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Psychopolitical validity in the helping professions: applications to research, interventions, case conceptualization, and therapy

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Introduction

What is preventing the advancement of liberation psychiatry? Why is it that after so many volumes of critique, the helping professions are still firmly grounded in traditional medical models (Prilleltensky, 1994; Teo, 2005)? How can we challenge the regnant deficit, reactive, disempowering, and individualistic oriented approaches in psychology, psychiatry, social work, counseling, and allied professions? This chapter is a modest attempt to translate the abundant theoretical critique of the helping professions into practical guidelines for action. In our view, there is a wide gap between the cogent reservations about dominant paradigms and actionable formulations. Unless we manage to convert critique into construction, and deliberation into delivery of new practices, the gap between discourse and action will continue to grow, leaving behind a trail of doubly disaffected practitioners; disaffected with the medical model, and disaffected with critical approaches that fail to suggest convincing alternatives for practice.

We build our case for action around the concept of psychopolitical validity. Following an introduction of the construct and its rationale, we articulate its implications for research, interventions, case conceptualization and therapy. The first two areas of interest apply to all the helping professions, whereas the last two pertain more directly to therapeutic interventions.

What is psychopolitical validity?

Psychopolitical validity is a criterion for the evaluation of understanding and action in professions dealing with oppression, liberation, and well-being. The

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criterion consists of the level of attention given to the role of power in explaining psychological and political phenomena affecting suffering and well-being. The term psychopolitical denotes the inseparable nature of psychological and political dynamics. Affective, behavioral and cognitive experiences cannot be detached from power plays being enacted at the personal, relational, and collective levels of analysis. Similarly, political contexts cannot be understood without an appreciation of the subjective, ideological, and cultural forces shaping power relations. This dialectic accounts for the term psychopolitical. As Oliver recently pointed out:

> We cannot explain the development of individuality or subjectivity apart from its social context. But neither can we formulate a social theory to explain the dynamics of oppression without considering its psychic dimension. We need a theory that operates between the psyche and the social. (Oliver, 2004, p. xiv)

When it comes to the psychological, why focus on power and not, for example, on cognitive distortions or the unconscious? When it comes to the political, why focus on power and not, for example, on values or philosophical ideology? In both cases, the alternatives are valid foci of attention. In fact, they have received wide recognition and literally volumes of attention. What we are still missing in the helping professions is a clear articulation of how power dynamics affect cognitive distortions, the unconscious, values and ideology, and what we can do about it.

Power is a central construct in well-being. In the literature, power is dealt with through a variety of proxies, including sense of control, locus of control, empowerment, self-determination, self-efficacy, feelings of inferiority, authoritarian personality, and others. In most cases, however, power is individualized, subjectivized, and decontextualized. Respectively, this means that power is treated as an attribute of individuals, that it is regarded as a phenomenological perception, and that it can be interpreted regardless of surrounding circumstances. Power contains much explanatory merit that has not been captured yet. By bringing to light the collective dynamics of power, its objective sources, and its contextual variables, we stand a better chance of understanding oppression, liberation, and well-being. In essence, the collective, objective, and contextual variables account for the political side of the psychopolitical equation. The more we situate psychological experiences of power in political dynamics, the richer our understanding of oppression, liberation, and well-being.

In short, psychopolitical validity derives from the simultaneous consideration of power dynamics operating in psychological and political spheres at various levels of analysis, from the personal to the relational to the collective. The more

we understand how power influences oppression, liberation, and well-being, the more effective we are likely to be in bringing about a more satisfactory state of affairs for individuals, families, groups, communities, and societies. We can claim that psychopolitical validity is achieved when power has been fully factored into these experiences at the various levels of analyses. When this kind of analysis is applied to research, we refer to *epistemic* psychopolitical validity. When it is applied to interventions, we refer to *transformational* psychopolitical validity.

To be even more precise in our definition of psychopolitical validity, however, we have to offer a precise definition of power. For us, power consists of ten postulates:

(1) *Power refers to the capacity and opportunity to fulfil or obstruct personal, relational, or collective needs.*
(2) *Power has psychological and political sources, manifestations, and consequences.*
(3) *We can distinguish among power to strive for wellness, power to oppress, and power to resist oppression and strive for liberation.*
(4) *Power can be overt or covert, subtle or blatant, hidden or exposed.*
(5) *The exercise of power can apply to self, others, and collectives.*
(6) *Power affords people multiple identities as individuals seeking wellness, engaging in oppression, or resisting domination.*
(7) *Whereas people may be oppressed in one context, at a particular time and place, they may act as oppressors at another time and place.*
(8) *Due to structural factors such as social class, gender, ability, and race, people may enjoy differential levels of power.*
(9) *Degrees of power are also affected by personal and social constructs such as beauty, intelligence, and assertiveness; constructs that enjoy variable status within different cultures.*
(10) *The exercise of power can reflect varying degrees of awareness with respect to the impact of one's actions.*

According to the first tenet, power is an amalgam of ability and opportunity. The aim is to influence a course of events. This definition of power combines aspects of agency, or volitional activity on one hand, and structure or external determinants on the other. Agency refers to ability whereas structure refers to opportunity. The exercise of power relies on the reciprocal determinism of agency and contextual dynamics (Martin & Sugarman, 2000). Agency and contextual dynamics always incorporate psychological as well as political dimensions. Our capacity to act as agents of change for personal or collective benefit depends on subjective, cognitive, behavioral, and affective variables as well as political, economic, and societal factors. In essence, we embrace an ecological view of power (Kelly, 2006).

Power is not tantamount to coercion though, for it can operate in very subtle and concealed ways, as Foucault demonstrated in detailed historical analyses of population control (1979). Eventually, people come to regulate themselves through the internalization of cultural prescriptions. Hence, what may seem on the surface as freedom may be questioned as a form of acquiescence whereby citizens restrict their life choices to coincide with a narrow range of socially approved options. In his book *Powers of Freedom*, Rose (1999) claimed that:

> 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 or sought out by the troubled through the market. Thus, in a very significant sense, it has become possible to govern without governing *society* – to govern through the 'responsibilized' and 'educated' anxieties and aspirations of individuals and their families. (p. 88)

Power, then, emanates from the confluence of personal motives and cultural injunctions. It is not just a matter of persons acting on the environment, but it is a matter of individuals coming into contact with external forces that, to some extent, they have already internalized (Kelly, 2006; Oliver, 2004). The implication is that we cannot just take at face value that individual actions evolve from innate desires. Desires grow from norms and regulations. This is not to adopt a socially deterministic position however, for even though a person's experience depends on the prescriptions of the day, agency does play its part. As Martin and Sugarman (2000) claimed that:

> While never ceasing to be constructed in sociocultural terms, psychological beings, as reflection-capable, intentional agents, are able to exercise sophisticated capabilities of memory and imagination, which in interaction with theories of self can create possibilities for present and future understanding and action that are not entirely constrained by past and present socio-cultural circumstances. (p. 401)

If our goal is to enhance wellness and fight oppression, awareness of our actions and those of our students, clients, and community partners is crucial. People may be aware of being oppressed, but not of being oppressors. We may wish very strongly, and consciously, to liberate ourselves from social regulations, but we may be buying, less consciously, into oppressive cultural norms. Young women may think that dieting is fashionable and will help them achieve popularity, but with dieting come the risks of eating disorders and perpetuating commercialism and consumerism. Contradictions abound. Humanists, for instance, wished to promote individual well-being without recognizing their contribution to the status

quo by individualizing sources of suffering (Prilleltensky, 1994). They wished to advance personal liberation without changing social oppression.

As seen from the foregoing discussion, our conceptualization of power cascades into three subsidiary constructs that also deserve precise definition: oppression, liberation, and well-being. Oppression entails a state of asymmetric power relations characterized by domination, subordination, and resistance, where the dominating persons or groups exercise their power by the process of restricting access to material resources and imparting in the subordinated persons or groups self-deprecating views about themselves (Bartky, 1990; Fanon, 1963; Freire, 1970, 1975, 1994; Memmi, 1968). Oppression, then, is a series of asymmetric power relations between individuals, genders, classes, communities, and nations. Such asymmetric power relations lead to conditions of misery, inequality, exploitation, marginalization, and social injustices.

The dynamics of oppression are internal as well as external. External forces deprive individuals or groups of the benefit of personal (e.g., self-determination), relational (e.g., democratic participation), and collective (e.g., distributive justice) wellness. Often, people internalize these restrictions (Moane, 1999; Mullaly, 2002; Prilleltensky & Gonick, 1996). In short, we define political and psychological oppression as follows:

(1) Political oppression, which is the creation of material, legal, military, economic, and/or other social barriers to the fulfillment of self-determination, distributive justice, and democratic participation, results from the use of multiple forms of power by dominating agents to advance their own interests at the expense of persons or groups in positions of relative powerlessness.
(2) Psychological oppression, in turn, is the internalized view of self as negative, and as not deserving more resources or increased participation in societal affairs, resulting from the use of affective, behavioral, cognitive, material, linguistic, and cultural mechanisms by agents of domination to affirm their own political superiority (Prilleltensky & Gonick, 1996).

Liberation, in turn, refers to the process of resisting oppressive forces. As a state, liberation is a condition in which oppressive forces no longer exert their dominion over a person or a group. Liberation may be from psychological and/or political influences. Following from the previous interpretation of oppression, there is rarely political without psychological oppression, and vice versa (Moane, 1999; Mullaly, 2002).

Building on Fromm's dual conception of "freedom from" and "freedom to" (1965), liberation is the process of overcoming internal and external sources of oppression (freedom from), and pursuing wellness (freedom to). Liberation from social oppression entails, for example, emancipation from class exploitation, gender domination, and ethnic discrimination. Freedom from internal and psychological

sources includes overcoming fears, obsessions, or other psychological phenomena that interfere with a person's subjective experience of well-being. Liberation to pursue well-being, in turn, refers to the process of meeting personal, relational, and collective needs. In fact, we define well-being as a positive state of affairs, brought about by the simultaneous satisfaction of personal, relational, and collective needs of individuals, groups, communities, and societies.

Having defined psychopolitical validity (epistemic and transformational), power, oppression, liberation, and well-being, we are now in a position to explore how psychopolitical validity can inform research in the helping professions. Following that, we examine how psychopolitical validity can inform interventions, case conceptualization, and therapy.

How does psychopolitical validity inform research in the helping professions?

At the macro/collective level, oppressive structures and major paradigms are diminishing the well-being of individuals and communities. Structural components of the status quo (i.e., laws, national culture, HMOs) and fundamental paradigms (i.e., the medical model, capitalism, rugged individualism) are often the underlying causes of oppression, barriers to liberation, and bases of the collective gaps in well-being. Macro-level academic incentive structures also reify the status quo with "in the box" research (Stancato, 2000; Tierney, 1997). Without research designs and processes addressing the underlying structural causes of the issues faced by the helping professions on a daily basis, there will be an eternal revolving door of clients needing services and a never-ending stream of research results that either reify or ineffectively face the oppressive status quo.

The accountability for establishing the relevancy of ecological connections and analyzing power differentials in research design currently falls on the *critics* of research practice, not on the researchers carrying out potentially ecologically and psychopolitically invalid work. As no discipline can realistically hope for a top-down mandate for critical reflection on the dominant paradigm of inquiry, the critical researcher is the premier hope for pursuing liberation in research practice (Table 6.1).

By raising the consciousness of research participants through education and increased control over the research process (Freire, 1970), critical researchers will shift needed power to the community (Nelson & Prilleltensky, 2005). It is the responsibility of the researcher to seek out participation, as research participants may have no exposure to their potential part in the research process (Maguire, 1987). Shifting structural norms and incentives toward creating interdisciplinary research teams will yield better triangulation of research data, a

Table 6.1. Applications to research

Stages of wellness/ empowerment ► / Level of analysis/ intervention▼	Oppression (state):	Liberation (process):	Well-being (outcome):
Macro/collective/ structural/ community	Nomothetic, ameliorative based paradigm of research. Academic research and training structures that reify the status quo.	Shift to culturally conscious, preventative research paradigm. Efforts to build collaborative relationships between disciplines.	Culturally sensitive, preventative, participant driven research. Support for transdisciplinary researchers and teams working in partnership with communities.
Meso/ organizational/ Group/relational	Expert-driven research design and implementation. Dehumanization of research participants.	Seek out participation in all aspects of research. Empower research participants through process and as an outcome.	Empowered stakeholders participating in all aspects of the research process. Equalized power between all parties.
Micro/individual/ personal/ psychological (emotional, cognitive, behavioral, spiritual)	Participants seen as "subjects", passive instruments of the researcher. Labeling/diagnostic focus of research.	Increased voice and choice of participants in research. Shift from diagnosis of weaknesses to cultivation of strengths.	Participants seen as expert agents in the research project. Strengths and resiliency of participants identified and supported.

better understanding of oppressive conditions, and create a collaborative atmosphere that welcomes critical reflection on the research questions, process, and outcomes. Only once practical exemplars of participatory research become common will policy and institutional culture shift away from its oppressive roots.

Research that supports the well-being of communities and societies is participatory, culturally appropriate, and pursues well-being over adjustment to existing conditions. This not only requires measuring traditional variables of focus, but also tracking the shifting position of the researcher within the ecological

topography of the research setting and the constantly changing power dynamics between all participants (Hesse-Biber *et al.*, 2004). Macro-level structures and paradigms change slowly and with much effort, but enduring transformation at this level will have an effect on many oppressed communities and individuals – often eroding the root causes of countless crises, making collective change a necessary part of liberation.

At the meso/relational level, the interaction between researcher and participants is largely expert-driven (Prilleltensky, 2005) – wherein the researcher is seen as the holder of knowledge and the "subjects" are seen as data. As a result of this relationship, research results accumulate as academic and medical knowledge, not as actionable information available to the communities and individuals that need it most. The dehumanization of participants parallels their disempowerment in other civic and social relationships (Kenig, 1986), making normal research in the helping professions just another cog in the oppressive machine of society.

Liberation and empowerment of research participants must be seen as more than a purely individual endeavor, instead focusing on mutual respect and democratic participation between all stakeholders and researchers (Perkins & Zimmerman, 1995). At the meso-level, liberation research conceptualizes and measures interpersonal and organizational interactions as the units of analysis (Peterson & Zimmerman, 2004), while fostering the development of social power for participants (Speer & Hughey, 1995). By granting voice and choice to participants in all interactions within the research process, participation and empowerment will become a cultural norm in interpersonal research discourse. These elements of liberation also open the door to actionable research outcomes, rather than merely seeking an accumulation of catalogued data.

Research that fosters interpersonal well-being is collaborative, empowering, reflective, and action oriented (Speear & Hughey, 1995). Participants are given a seat at the research table – wherein they have reasonable power over all aspects of the research process and are fully aware of their position, the research purpose, and the actual and potential effects of the research outcomes. The goal of relationships with – and between – participants is to equalize power and organize for the pursuit of well-being.

At the micro/personal level in our traditional research paradigm, participants are seen as mere 'subjects' serving only as the passive instruments of the researcher – virtually inanimate points of datum. Traditional research in the helping professions often aims to find individualistic etiology and treatment that fits into a nomothetic, universal framework. This paradigm is the accepted norm in psychiatric research for a number of useful reasons, like determining genetic markers of mental illnesses, compiling effective treatments, and so forth (Blashfield & Livesley, 1999; Raulin & Lilienfeld, 1999). The advantages of this approach alone

would be a boon to the helping professions, but the disadvantages often outweigh these achievements. The entire research process has disempowered participants – resulting in habituation to this unacceptable state of affairs, making the oppressive state seem justified and necessary (Montero, 1998).

Although empowerment is an interpersonal process, it is often misinterpreted as a responsibility to foist onto the individual as a means of micro-level transformation (Perkins & Zimmerman, 1995). Increased voice and choice of participants in research is necessary, but this power shift must be facilitated beyond the micro-sphere. In light of the stigmatization, suspicion, fear, and hostility experienced by individuals diagnosed with a psychopathology (Murphy, 1976), we must also challenge the continued taxonomic research paradigm. In order for the oppressive state of affairs to change, the normalcy of traditional research must be deconstructed.

Well-being at the micro-level includes participants as expert agents in the research process, with control over the research questions, processes, and applications. Personal empowerment is strengthened by participants' voice and choice in the research. Their strengths are sought and cultivated, rather than being subjected to systematic labeling and pathologizing. Researchers that support liberation and well-being at the micro-level are actively connected with the lives and experiences of the people that they work with, fostering self-determination and re-humanization of all participants.

How does psychopolitical validity inform interventions in the helping professions?

In this section, we define interventions as organizationally or institutionally based coordinated efforts to affect a single problem or set of issues in a population. This can be a state-run case management of people experiencing homelessness, for-profit community mental health centers, the action component of an action research project to reduce depressive symptoms in a community, or any number of coordinated efforts to aid people in need. What separates interventions from therapy in this context is the coordinated – often meso level – effort, rather than an individual therapeutic setting.

At the macro/collective level, organizations and practitioners intervening in social and community settings have the collective ability to avoid numerous pitfalls of individual practice, but many interventions still commit the *context minimization error* by ignoring or downplaying enduring contextual factors when more sensitivity to multi-level issues of power and ecological influence are warranted (Shinn & Toohey, 2003). Although many interventions started with a liberatory mission, structural and cultural influences eroded the vision and practice over time. As an

example, the community mental health movement fell from its original social mission by the early 1980s due to funding decreases, diminished media attention, and a lack of unified ideals and practice (Kenig, 1986).

The erosion of ideals in interventions paved the way for a top-down process of psychiatric colonization (Table 6.2). Context has taken a back seat to establishing nomothetic responses to mental illnesses in interventions, rather than examining the relevant ecological and psychopolitical factors that weigh heavily on the presentation of mental illness. We know that mental illnesses such as schizophrenia have clearly traceable biological components, but none stand alone as causal (Green, 1998). Many other mental illnesses have tenuous biological or genetic etiology at best, making the wholesale minimization of macro level influences a dangerous leap of faith (Gorenstein, 1984).

In order to pursue liberation at the collective level, interventions must understand and act upon the cultures and societies that an individual or population is embedded in. To affect the lives of people who are experiencing homelessness and mental illness, a coordinated intervention should not just hand out psychotropic medications, but create or find affordable and sustainable housing, reduce social stigma of the target population, seek to change social policies that create undue economic stress, etc. An intervention that continuously commits the context minimization error not only eschews a mission of liberation, but also aids the status quo by reifying a structure that requires individualized pharmaceutical-induced adjustment to oppression.

Interventions that support well-being at the macro-level utilize professional resources to advocate for structural change and organize populations to achieve their own liberation within society. Such an intervention would prevent and ameliorate the effects of globalization and colonialism, instead of just accepting macrospheric forces as unfortunate givens.

At the meso/interpersonal level, there is an acute tension between Western diagnosis and community culture. Western psychiatry constructs universal causes and cures, while many communities and cultures understand the elements of human interaction missing in Western interventions (Castillo, 1997; Kirmayer, Young, & Hayton, 1998). Fromm (1958) captures the interpersonal issues that are raised by mental illness – often ignored by current interventions: "Mental illness is always a sign that basic human needs are not being satisfied; that there is a lack of love, a lack of reason for being, a lack of justice; that something important is missing and, because of this, pathological trends are developing" (p. 2).

Fabrega (1989) asserts that the biomedical science of the West – touted as pure objective fact – is merely another culturally grounded theory. This "theory" has been used as a biological marker to exclude people from society, ala racism, sexism, and xenophobia. Without needing to refute biological evidence, we must include

Table 6.2. Applications to intervention

Stages of wellness/ empowerment ► / Level of analysis/ intervention▼	Oppression (state):	Liberation (process):	Well-being (outcome):
Macro/collective/ structural/community	Top-down process of psychiatric colonization. Decontextualized, culturally insensitive intervention strategies. Deficit based interventions aiming to adjust patients/clients to existing macro-structures.	Increased control and participation of intervention recipients. Inclusion of context and culture in intervention planning. Investigation of client and community strengths, structural change to promote a healthy society.	Partnerships between professionals, communities, and individuals to execute interventions. Culturally and contextually valid strategies. Strengths based focus, social programs and collective cultures that put health over profit.
Meso/organizational/ group/relational	Devaluization of local knowledge. Western science and perspective viewed as objective fact. Diagnostic focus creates stigmas for people seeking help.	Wider use of cultural knowledge in the DSM-IV and in intervention planning. Western medical model can be seen as just another culturally bound perspective. Shift to participatory and narrative approaches to rehumanize people seeking help.	Partnerships between professionals and help-seekers to plan and execute interventions. Equal weight given to the advantages of all culturally bound knowledge, whether Western or local. Valued interplay between experience and taxonomic knowledge.
Micro/individual/ personal/psychological (emotional, cognitive, behavioral, spiritual)	No ownership by clients of intervention goals, processes, or outcomes. Addiction, low self-esteem and low self-efficacy brought on by oppressive conditions.	Education about and participation in interventions. Consciousness raising and skill building.	Participant knowledge and ownership of the intervention. Individuals with high self-efficacy and esteem participating in interventions, political processes, and organizing.

community-level contextual factors in the formulation and execution of interventions in the helping professions to avoid further marginalization of those seeking help.

Widiger and Clark (2000) note a growing acceptance in mainstream psychiatry of including cultural factors in the diagnosis of psychopathology, as evidenced in the DSM-IV. Although this is a step in the right direction, this shift will likely fall short of advancing well-being without changes in other areas of the medical model. Interventions must move beyond changes in diagnosis to changes in conceptualization of mental and social ills. Local knowledge can be captured in narratives (White & Epston, 1990) or through participatory research (Maguire, 1987) to inform interventions.

At the interpersonal level, well-being includes partnerships between professionals, communities, and individuals to execute interventions (Israel *et al.*, 1998). Pooling the knowledge of all stakeholders alleviates many of the pitfalls of Western diagnosis, while the relationships formed through partnerships reflexively inform the intervention process. Well-being requires awareness and action at the interpersonal level, wherein control is commensurate with stake, and symptoms are recognized as a community issue rather than a purely medical one.

At the micro/personal level, affected stakeholders have little or no ownership of intervention goals, processes, and outcomes. Individuals are labeled, categorized, managed, treated, and pushed through a system that alienates and stigmatizes them (Murphy, 1976). From this vantage, interventions appear to be an organized effort to manage and medicate clients that are seeking help. Individuals may internalize these or other oppressive conditions, potentially leading to disempowerment, addictions, diminished mental health, or myriad other personal issues (Prilleltensky, 2003).

An increase in participation in the intervention process also aids in liberation at the personal level. Power over goals and strategies helps individuals build identity and resist oppression (Prilleltensky, in press). Liberation should also include raising the consciousness of individuals through educational projects (Freire, 1970) and educational components of helping interventions. Individual strengths must be noticed and fostered, as the skills of the individual are an essential part of multi-level liberatory action (Watts, Williams, & Jagers, 2003).

The well-being of the individual extends beyond mere participant ownership of the intervention. People experiencing wellness are also freely participating in political processes, experiencing enhanced physical health, and have a greater self efficacy (Prilleltensky, 2005). The liberated individual personally experiences the positive state of affairs brought about by their path to well-being, rather than being a passive recipient of collective or interpersonal benefits.

How does psychopolitical validity inform case conceptualization in the helping professions?

In this section we focus on the application of psychopolitical validity and the constructs of oppression, liberation, and well-being to the lives of clients who present for counseling and psychotherapy. We highlight some key problems with traditional approaches to client assessment and case conceptualization and provide an alternative framework that is consistent with empowerment and well-being.

It is probably safe to say that the vast majority of helping professionals have received solid training in assessment and case conceptualization. Most professionals would agree that setting goals and developing an appropriate intervention plan is contingent upon a thorough exploration and understanding of troublesome aspects in the lives of clients. Once a client tells her story and explicates her reason for seeking therapy, a thorough and collaborative exploration of the components of the problem can set the stage for intervention. This typically includes an understanding of overt behaviors, affective components, and cognitions and beliefs associated with presented concerns. Case conceptualization from a cognitive-behavioral framework also includes an exploration of the frequency, intensity, and duration of the problem as well as its antecedents, consequences, and pattern of contributing variables (Table 6.3) (Cormier & Cormier, 1997; Hackney & Cormier, 2005).

Professional literature on case conceptualization emphasizes that a thorough analysis of problem areas should be supplemented with details on client strengths, assets, and resources. However, we venture to say that in most intake interviews, case conceptualization notes, and psychological and psychiatric reports, there is a stark imbalance between the wealth of information denoting problem areas and the dearth of information on client strengths and resources. "Being problem-oriented, the clinician easily concentrates on pathology, dysfunction, and troubles, to the neglect of discovering those important assets in the person and resources in the environment that must be drawn upon in the best problem-solving efforts" (Wright & Lopez, 2002, p. 36). Psychiatry, as a field, has focused on the diagnosis and treatment of mental illness and, as such, has concentrated on the pathological and abnormal components of human functioning. Clinical psychology has followed in the steps of psychiatry in its efforts to develop interventions and best practices that can cure mental illness, or at least minimize its destructive impact on the lives of affected individuals. As a result, there has been a much greater focus on assessing pathology and mental illness than on identifying and amplifying well-being (Maddux, 2002; Seligman, 2002a, b). Seligman (2002a, b) quips that the National Institute of Mental Health (NIMH) formed in 1947 may well have been called the National Institute of Mental Illness, given its almost exclusive focus on mental disorders and neglect of mental health.

Table 6.3. Applications to case conceptualization

Stages of wellness/ empowerment ► / Level of analysis/ intervention▼	Oppression (state):	Liberation (process):	Well-being (outcome):
Macro/collective/ structural/ community	Context minimization error: failing to assess for and highlight the role of macro-level systemic factors (i.e., poverty, neighborhood violence) as well as social policies and cultural norms (i.e., xenophobia; blame the victim mentality) that increase problematic functioning and decrease well-being. In a similar vein, failing to assess macro-level factors (i.e., greater gender equality) that enhance well-being.	Highlighting macro-level constraints and their correlation with problematic functioning at the personal, interpersonal and familial level.	Highlighting the interdependence between personal, organizational, and collective well-being. Acknowledging that micro-level interventions are necessary but insufficient and must be supplemented with meso and macro-level interventions. Must realize that personal well-being cannot be attained in the absence of organization and collective well-being.
Meso/ organizational/ group/relational	Failing to assess for, or giving insufficient weight to contextual factors and organizational structures (i.e. school climate, work environment) that increase problematic functioning and decrease well-being. Failing to assess for contextual factors and organizational structures that reduce problems and enhance	Identifying meso-level constraints that increase dysfunction and reduce well-being (i.e., bullying at school; an unhealthy work environment). Identifying and amplifying meso-level factors that currently serve as protective factors (i.e., positive school climate; collaborative work environment).	Clear guidelines for meso-level interventions designed to alleviate distress, dysfunction and/or mental illness. Clear guidelines for meso-level interventions designed to enhance well-being, flourishing, and mental health. Clear guidelines for strengthening and building on positive structures.

	well-being, as well as factors and structures that have the potential for doing so.	Assessing ways of building on healthy structures and affecting those that impede well-being.	
Micro/individual/ personal/ psychological (emotional, cognitive, behavioral, spiritual)	Amplifying deficits and dysfunction. Ignoring strengths and resilience. Focusing exclusively on alleviating illness and distress. Overlooking potential for flourishing and well-being.	Supplementing problem assessment with situations when said problem was resisted or overcome. Assessing for internalized oppression. Inquiring about health-enhancing relationships and problem-free spheres in the client's life. Assessing for personal strengths, assets, and examples of thriving and well-being.	A balanced assessment process that builds on personal strengths, assets, and resources (i.e., good social skills; perseverance). Clear guidelines for individually based interventions designed to alleviate distress, dysfunction and/or mental illness. Clear guidelines for individually based interventions designed to enhance well-being, flourishing, and mental health.

A case conceptualization that it is largely based on explicating deficiencies of the individual in question misses the mark on several fronts. Not only are personal strengths and assets not given due consideration, but the role of the environment in shaping personal experience and psychological functioning recedes to the background (Wright & Lopez, 2002). Drawing upon research on information processing, perception and social psychology, Wright and Lopez (2002) make a cogent case for how we systematically undermine the potency of the environment in undermining or enhancing mental health and well-being as well as creating pathology or protecting from it, as the case may be. By definition, environment is at the background while individuals are at the foreground, "active, moving in space, commanding attention by their behavior" (p. 32). Furthermore, "where the primary mission of a treatment center is to change the person, assessment procedures will be directed toward describing and labeling person attributes. The danger is that the environment scarcely enters the equation in understanding behavior" (p. 35). To this, we add that environment should not be seen as a single construct. Thus, when it is taken into consideration in the assessment process, it is often at the level of immediate contexts and relationships versus organizational and systemic structures that can impede or enhance well-being. Meso-level organizational structures and macro level systemic barriers rarely find their way into the process of assessment and diagnosis.

Wright and Lopez (2002) assert that professional tendency to focus on personal dysfunction and undermine the role of the environment can be addressed by adopting a four-front approach to assessment. The four components entail personal weaknesses and deficiencies; personal strengths and resources; environmental lacks and deficiencies; and environmental resources and opportunities. Elsewhere, we suggested a similar assessment process using the acronym ROWS: "Risks" and "opportunities" pertain to the environment whereas "weaknesses" and "strengths" pertain to the person (Prilleltensky & Prilleltensky, 2006).

We further contend that case conceptualization that highlights personal deficiencies, ignores personal strengths, and minimizes environmental barriers, is disempowering, oppressive, and contraindicated with mental health and well-being. This is particularly applicable to marginalized populations that, on a daily basis, have to contend with a host of structural and systemic barriers that are played out in the arena of their personal lives. Bronfenbrenner's ecological theory emphasizes that environment extends far beyond the immediate settings in which a person engages. It includes relationships between arenas, influences of larger settings in which the person may not directly participate, as well as the culture at large (Lemme, 2006). Thus, daily exposure to an unhealthy and oppressive work environment will likely spill over to the home front, just as a board decision to close down an unprofitable plant could lead to dire consequences for particular individuals and families. Factors such as these, however, are rarely taken into consideration when Johnny's parents

are summoned to a school conference to discuss his problem behavior or when a previously happily married couple experiences a high level of marital discord. In the words of relationship scientist Ellen Berscheid, sayings such as "love conquers all" are based on romantic beliefs that "close, committed, and loving relationships are impermeable and unsinkable vessels that can sail through any environmental storm with impunity" (Berscheid, 2004, p. 31).

As we stated earlier, psychological and political dynamics are intertwined. As indirect and unrelated as it may seem, the well-being of individuals is highly affected by the distribution of societal resources and by power plays being enacted at the personal, relational, and collective levels of analysis. If our goal is to move from a problem-saturated, person-centered and thus oppressive assessment process toward one that is broad-based, affirming, and liberating, a paradigm shift is in order. We propose an assessment process that will integrate individual-relational, organizational, and systemic factors that can hinder or facilitate well-being. These correspond to the micro-, meso-, and macro-levels of analysis, respectively. Given our focus on case conceptualization, the micro (personal-relational) level of analysis is most closely related and thus easiest to understand. We suggest, for example, that an empowering assessment process would directly explore client strengths, assets, and examples of thriving and well-being. Some of the recent literature on human flourishing provides operational definitions of symptoms of mental health. Rather than simply assessing for the absence or presence of pathology, health care professionals can assess for indications of mental health as well as assist their clients to move in this direction (Keyes, 2003).

Moving up to the meso-level of analysis, a liberating and empowering assessment process would highlight abuses of power and organizational constraints (i.e., bullying at school; top-down, hierarchical work environment) that interfere with well-being, and explore ways of affecting change. Such an assessment process should result in clear guidelines for interventions, not only at the individual and interpersonal level, but at the organizational level as well. We cannot help a child who is the victim of bullying without dealing with the bullies and the system that allowed the behavior to take place.

As a final example, a liberating assessment process must acknowledge the insidious, almost invisible relationship between cultural norms, power imbalances, and unjust allocation of societal resources on the one hand, and distress and maladaptive functioning at the personal, interpersonal, and familial level, on the other. Thus, an atmosphere of xenophobia and collective anger toward undocumented workers "who are taking our jobs" is likely to permeate the work environment and the school climate and potentially infect marital and family relationships. An undocumented worker who suffers from powerlessness on the job may nonetheless abuse power in his relationship with his wife and children. Internalizing the oppression is also a

definite risk, whereby one comes to believe that he is not worthy or deserving of more resources or more control over his life. Next, we explore the implications and applications to counseling and psychotherapy.

How does psychopolitical validity inform counseling and psychotherapy in the helping professions?

An assessment process that is grounded in client deficiencies and problem areas will invariably result in a treatment plan designed to "fix" the individual in question. As long as we consider the problem as residing within the individual client or family unit and limit our goal to the elimination or reduction of problematic functioning, we will design a person-centered treatment plan that is unlikely to consider broad environmental factors or focus on flourishing and well-being. We are not suggesting that maladaptive functioning at the personal level should not be targeted for intervention. Nonetheless, if done in the absence of accentuating client strengths and without proper grounding in interpersonal, organizational, and systemic contexts, it is ineffective at best, and harmful at worse.

The importance of contextualizing personal experience is central to feminism and feminist therapy. "Although we view people as active agents in their own lives and as such, constructors of their social worlds, we do not see that activity as isolated . . . rather, we locate individual experience in society and history, embedded within a set of social relations which produce both the possibilities and limitations for that experience" (Acker *et al.*, 1991, p. 135). While written in reference to feminist approaches to research, the above quote has clear implications for therapeutic interventions. The political analysis of psychological distress is at the heart of feminist therapy. This is represented by one of its core principles "the personal is political" and is highly consistent with the construct of psychopolitical validity. One of the major goals of feminist therapy is the empowerment of women who are struggling with sexual and other forms of inequalities (Brown, 1994; Watson & Williams, 1992). Nonetheless, its principles and strategies are applicable to multiple sources of inequality and oppression and to therapeutic interventions with women as well as men.

Feminist therapy, along with narrative therapy (Morgan, 2000; White & Epstein, 1990), critical psychology (Prilleltensky, 1997; Prilleltensky & Nelson, 2002), community counseling (Lewis *et al.*, 2003), and multicultural counseling and therapy (Ivey *et al.*, 2002), represent alternative therapeutic paradigms that directly address discrimination, oppression, and other systemic barriers (Table 6.4). As such, they pass the test of psycho-political validity and are consistent with liberation, empowerment, and well-being. In addition to addressing personal and interpersonal sources of distress as well as their extra-personal correlates, these paradigms focus on

Table 6.4. Applications to counseling and psychotherapy

Stages of wellness/ empowerment ► / Level of analysis/ intervention▼	Oppression (state):	Liberation (process):	Well-being (outcome):
Macro/collective/ structural/ community	Failing to address macro-level systemic factors (i.e., poverty, neighborhood violence) as well as social policies and cultural norms (i.e., xenophobia; blame the victim mentality) that increase problematic functioning and decrease well-being. In a similar vein, failing to amplify and build upon macro-level factors (i.e., greater gender equality) that enhance well-being.	Provide information and education on the interdependence of personal, organizational, and collective well-being. Develop alliances with groups committed to social justice. Identify problems that are best addressed through social/political action. Work along with stakeholders and allies to lobby legislatures and affect public policy.	Highlighting the interdependence between personal, organizational, and collective well-being. Partner with social movements and other community organizations working to advance the well-being of disadvantaged populations.
Meso/ organizational/ group/relational	Failing to address contextual factors and organizational structures (i.e., school climate, work environment) that increase problematic functioning and decrease well-being. "Helping" clients adapt to flawed structures and organizations without attempting to affect change at the level of the organization.	When appropriate, direct advocacy on behalf of clients in order to help them gain access to needed resources and services. Working to change organizational structures, policies, and practices that increase dysfunction and reduce well-being (i.e., bullying at school; an unhealthy work environment). Amplifying and building on meso-level factors that currently serve as protective factors (i.e., positive school climate; collaborative work environment).	Power-brokers gain a better understanding of environmental constraints and authorize health-enhancing services and resources. Personal and interpersonal change is supplemented with organizational change.

Table 6.4. (cont.)

Stages of wellness/ empowerment ▶ Level of analysis/ intervention▼	Oppression (state):	Liberation (process):	Well-being (outcome):
Micro/individual/ personal/ psychological (emotional, cognitive, behavioral, spiritual)	Targets for intervention narrowly defined as deficits and dysfunction within the person. Client is not encouraged to contextualize problematic functioning within broader systemic factors. Strengths, resilience and potential for flourishing and well-being are not actively pursued.	Problems are contextualized within broader systemic factors (i.e., the personal is political) and internalized oppression is a target for intervention. Focusing on health-enhancing relationships and problem-free spheres in the client's life and looking for situations when the problem does not occur. Targeting factors associated with well-being (self-determination; environmental mastery; optimism; positive relationships; social engagement).	Client comes to understand struggles as emanating from intrapersonal, interpersonal, and extrapersonal sources. Client takes responsibility for own behavior and functioning and works to change whatever is within her control. Client considers possibility for working toward meso- and macro-level changes.

harnessing client strengths and helping clients explore ways of resisting oppressive forces. For example, narrative therapists believe that people make meaning through the stories they tell about their lives. Life stories that are experienced as oppressive and diminishing are often based on "thin conclusions" made about individuals by others in position of power and authority. Once these thin conclusions take hold, there is a tendency to focus solely on gathering evidence that support the problem-saturated stories (Morgan, 2000; White & Epstein, 1990). Narrative therapists help their clients develop alternative stories by which they would like to live their lives. "Just as various "thin descriptions" and conclusions can support and sustain problems, alternative stories can reduce the influence of problems and create new opportunities for living" (Morgan, 2000, p. 14). This is particularly important as some dominant cultural stories about certain groups are oppressive and diminishing. Rather than making meaning through these stories, clients can create new stories of resistance, empowerment, and liberation.

Micro-level interventions with clients include building on strengths that can serve as protective factors and buffer against dysfunction and adversity. Understanding and nurturing optimism and hope, building social skills and emotional intelligence, and enhancing self-efficacy and environmental mastery are examples of positive interventions designed to enhance well-being rather than simply ameliorate dysfunction (Lewis *et al.*, 2003; Seligman, 2002a). It is also important to remember that marginalized and vulnerable citizens often have to interact with representatives of organizations in positions of power that act as gate keepers and have a lot of control over the allocation of services and resources. Thus, in accordance with self-efficacy, environmental mastery, and self-determination, therapeutic work with clients can include communication, influencing, and problem-solving skills that can help them become more proficient in negotiating systems and becoming strong self-advocates. This is particularly important given the constant shrinking of the social safety net and fierce competition for dwindling resources.

As effective as they may be, micro-level interventions with individual clients and families are not enough. Clients may well benefit from gaining a host of health-enhancing skills and competencies. Nonetheless, if the source of the dysfunction is in the systems with which they interact, those systems should be the target of intervention. In Ora Prilleltensky's research on disability, a number of participants commented on growing up with a physical disability and attending special schools. Consistently, they commented on the lack of emphasis placed on academic achievement and on the poor quality of education that they received: "There was such an emphasis on students doing things like physiotherapy and so kids would be pulled out of class to go to therapy . . . the level of the school was not the same as it was in the integrated programs . . . it was also like this huge playground . . . there weren't the expectations that you do your homework or that you have any

movement toward adult responsibilities or any kind of responsibilities" (Prilleltensky, 2004, p. 110). No one would suggest that the children in question should adapt in order to fit the system. Clearly, the target of intervention here should be the school system and not the individual client. Although assisting from the sideline is generally preferred, it may also be appropriate to help clients gain access to needed resources by directly negotiating for relevant services and resources on their behalf. Mental health professionals can use their effective communication skills and privileged status to intervene with power brokers who can authorize wellness-enhancing services that can make a difference in the lives of vulnerable clients (Kiselica & Robinson, 2001; Lewis *et al.*, 2006).

If we accept the premise of psycho-political validity that psychological and political dynamics are intertwined, our interventions cannot focus exclusively on the psychological or even the organizational to the total neglect of the political. "Given the impact of the environment on the well-being of clients, counselors need to influence educational, corporate industrial, social, and political systems. They can do this by raising the general awareness of the problems common to their clients, gaining support from policy makers, and encouraging positive community action" (Lewis *et al.*, 2003, p. 34). This might seem like a tall order and a daunting task for many of us in the helping professions who feel that we lack the time and the expertise to affect macro-level forces. After all, social change and systems advocacy are typically not part of the toolbox we painstakingly assembled over the course of our training and internships. In the field of counseling at least, this is becoming increasingly recognized by training programs that are supplementing interventions for personal change with advocacy skills and systems change. Furthermore, there is a growing body of literature that can serve as a roadmap on how this can be accomplished (Kiselica, & Robinson, 2001; Lewis *et al.*, 2003; Prilleltensky & Nelson, 2002). Recently, Lewis, Arnold, House and Toporek (2006) have generated an extensive list of advocacy competencies, much like the multicultural competencies that have become widely accepted by counseling professionals (Sue *et al.*, 1992). Common to all such attempts to operationalize macro-level interventions is the reminder that we don't have to do it all and we don't have to do it alone. But, we have to do it.

Conclusion

L. F. Harrell – one of my (Courte) mentors – shared with me an oft overlooked or ignored reality in the helping professions: There is an inherent contradiction between pursuing well-being and pursuing adjustment to the status quo. Many technologies – i.e. tests, data collection methods, behavioral techniques, etc. – available to researchers, practitioners, and students are neutral until the values of the user are applied (L. F. Harrell, personal communication, 2006). Whether in research, interventions,

case conceptualizations, or therapy, we choose the direction that these technologies take. If we follow the path of least resistance, we likely align ourselves with adjustment to the status quo. Only by critically engaging with our institutions, colleagues, disciplinary traditions, communities, clients, etc., will we be able to pursue liberation and well-being. Both goals cannot be pursued simultaneously.

We assert that only through the coordination or combination of research, intervention, case conceptualization, and therapy can we clearly see the oppressive status quo, work toward liberation at all levels, and support well-being for those seeking help and society at large. We must avoid the myopic tendency that led to current paradigms in the helping professions, instead advancing liberation on all fronts.

The optimist assumes that most people entered the helping professions to advance the well-being of individuals, families, communities, and society rather than to advance the continued stratification and power inequality existing across the globe. Following this assumption, the structures that train and support researchers and practitioners have diverted many well-meaning helpers from the path of liberation. Therefore, liberation is not only the work of existing critical helpers or those new to research and practice, but to all who entered their profession for the sake of pursuing well-being that have been forcefully adjusted to the structures of their guild. This structural influence underscores the need for internally focused liberation as well as externally focused efforts. To use a well-known analogy: In the event of a loss of cabin pressure, you must put your oxygen mask on first, then assist those unable to do so themselves.

NOTE

(1) The authors have equally contributed to this chapter and are listed in alphabetical order.

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