject of politics and exploitation are transformed into technical problems to be fixed with better management of resources and more fiscal responsibility. Social justice is a non-issue in the mainstream media. It is only resistance groups that still use the language of justice. Unfortunately, their voice is inaudible amidst the cheer of system apologists.

Resources

The allocation of resources in society is tied to the concept of social justice. The predominant philosophy of individualism, self-interest and survival of the fittest lead to a model of personal responsibility (Eichler, 1997). Society is not to blame for personal misfortune, which means that insufficient resources are a private matter. This model of individual responsibility has lead many countries in the west to dismantle the welfare state. As a consequence, the poor and the disadvantaged have less access to basic necessities such as decent housing and proper medical care (Griffin Cohen, 1997).

A model of social responsibility would uphold the values of social justice, collectivism, cooperation and solidarity. Under such philosophy, resources would be allocated according to need, but the reality is that many Western nations are retreating from this model. Some European countries like Denmark, Sweden and Holland have retained this philosophy of social responsibility, thus ensuring the provision of adequate resources for the poor (Prilleltensky, Nelson, & Peirson, 1999).

Mental Health

The moment we define mental health as a state of affairs in which certain basic needs are met, it becomes clear that mental health is connected to resources. When psychological and material resources are present, chances are that mental health will ensue. When resources of either kind are scarce, chances are mental health will be poor. The ability of parents to satisfy children=s need for love, secure attachments, empathy, and stimulation, is related to parents= mental health and levels of stress. Parents= mental health, in turn, is related to socioeconomic status and educational opportunities. In other words, parental and family wellness is related to community wellness, which includes elements such as safety, formal and informal supports, solidarity, cohesion, social services and recreational facilities. Community wellness, in turn, depends on societal wellness, which is characterized by conditions of employment and economic security, decent housing, health insurance, democratic institutions, and a culture of peace (McLoyd, 1998; Prilleltensky, Nelson, & Peirson, 1999).

The problem with current definitions of mental health is that they concentrate on the person and neglect to take into account the interdependence of personal wellness with parental, family, community, and societal wellness. As a result of

narrow definitions of mental health, we see an ever increasing number of people suffering from psychological problems. In Canada, for instance, which has been voted six years in a row by the United Nations as the best country in the world, it is estimated that 26% of children experience behavioral, learning, emotional, or social problems (Offord, Boyle, & Szatmari, 1987). In the province of Ontario, research has found that:

31% of men and 21.1% of women reported having been abused while growing up. Childhood sexual abuse was reported by 12.8% of women and 4.3% of men. Severe abuse was reported by 10.7% of men and 9.2% of women, and severe sexual abuse was reported by 11.1% of women and 3.9% of men@ (Brown, 1997, p. 867).

In the early 90s, Kramer (1992) documented what he called the A**pandemic@ of mental and emotional disorders, claiming that current global trends in poverty and family breakdown will result in unprecedented numbers of children and adults suffering from psychological problems. Using a rather conservative estimate of prevalence rate of 12% for mental, behavioral and developmental disorders in children around the world, Kramer reported that:**

the total number of cases of mental disorders in children under 18 years of age would increase from 237.8 million in 1990 to 261.5 in the year 2000, an increase of 10%. In the more developed regions the number of cases would increase from 37.8 million to 38.2 million@ (Kramer, 1992, p. 15).

According to the U.S. Institute of Medicine (1994), at least 12% of children A**suffer from one or more mental disorders, including autism, attention deficit hyperactivity disorders, severe conduct disorder, depression, and alcohol and psychoactive substance abuse and dependence@ (p. 487). The same source indicates that 20% of adults in the U.S. currently suffer from a psychiatric impairment, and 32% can be expected to develop such an illness during their life time.**

These are alarming figures that call for a dramatic change in the way we deal with psychological problems. As I shall suggest below, two major changes that are required have to do with shifting the emphasis from treatment to prevention, and expanding the scope of care from the individual to the family, the community, and society as a whole. But for these transformations to take effect, the cultural assumptions that locate pathology strictly within the individual must be challenged.

Challenging the Status Quo

A philosophy of individualism rests at the core of many Western cultures. This credo has an impact on the mental health of the population by eroding a vital sense of community, fostering isolation, and limiting treatment to person-centred approaches that obviate the need for social interventions. In addition, an individualistic mentality permeates constructions of social justice, leading to distributions of rewards based on personal merit alone, dismissing the value of other criteria such as need, inequality of opportunity, and disadvantage. In the absence of these criteria, and with an exclusive focus on personal merit, those who lack access to resources are blamed for their condition. Thus, the poor and the oppressed suffer not only from lack of resources, but also from social accusations of laziness, incompetence, and exploitation of the system (Leonard, 1997; Rose, 1999; Wilson, 1996). Under these conditions of deprivation and stress, few people can escape negative mental

health outcomes (Zill et al., 1995). In this section I challenge cultural assumptions of individualism, prevailing concepts of social justice, current allocations of resources, and, ultimately, the way we define and treat mental health problems.

Cultural Assumptions

Predominant conceptions of the good, the bad and the unworthy are created in many cultural sites (Rose, 1999). As we have seen, two vehicles for the creation and proliferation of unquestioned cultural assumptions are societal and psychological discourses. I challenge each one in turn.

***Societal Discourses*. I have claimed elsewhere that bogus dichotomies between the needs of the individual and the needs of the community are pernicious to the mental health of the population (Prilleltensky, 1997). Philosophical schools of thought oppose liberalism, with its emphasis on the needs of the individual for freedom and choice, with communitarianism, which focuses on responsibility towards the common good. These binary classifications are abstractions that do not represent the actual needs of individuals in communities. In actuality, people require both rights and responsibilities to survive and co-exist. A supreme obsession with personal gain leads to a distortion of self-determination into self-preoccupation, whereas relentless sacrifice for the good of the community leads to neglect of personal needs. In societies that exalt individualism we observe an erosion in the sense of community, whereas in communities that demand personal abnegation we notice a craving for individual liberties (Prilleltensky, 1997). This is an indication that what we need is a balance between values that uphold personal rights and needs, and values that protect the integrity of vital community structures (Prilleltensky, Laurendeau, Chamberland, & Peirson, 1999).**

Whether we like or not, our personal fate is linked to the fate of the common good. For instance, personal health depends on rules for environmental protection and on adequate budgets for national health insurance. The tenet that personal effort alone can lead to happiness is unfounded (Sampson, 1999). We all depend on others and on community structures like schools, sanitation systems, hospitals, housing standards, and civil society for survival and progress. The problem in many Western societies is that those who achieve success are invested in defining health as a personal matter, thereby absolving themselves of the need to pay taxes or contribute to the common good. Entire ideologies are built to justify the status quo, and individualism is at the root of most of them. For as long as neo-liberal philosophies obscure the need for more communitarian social policies, we can expect a perpetuation of the dominant model of personal responsibility. The time has come to ask whose interests are protected and whose needs are neglected by the current neo-liberal philosophies (O=Neill, 1994).

***Psychological Discourses*. Psychology has traditionally operated from an individualistic paradigm that defined and treated problems as atomized events inside people=s minds. Even community psychology interventions, which are supposed to enlarge the scope of solutions, are primarily limited to person-centred coping skills (Prilleltensky & Nelson, 1997). The dilemma resides in trying to frame human problems in interdisciplinary terms, but without giving up the allegiance to the mother discipline of psychology, which is ultimately very limiting in scope (Sampson, 1999; Sloan, 1996). New developments in critical psychology offer praxis frameworks for overcoming parochial epistemological and action approaches (Prilleltensky, 1999a).**

There is a need to turn the gaze of psychology from the victim and the oppressed to the oppressor. Well meaning

professional concentrate of the needs of the disadvantaged, and for good and valid reasons. But we also need to examine what are the motivations that lead so many people to exploit others economically and psychologically with impunity. Surely we need to empower the weak and the oppressed, but we equally need to depower the rich and the exploitive. Psychology should turn its gaze and explore not only Awhat is wrong@ with the poor, but also Awhat is wrong@ with the rich and the greedy and the oppressive. After all, many of these people are the guardians of injustice.

Social Justice

Challenging the status quo means reclaiming the language of social justice. A major victory for the apologists of globalization and capitalism must be the eradication of the term from social debate altogether. Instead, social ills are defined in terms of uncontrollable and unexpected economic turns, devoid of any political connotations or relation to structures of social injustice (Allahar & Côté, 1998). Unless we re-introduce the language of social justice in the public domain, and unless we challenge narrow conceptions of social justice based on merit, chances are psychological problems tied to disadvantage will deepen.

What we need is a process of conscientization. This concept, developed by the Brazilian educator Paulo Freire (1994), refers to the process whereby people attain an insightful awareness of socioeconomic, cultural, psychological and political circumstances affecting their lives, and of their potential to transform that reality. Conscientization is achieved by the concurrent implementation of two tasks, namely denunciation and annunciation. While the former deconstructs ideological messages that distort people=s awareness of oppressive conditions, the latter elaborates means of advancing emancipation and liberation.

Resources

Neo-liberal and neo-conservative governments alike have coopted the language of community development and have used it to reduce resources. Under the pretence that Aempowered@ communities can deal with their own problems, many governments gradually withdraw or privatize essential services such as health (Leonard, 1997). If the poor and the oppressed are to be protected from the severe reduction in resources, governments must be challenged to retain essential services and restore those that have already been cut. Without vital resources, we cannot expect the mental health of the disadvantaged to improve.

Mental Health

Two challenges in promoting wellness and improving mental health are; 1) to expand the definition and scope of interventions from the individual to community and societal levels of analysis; and 2) to shift the emphasis from treatment to prevention (Albee, 1986). The individualistic and reactive nature of psychological treatments is rooted in the cultural model of personal responsibility. Psychology is not and cannot be detached from the predominant values and cultural assumptions of our time. Although some researchers wish psychology could render Aneutral empirical and theoretical truth@ (Kendler, 1993, p. 1046), such an ideal is unattainable.

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 (Prilleltensky, 1999b). 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 (Fox & Prilleltensky, 1997; Prilleltensky, 1999a). Only then can we hope to challenge cultural assumptions that are inimical to mental health and social justice.

References

Albee, G. W. (1986). Toward a just society: Lessons from observations on the primary prevention of psychopathology. *American Psychologist, 41,* 891 898.

Allahar, A. L., & Côté, J. E. (1998). *Richer and poorer*. Toronto: Lorimer.

Basic Behavioral Science Task Force of the National Advisory Mental Health Council. (1996a). Basic behavioral science research for mental health: Family processes and social networks. *American Psychologist, 51,* 622-630.

Basic Behavioral Science Task Force of the National Advisory Mental Health Council. (1996b). Basic behavioral science research for mental health: Vulnerability and resilience. *American Psychologist, 51,* 22-28.

Boggs, C. (1976). *Gramsci's Marxism*. London: Pluto Press.

Brown, C. (1997). Child abuse survey stuns Ontarians. *Canadian Medical Association Journal, 157,* 867.

Cohen, C. (1993). Poverty and the course of schizophrenia: Implications for research and policy. *Hospital and Community Psychiatry, 44,* 951-958.

Cohen, C. (1997). The political and moral economy of mental health. *Psychiatric Services, 48,* 768-774.

Cohen, D. (Ed.). (1990). Challenging the therapeutic state: Critical perspectives on psychiatry and the mental health system. [Special issue]. *Journal of Mind and Behavior, 11*(3/4).

Cohen, D. (Ed.). (1994). Challenging the therapeutic state, Part Two: Further disquisitions on the mental health system. [Special issue]. *Journal of Mind and Behavior, 15*(1/2).

Cushman, P. (1990). Why the self is empty: Toward a historically situated psychology. *American Psychologist, 45,* 599-611.

Dobbin, M. (1998). *The myth of the good corporate citizen: Democracy under the rule of big business*. Toronto: Stoddart.

Eichler, M. (1997). *Family shifts: Families, policies, and gender equality*. Toronto: Oxford University Press.

Fox, D. (1997). Psychology and law: Justice diverted. In D. Fox & I. Prilleltensky (Eds.), *Critical psychology: An introduction* (pp. 217-232). London: Sage.

Fox, D., & Prilleltensky, I. (Eds.). (1997). *Critical psychology: An introduction*. London: Sage.

Freire, P. (1994). *Pedagogy of the oppressed* (rev. ed.). NY: Continuum.

George, V., & Wilding, P. (1976). *Ideology and social welfare*. Boston, MA: Routledge & Kegan Paul.

Gramsci, A. (1971). *Selections from the prison notebooks*. London: Lawrence & Wishart.

Griffin Cohen, M. (1997). From the welfare state to vampire capitalism. In P. M. Evans and G. R. Wekerle (Eds.), ***Women and the Canadian welfare state*** **(pp. 28-67). Toronto: University of Toronto Press.**

Kendler, H. H. (1993). Psychology and the ethics of social policy. ***American Psychologist, 48,*** **1046-1053.**

Kohn, A. (1986). ***No contest: The case against competition*****. Boston: Houghton Mifflin.**

Korten, D. (1995). ***When corporations rule the world*****. San Francisco: Berrett-Koheler.**

Kramer, M. (1992). Barriers to the primary prevention of mental, neurological, and psychological disorders of children: A global perspective. In G. W. Albee, L. A. Bond, & T. V. Cook Monsey (Eds.), ***Improving children=s lives: Global perspective son prevention*** **(pp. 3-36). Hanover, NH: University Press of New England.**

Leonard, P. (1997). ***Postmodern welfare: Reconstructing an emancipatory project*****. London: Sage.**

Macedo, D. (1994). ***Literacies of power*****. Boulder, CO: Westview.**

Mack, J. E. (1994). Power, powerlessness, and empowerment in psychotherapy. ***Psychiatry, 57,*** **178 198.**

McLoyd, V. C. (1998). Socioeconomic disadvantage and child development. ***American Psychologist, 53,*** **185-204.**

Melucci, A. (1996). ***The playing self: Person and meaning in the planetary society*****. New York: Cambridge University Press.**

Miller, D. (1978). ***Social justice*****. Oxford: Clarendon.**

Offord, D., Boyle, M., & Szatmari, P. (1987). Ontario Child Health Study, II: Six month prevalence of disorder and rates of service utilization. ***Archives of General Psychiatry, 44,*** **832-836.**

O=Neill, J. (1994). ***The missing child in liberal theory*****. Toronto: University of Toronto Press.**

Pilgrim, D. (1992). Psychotherapy and political evasions. In W. Dryden & C. Feltham (Eds.), ***Psychotherapy and its discontents*** **(pp. 225 242). Bristol, PA: Open University Press.**

Prilleltensky, I. (1994). ***The morals and politics of psychology: Psychological discourse and the status quo*****. Albany, NY: State University of New York Press.**

Prilleltensky, I. (1997). Values, assumptions, and practices: Assessing the moral implications of psychological discourse and action. ***American Psychologist, 47,*** **517- 535.**

Prilleltensky, I. (1999a). Critical psychology praxis. In M. Montero (Ed.), ***La Psicologia al fin del siglo [Psychology at the end of the century*****] (pp. 279-304). Caracas: Sociedad Interamericana de Psicologia.**

Prilleltensky, I. (1999b). Critical psychology foundations for the promotion of mental health. ***Annual Review of Critical Psychology, 1,*** **95-110.**

Prilleltensky, I., & Gonick, L. (1996). Polities change, oppression remains: On the psychology and politics of oppression. ***Political Psychology, 17,*** **127-147.**

Prilleltensky, I., Laurendeau, M.C., Chamberland, C., & Peirson, L. (1999). Vision and values for child and family wellness. In I. Prilleltensky, G. Nelson, & L. Peirson (Eds.), ***Promoting family wellness and preventing child maltreatment: Fundamentals for thinking and action*****. Book submitted for publication.**

Prilleltensky, I., & Nelson, G. (1997). Community psychology: Reclaiming social justice. In D. Fox & I. Prilleltensky

(Eds.), ***Critical psychology: An introduction*** **(pp. 166- 184). London: Sage.**

Prilleltensky, I., Nelson, G., & Peirson, L. (Eds.). (1999). ***Promoting family wellness and preventing child maltreatment.*** **Book submitted for publication.**

Ransom, D. (1999, May). The dictatorship of debt. ***New Internationalist, 312,*** **7-10.**

Rose, N. (1999). ***Powers of freedom*****. New York: Cambridge University Press.**

Sampson, E. E. (1983). ***Justice and the critique of pure psychology*****. New York: Plenum.**

Sampson, E. (1999). Liberating psychology. In M. Montero (Ed.), ***La Psicologia al fin del siglo [Psychology at the end of the century*****] (pp. 305-322). Caracas: Sociedad Interamericana de Psicologia.**

Sarason, S. B. (1981). ***Psychology misdirected*****. New York: Free Press.**

Saul, J. R. (1995). ***The unconscious civilization*****. Concord, Ontario: Anansi.**

Sloan, T. (1996). ***Damaged life: The crisis of the modern psyche*****. London: Routledge.**

Stauber, J., & Rampton, S. (1995). ***Toxic sludge is good for you*****. Monroe, ME: Common Courage Press.**

Tyler, T. R., Boeckman, R. J., Smith, H. J. & Huo, Y. J. (1997). ***Social justice in a diverse society*****. Boulder, CO: Westview Press.**

U. S. Institute of Medicine (1994). ***Reducing risks for mental disorders: Frontiers for preventive intervention research.*** **Washington, D.C.: National Academy of Science.**

Wilson, M. (1996). Citizenship and welfare. In M. Lavalette & A. Pratt (Eds.), ***Social policy*** **(pp. 182-195). London: Sage.**

Zill, N., Moore, K. A., Wolpow Smith, E., Stief, T., & Coiro, M. J. (1995). The life circumstances of children in welfare families: A profile based on national survey data. In P. L. Chase Landsdale & J. Brooks-Gunn (Eds.), ***Escape from poverty: What makes a difference for children*****? (pp. 38-59). New York: Cambridge University Press.**

Figure Caption

Figure 1: <u>The Direct and Indirect Impact of Cultural Assumptions on Mental Health</u>