Journal of Human Rights and Social Work (2018) 3:202–215
https://doi.org/10.1007/s41134-018-0061-8

Transformative Consciousness of Health Inequities: Oppression Is a Virus and Critical Consciousness Is the Antidote

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Published online: 6 July 2018

Abstract
Oppression has been identified as a fundamental cause of disease. Like a self-replicating virus, it infects systems from the biological to the political, contributing to personal (e.g., substance use, low self-esteem) and social (e.g., community violence, mass incarceration) dysfunction. Paulo Freire's critical consciousness (CC) is a philosophical, theoretical, and practice-based framework that has been identified as an antidote to oppression. Critical consciousness constitutes an awareness of, and action against, institutional, historical, and systemic forces that limit or promote opportunities for certain groups. Although the CC theory has been used to address inequity, very few scholars have attempted to conceptualize, operationalize, and describe the development process of CC. In response to the conceptual inconsistencies widely noted in the CC literature, this paper presents a new construct, transformative consciousness (TC), composed of three domains: awareness, behavioral-response, and consequence, for each level of the socio-ecosystem. The staged process of TC development is also described. The theoretical framework of TC can be applied to various social issues, such as violence, targeted incarceration, homelessness, HIV/STI infection, and substance use—all of which have tremendous implications for health and well-being as a human right. With further research, transformative consciousness may prove necessary to move persons in the direction of anti-oppressive, individual, and collective action to overcome and dismantle oppression, creating a healthier and more just and liberated society.

Keywords Critical consciousness · Oppression · Inequity · Social justice · Liberation health

> The human right to health means that everyone has the right to the highest attainable standard of physical and mental health, which includes access to all medical services, sanitation, adequate food, decent housing, healthy working conditions, and a clean environment. (NESRI, 2017)

Paulo Freire's (Freire 2000) critical consciousness (CC) is a philosophical, theoretical, and practice-based framework encompassing an individual's understanding of and action against the structural roots of personal (e.g., low self-esteem, substance use) and societal (e.g., community violence, targeted incarceration) problems. When applied to socio-structural determinants of health (e.g., stigma, substandard housing, lack of access to employment and health care), critical consciousness may present a model for achieving health equity (Barr 2014; Chronister and McWhirter 2006; Windsor et al. 2015a). Oppression is a pervasive and deeply ingrained process within our daily American social reality, such that "it can be difficult to discern, like the water we swim in or the air we breathe" (Speight 2007, p. 126). Social constructions, like race and gender, reflect social, economic, and political power and access to opportunities. The differential treatment of people based on these socially constructed phenomena (e.g., racism, sexism) has demonstrable impact within the health domain, denying marginalized populations their human right to health. The cyclical nature between processes (e.g., community policing practices) and outcomes of social injustice (e.g., racial disparity in targeted incarceration) creates a self-perpetuating phenomenon; like a virus, social injustice infects the host system at various levels and scales, from individuals to families to institutions. The infected system malfunctions and produces oppressive outcomes. The health care system provides a strong practical example in that this system, meant to support health and well-being, has mass-produced gross inequities that hurt marginalized populations (Macias 2017).

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Public health research has documented health inequities between racial/ethnic groups, with African Americans and Latinos experiencing greater negative health consequences and less access to quality health care than their white counterparts (Boardman and Alexander 2011; Jackson et al. 2010). Specifically, African Americans are disproportionately plagued by chronic health conditions from obesity to diabetes to heart disease (Jackson et al. 2010) and have higher prevalence rates for related conditions (i.e., heart failure, coronary heart disease, hypertension, and stroke) compared to their white counterparts (James et al. 1983; Mead et al. 2008). One could interpret these disparities as caused by individual differences or lifestyle choices between whites and non-whites. However, research suggests explanatory variables for these health disparities are lodged in differential treatment and structural factors. Thus, social problems (e.g., substance use, HIV/STI infection, targeted incarceration) represent symptoms of the underlying inequitable conditions; and the underrecognized role of systemic inequity in social problems perpetuates health inequities.

Empirical studies on discrimination and health over the last two decades have provided evidence of the relationship between oppression and health (Krieger 1999; Paradies 2006; Williams and Mohammed 2009; Williams et al. 2003). Underlining the pervasive influence of racism, blacks in the USA are more likely to have a chronic illness or disability when controlling for age and income (Barr 2014; Mead et al. 2008). These racial disparities in health are rooted in and perpetuated by several intersecting socio-structural inequities that disadvantage marginalized populations. Such inequities include inadequate housing, poor access to nutrition, neighborhood segregation, community violence, lack of green space, toxic segregation, neglect of public services such as sanitation, and other health hazards and environmental factors disproportionately harming communities of color (Barr 2014; Mead et al. 2008). Compounding these socio-structural determinants are failures within the health care system, such as problems accessing services, lower quality of care for minority populations, and oppressive beliefs and behaviors of health care providers (Barr 2014; Mead et al. 2008). For example, black and white women are equally likely to have a mammogram; however, health care professionals are less likely to adequately communicate the screening results to their black patients, particularly if the mammogram results are abnormal (Jones et al. 2007). As such, tools of oppression, such as systemic discrimination (e.g., racism, classism, sexism), "have received increasing recognition as one of the main mechanisms to explain racial and ethnic inequities in health in the U.S." (Abdulrahim et al. 2012, p. 2116).

Consequently, racial/ethnic discrimination, systemic inequity, and differential treatment as a form of toxic stress and trauma present another pathway to poor health (Bryant-Davis and Ocampo 2005; Carter 2007) that can greatly compromise psychological and physical health and well-being (Brown-Reid and Harrell 2002; Clark et al. 1999; Jackson et al. 2010) and contributing to crime, substance use, and related health risk behaviors (Franklin and Boyd-Franklin 2000; Franklin et al. 2006). Stress can affect health directly through immune, neuroendocrine, and cardiovascular mechanisms, or indirectly through physiological responses and/or coping mechanisms (Abdulrahim et al. 2012). As a direct impact, "prolonged or severe stress has been shown to weaken the immune system, strain the heart, damage memory cells in the brain and deposit fat at the waist rather than the hips and buttocks (a risk factor for heart disease, cancer and other illnesses)" (Barr 2014, p. 58). Biochemical markers of cellular injury from chronic exposure to stress, which are related to and highly predictive of disease, include chronic elevation of cortisol, hormones, blood pressure, and allostatic load (Barr 2014). Moreover, extensive evidence of the harmful impact of toxic stress provides insight into causal mechanisms linking adversity (e.g., discrimination) to impairments in biopsychosocial functioning (Barr 2014; Shonkoff et al. 2012). Indirectly, stress associated with oppression for those who are targeted may arouse physiological responses such as anger, frustration, and helplessness and lead to negative short- and long-term psychological and physical consequences (Borrell et al. 2006; Carter 2007; Speight 2007). Moreover, negative, self-destructive, and maladaptive coping styles may develop to manage toxic stress (Windsor et al. 2010). Oppressed individuals might turn to alcohol and other drugs to anesthetize the mind from the psychic pain of discrimination, oppression, and hopelessness. Such coping strategies lead to other health issues. Substance use increases engagement in health risk behaviors such as prostitution, sharing needles, and unprotected sex, thereby exacerbating HIV/hepatitis C virus (HCV) risk (Arasteh and Des Jarlais 2009; Des Jarlais et al. 2013; Gebo et al. 2005). This relationship between systemic inequity and negative coping strategies perpetuates the cycle of poor health.

Critical Consciousness Systemic inequity and social injustice, rooted within mainstream norms and values, flourish in societies that have limited capacity for analysis of, and action against, oppressive socio-structural forces—that is, societal contexts with limited critical consciousness (Freire 2000). The lack of CC within society creates the supportive environment for oppression to rampantly spread and infect systems from the individual to the macro levels. As a result, the social condition of oppression has been identified as a fundamental cause of disease (Link and Phelan 1995; Williams et al. 1997) and CC has been deemed the antidote to external and internalized oppression (Watts et al. 1999; Windsor et al. 2014a, b). The way to interrupt this viral cycle of oppression is to (1) build antibodies, activists, who will fight and resist, and (2) inoculate the minds of the masses. What Freire describes as "the process whereby people achieve an illuminating

awareness of the socioeconomic and cultural circumstances that shape their lives and their capacity to transform that reality" (Freire 1975, p. 800) is parallel with an empowerment process, an active, participatory process through which individuals and groups gain greater control over their identities and lives, protect human rights, and reduce social injustice (Maton 2008; Rappaport 1981; Wallerstein and Bernstein 1994). The CC framework prepares people to address inequity, the underlying causes of health disparities, rather than focusing only on symptoms of inequity. Thus, CC is an important construct in addressing the personal and social ills that plague our society.

Social work is a prime field for the incorporation of CC theory. According to the NASW (2017) Code of Ethics, social workers should advocate for changes in individuals, communities, and policy to meet human needs and promote social justice. At the core of the social work profession is a commitment to basic human rights, and to preventing and eliminating domination, exploitation, and discrimination that pose barriers to life, freedom, and justice (Androff and McPherson 2014). Although the field of social work has an ethical and professional mandate to address inequity, theoretical and treatment approaches at the micro level usually focus on individual behavior and fail to address historical and structural contexts—ignoring the evidence suggesting that structural inequities and differential treatment of groups may account for much of the variance in health status between white and non-white populations (Barr 2014; Windsor et al. 2014a, b). Unfortunately, from the beginning of academic study through career specialization, US-based social workers are siloed in either the micro or macro practice method (Androff and McPherson 2014). Micro practice focuses upon helping individuals and families in need through direct engagement, while macro practice focuses upon the transformation of the social structure through social planning, policy, and action (Androff and McPherson 2014; Austin et al. 2016). This micro/macro divide limits the social work profession in practice, education, and research and is inconsistent with social work's ethical and professional commitment to eradicating inequity (Androff and McPherson 2014). Social work practitioners with an exclusive focus on individual (micro) or social (macro) concerns violate social work's foundational principles and theories such as the person-in-environment perspective and ecological frameworks (Androff and McPherson 2014; Austin et al. 2005; Lane et al. 2017). Human rights-based social work practice requires social workers to bridge the micro/macro divide with an "integrative approach linking the legal framework, language, and institutions of human rights with social work practice, and demands intervention on the individual and societal levels" (Androff and McPherson 2014, p.1).

Social work practice should bridge individual and community practice by acknowledging that macro forces have micro consequences and micro practices are reflective of macro socio-political processes—and by opposing the structural forces that underlie problems experienced at the individual level. In other words, micro and macro practices inform the other (Austin, Anthony, Knee, and Mathias 2016). According to Mullaly (2002), conventional social work addresses the suffering or symptoms caused by oppression, such as homelessness, depression, substance abuse, and unemployment, while ignoring the oppression and social injustice issues at their core. In addition to helping individuals cope with oppressive systems, social work practice should transform systems to help individuals by incorporating anti-oppressive frameworks that create innovative individual and structural solutions (Mullaly 2002). By adopting an anti-oppressive framework, which incorporates oppression theory into social work interventions, social workers can make visible typically hidden socio-structural factors, including institutionalized white privilege, and resist training and socializing oppressed populations to adapt to marginalized roles and inferior treatment (Jemal 2017a). To end injustice and promote health equity, the social worker must internalize two roles: (1) developer of one's own critical consciousness, and (2) developer of critical consciousness in others (Jemal 2017b). The capacity of individuals to consciously situate their circumstances and/or the circumstances of others within structural systems of oppression is vital to the protection of human rights, specifically the right to health.

Although CC has a scholarly following and has been used as a theoretical basis to inform research addressing HIV (Campbell and MacPhail 2002), domestic violence (Chronister and McWhirter 2006), and substance use (Windsor et al. 2014a), scholars have reinterpreted CC to have various conceptualizations (Baker and Brookins 2014; Diemer et al. 2014; Jemal 2017b; Watts et al. 2011). For example, scholars have used conflicting definitions and assessments of the CC construct (Baker and Brookins 2014; Diemer et al. 2014; Jemal 2017a; Watts et al. 2011). This causes some concern over the future and utility of CC theory, research, and practice. The use of such varied conceptualizations and methods of assessment makes it difficult to compare results across studies, to link CC to outcomes, or to know if different scholars are referring to the same construct when referencing CC. The lack of a coherently conceptualized construct limits our understanding, inhibits application in addressing personal and social dysfunction, and prevents the advancement of the CC field (Goodman et al. 1998). As a result, the importance of CC as a key phenomenon of interest for scholars of social and health inequity may be minimized, unless its theoretical and conceptual limitations are addressed with greater precision. Considering the practical advantages and theoretical pitfalls of CC, this paper presents a new construct, transformative consciousness (TC), derived from a scholarly interpretation of CC, but created to address the theoretical limitations in the CC literature (Jemal 2017a).

Transformative Consciousness

To inform the author's thinking and to accomplish the conceptualization of TC, the author used three main resources: (1) the author's practice and research experience as co-developer and facilitator of a CC-based health intervention; (2) interviews with experts in the field of CC at the VIII International Meeting of the Paulo Freire Forum; and (3) existing CC literature. The interviews helped to define the construct and identify the domains (Goodman et al. 1998). As co-developer and facilitator for *Community Wise*, a behavioral-health intervention grounded in CC theory, the author observed participants as they engaged in CC development (Windsor et al. 2014a, b). Through informal observation of the intervention, the author learned the following: Critical thinking skills are needed for CC development to conduct a deeper level of analysis regarding how the historical context and structural barriers impact individual behaviors. Gaining CC is a continuous process that fluctuates over time and is influenced by experience and topic. Gaining CC without empowerment—that is, without the tools, skills, ability, and self-efficacy required to make meaningful change—can lead to antipathy and complacency. In addition to working on the development and facilitation of an intervention grounded in CC theory and interviewing scholar-experts, the author conducted an in-depth literature review of CC that informed the conceptualization of TC.

From scholarly interpretations of Freire's work, most conceptualizations of CC have used a two-dimensional model: reflection and action (Campbell and MacPhail 2002; Diemer and Blustein 2006). Similarly, transformative consciousness is one dimension of a larger theoretical model called transformative potential. Transformative potential (TP) constitutes levels of consciousness and action that produce potential to transform the contextual factors and relationships that perpetuate oppressive conditions and are necessary for equitable change at one or more socio-eco-systemic (e.g., individual or institutional) levels. A person with a high level of transformative potential critically reflects on the conditions that shape their life and actively works with self and/or others to change problematic conditions (Campbell and MacPhail 2002). The process of transformation requires the simultaneous processes of objectifying and acting (Freire 2000). Merely reflecting on realities without intervention will not lead to transformation; and, moreover, one cannot truly perceive the depth of the problem without being involved in some form of action involving the problem (Freire 2000). With these ideas in mind, mirroring the way many scholars have conceptualized critical consciousness, TP comprises two dimensions: transformative consciousness (TC) and transformative action (TA) (see Fig. 1).

The TC and TA dimensions align with CC's reflection and action dimensions, respectively. However, two major differences between the CC reflection and the TC dimensions are that TC has three domains (i.e., awareness, behavioral-response, and consequence) and each domain has three levels of consciousness (i.e., critical, blame, denial) (Jemal 2016). Lastly, TC can be applied to any problem to identify the issue's structural oppressive roots (e.g., racism, sexism, classism, etc.) (Jemal 2016).

Domains of Transformative Consciousness

Transformative consciousness is operationalized to have three domains (see Fig. 2): awareness, behavioral-response, and consequence.

Transformative consciousness is a person's level of socio-ecosystemic reflection on (1) the inequitable elements, factors, and causes that perpetuate their identified problem; (2) potential behavioral responses to the inequity within the identified problem; and (3) the consequences of the inequity for the development and implementation of potential solutions. The definitions of each domain were informed by and synthesized from the CC literature to include (1) a critical and analytical awareness of one's socio-political and cultural environment to identify the contextual factors and relationships necessary for change (Carlson et al. 2006; Chronister et al. 2004; Houser and Overton 2001; Watts et al. 1999); (2) competencies that allow the individual to interact with others and with their environment to transform personal and social realities (Diemer and Blustein 2006; Diemer et al. 2006; Getzlaf and Osborne 2010); and (3) a sense or assessment of the impact of the problem on the individual, the individual's role in the perpetuation of contextual factors prohibiting change, and the individual's ability to control these issues (Mustakova-Possardt 1998; Watts et al. 2011). Awareness is a social analysis and conceptual grasp of the different axes along which inequity contributes to the identified problem (Thomas et al. 2014; Watts and Flanagan 2007). Behavioral-response is reflection on the level of reaction (behavioral, verbal) or the role of self and others that one believes is appropriate in response to the underlying inequity in the identified problem. As Kirkwood and Kirkwood express cogently, "Consciousness denotes not only an awareness [of the issue(s)], but also …, the capacity to make judgments and to have intentions" (Kirkwood and Kirkwood 1989, p. 36). The consequence domain is defined as the level of result or effect of inequity. These domains are supported by the literature (see Table 1).

Levels of Transformative Consciousness Each domain has three levels of consciousness (LOCs): denial (D), blame (B), and critical (C) (see Fig. 3 and Table 2). The C level is the highest level of TC, allowing the critical examination of socio-structural determinants underlying individual and community problems. Currently, no scholar has included these three levels in their conceptualization of CC, and Freire's work does not include levels of consciousness within the domains. Thus, one

major difference between commonly proposed interpretations of CC (reflection and action) and TC is that TC has three domains (awareness, behavioral-response, and consequence) and each domain has three levels (critical, blame, and denial) informed by a synthesis of the CC literature.

These levels are grounded in Freire's (Freire 1973) work that outlined the three stages of consciousness: magical consciousness, naïve consciousness, and critical consciousness. The magical stage was characterized by a lack of critical thought and insight about individual and social forces that shape people's lives. In this stage, people do not perceive the way in which their personal choices and social conditions undermine their health and well-being. They also do not perceive their own actions as capable of changing their conditions (Freire 1973). Freire's (Freire 1973) magical stage corresponds with the denial level of consciousness for each domain. The denial level of consciousness is defined as knowingly or unknowingly refusing to acknowledge the underlying individual and social causal factors perpetuating the identified problem or prohibiting solution(s) to the identified problem. Freire's (Freire 1973) second stage is naïve consciousness in which people perceive themselves and their social situations as essentially undamaged; but perceive others are to blame for personal and social problems. The naïve stage corresponds with blame consciousness. The blame level is characterized by the blaming of individuals, usually those the problem is most negatively affecting (i.e., the victim), to the exclusion of all other systemic factors or social forces of identified problems that shape of people's lives. "The purpose of consciousness-raising is to help those participating to view problems not as personal failures or shortcomings, but as being rooted in structures affecting the lives of those in similar situations alike" (Hatcher et al. 2010, p. 543). Thus, the critical level is characterized by critical thought in which individual and systemic forces are unveiled and individuals gradually become conscious of their own perceptions of reality; how their thoughts, beliefs, and assumptions shape their interpretations of that reality; and how their own responsibility for their choices either maintains or changes the inequitable reality (Freire 1973).

Individuals at the critical awareness level question the mundane realities of their lives and reexamine how health, well-being, and other problems relate to wider social forces (Hatcher et al. 2010). The critical level allows the conscientious evaluation of the underlying causal individual and structural factors perpetuating the identified problem or prohibiting the solution to the identified problem. Freire (Freire 1973, p. 41) stated that, as people "apprehend a phenomenon or a problem, they also apprehend its causal links. The more accurately men and women grasp true causality, the more critical their understanding of reality will be." Thus, levels of consciousness progress according to the understanding of the underlying causes of their identified issue. Achieving critical transformative consciousness (CTC) would indicate that a person has reached the critical level across the three domains of TC (see Table 3). To determine a person's level of CTC of an identified issue, that person's level of awareness, behavioral-response, and consequence regarding the issue will have to be assessed. As an example of TC's application in the awareness domain, consider the US criminal justice system, which disproportionately arrests and imprisons African Americans at higher rates than whites (Alexander 2010). Clearly, involvement with law enforcement and imprisonment poses multiple health risks (Wilper et al. 2009). People with the critical level of TC would reflect on what is happening to the group and recognize the explicit and implicit racial bias that produces the racial disparity. According to TC theory, people with blame level TC would blame the individuals victimized by the system and may think non-whites must be more violent or that only people who deserve to be in prison go to prison. Those with denial level TC would ignore or minimize the underlying racism.

Social-Ecological Model Transformative consciousness is informed by Bronfenbrenner's (Bronfenbrenner 1994) Social Ecological Systems Theory, a person-in-environment perspective which postulates that various personal and environmental factors are dynamically interrelated—individuals create their contextual environments, and contextual environments influence individual behavior and development (Bronfenbrenner 1994; McLeroy et al. 1988; Stokols 1992). As such, a person's level of TC is informed by their reflection on the interconnectedness of all things within the socio-ecosystem and of themselves as active participants in that ecosystem. In other words, differences in social perspectives and identities are grounded in sociopolitical processes, "because humans are socially constituted, as is evidenced by how the regard and treatment they receive from others informs their self-image and sense of

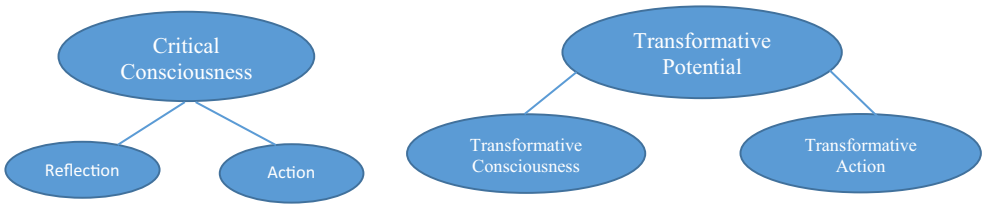

Fig. 1 Conceptual models of CC and TP. The dimensions of CC and TP for comparison

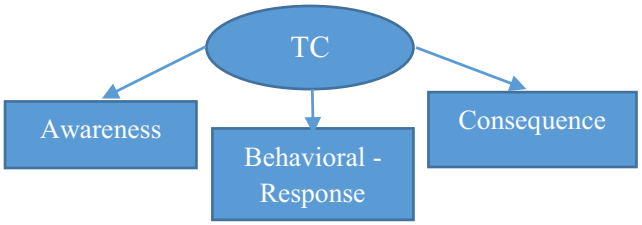

Fig. 2 Domains of transformative consciousness. The three hypothesized domains of transformative consciousness

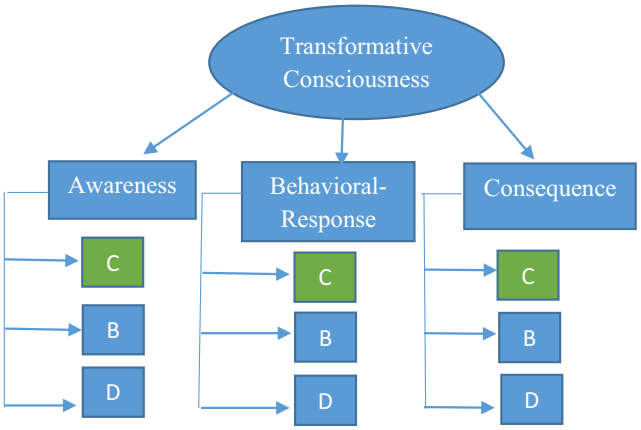

Fig. 3 Conceptual model of TC. The three levels of each domain of TC. C, critical; B, blame; D, denial

place in society" (Murray 2011, p. 154). It is important and necessary for TC to be informed by the socio-ecological model because forms of inequity operate at each socio-ecological level: from individual prejudice and discrimination, to institutional processes that create disparities, to cultural norms and values (Shin et al. 2016). Moreover, processes, practices, and outcomes of inequity at one level mutually reinforce inequitable processes, practices, and outcomes at the other levels (Shin et al. 2016). As such, the relevance of the social-ecological model to TC is multi-leveled. The model helps to identify contextual factors and relationships between self, others, and community that (1) identify potential causes and solutions at one or more socio-ecosystemic levels, and (2) shape an individual's socio-ecosystemic change-making ability or potential, whether the individual produces change or not. The critical analysis of each level opens the availability of options for creating equitable socio-ecosystemic change beyond the individual level. Thus, TC as informed by the social-ecological model, connects individual and community practice and change (Carlson et al. 2006; Campbell and MacPhail 2002). For instance, when addressing substance use frequency among oppressed populations, it is crucial to understand substance use as a complex phenomenon interrelated with poverty, violence, and low social capital (Dunlap and Johnson 1992; Schnittker et al. 2011). Treatment of oppressed individuals and families in isolation from their socio-political contexts ignores the influence of oppressive forces on the daily experiences of these individuals (Dunlap and Johnson 1992; Windsor et al. 2010). The socioecological model (Bronfenbrenner 1977) posits that programs will be most successful if changes are promoted at multiple levels, from person-oriented interventions to public policy (Stokols 1992).

For the purposes of TC, one element of Bronfenbrenner's (Bronfenbrenner 1977) original social-ecological model—the "individual" level—is divided into two levels: intrapersonal and interpersonal. Because TC requires the examination of how the self, identity, and internal processes have been influenced by oppression and privilege (Green 2009), this change is intended to capture the distinct factors related to an individual's cognitions, attitudes, and beliefs (intra), and those related to the individual's interactions with others that influence their life, problem, or environment (inter). Thus, the socio-ecosystem model has seven levels: intrapersonal (intra), interpersonal (inter), microsystem (micro), mesosystem (meso), exosystem (exo), macrosystem (macro), and chronosystem (chrono). The seven levels are referred to as the socio-ecosystem (see Table 4).

Transformative consciousness is assessed for each level of the socio-ecosystem. The development of TC "supposes that persons change in the process of changing their relations with their environment and with other people" (Chronister et al. 2004, p. 902). A key element of the critical level is that it requires an individual to examine the ways in which the individual level is influenced by the other levels and vice versa (Green 2009). Similar to the human rights-based approach (Androff and McPherson 2014) and community-centered clinical practice (Austin, Coombs, and Barr 2005), TC is individually and community focused, concerned with eradicating

Table 1 Domains of transformative consciousness and evidence from the literature for the domains as applied to health inequities

Domains	Description	Evidence from the literature
Awareness	Reflection on the underlying causal factors or potential solutions of health inequities	Carlson et al. 2006; Chronister et al. 2004; Houser and Overton 2001; Watts et al. 1999
Behavioral-response	Consciousness of potential actions to challenge health inequities within sociopolitical environments	Diemer and Blustein 2006; Diemer et al. 2006; Getzlaf and Osborne 2010
Consequence	A temporal aspect that helps reveal cause-and-effect relationships between social forces and social circumstances and the believed effect of health inequities	Mustakova-Possardt 1998; Watts et al. 2011

Table 2 Levels of transformative consciousness

Critical	The highest level of transformative consciousness takes into consideration the individual and social forces that shape people's lives or the identified problem (e.g., health inequities)
Blame	The second level of transformative consciousness blames individual(s) to the exclusion of all other systemic factors or social forces for problems (e.g., health inequities) and/or the shape of people's lives
Denial	The lowest level of transformative consciousness does not consider the individual and social forces that shape people's lives or the identified problem (e.g., health inequities)

inequity that violates human rights; focused on individual and community strengths rather than pathology; locates individual problems within sociopolitical, structural contexts of inequity; focuses on strengthening neighborhoods and organizations while addressing intrapersonal and interpersonal issues; and utilizes micro and macro level approaches and interventions (Austin, Coombs, and Barr 2005). The final model of TC assesses whether individuals are at the denial, blame, or critical levels within the awareness, behavioral-response, or consequence domains of TC for the intra, inter, micro, meso, exo, macro, or chrono socio-ecosystems (see Table 5 for example of levels of TC for the awareness domain within the intra, micro, macro, and chrono socio-ecosystems).

Absence of Privilege(d) An important limitation of the current conceptualization of CC is its failure to incorporate the concept of privilege. Some definitions only define CC as addressing oppression. For example, Garcia and colleagues (Garcia et al. 2009, p. 19) define CC "as the ability to recognize and challenge oppressive and dehumanizing political, economic, and social systems." Moreover, some scholars limit CC to a focus on oppressed or marginalized populations, such that CC refers to how marginalized populations reflect on oppressive realities (Baker and Brookins 2014; Diemer et al. 2014; Ginwright and James 2002; Watts et al. 2011). However, from a TC perspective, individual and social dysfunction is a direct consequence of systemic inequity: structural and internalized oppression *and* privilege (Chronister and McWhirter 2006; Mullaly 2002). Oppression manifests in limited access to opportunities and resources (Ho 2007; Jemal 2016), while privilege provides relatively unfettered access to opportunities and resources (Berman and Paradies 2010; Buhin and Vera 2009; DiAngelo 2011; Freire 2000; Jemal 2016; Nichol 2004). One way to identify systemic inequity (i.e., the presence and impact of oppression or privilege) is through evidence of disproportionality or disparity (Bradley and Engen 2016; Haight et al. 2014). The USA is criticized for having systemic differences in health outcomes that cannot be solely attributed to individual differences in behavior or lifestyle (Wise 2010) despite being one of the wealthiest countries in the world (Flynn et al. 2016). Thus, for TC to address health inequities, TC must include (1) an awareness of privilege in addition to oppression, and (2) a recognition by those in privileged positions of their part in perpetuating inequity and their role in implementing solutions.

Although there are many similarities between CC and TC, there are several key distinctions between the constructs. One major difference is that TC, unlike CC, does not include action as a domain. Key distinctions between current CC frameworks and the TC framework include (1) the TC construct

Table 3 Levels of transformative consciousness within each domain

	Awareness	Behavioral-response	Consequence
Critical	The consideration of thought(s) and insight about individual and social forces that shape people's lives or the identified problem	The consideration of reaction(s) (action or verbal) that responds to the individual and social forces that shape people's lives or the identified problem	The evaluation of present or potential events and their outcomes that takes into consideration individual and social forces that shape people's lives or the identified problem
Blame	An understanding of causal factors that blame individuals to the exclusion of all other systemic factors or social forces of identified problems that shape people's lives	The consideration of a response (action or verbal) aimed at the perceived blameworthy individual(s) to the exclusion of all other systemic factors or social forces of identified problems that shape of people's lives	The evaluation of present or potential events and their outcomes that blame individual(s) to the exclusion of all other systemic factors or social forces of identified problems that shape of people's lives
Denial	The lack of critical thought and insight about individual and social forces that underlie the identified problem and/or shape people's lives	The lack of consideration of reaction(s) (action or verbal) that responds to the individual and social forces that shape people's lives or the identified problem	The lack of evaluation of present or potential events and their outcomes that takes into consideration individual and social forces that shape people's lives or the identified problem

has three domains which not do exist within other conceptualizations of CC (i.e., awareness, behavioral-response, and consequence); (2) CC is not the latent variable but is conceptualized as the highest level of each domain of TC (i.e., critical awareness, critical behavioral-response, and critical consequence); (3) each domain incorporates three levels of consciousness (i.e., critical, blame, and denial) grounded in Freire's (Freire 1973) work, but not incorporated in the current CC conceptual models; (4) the TC construct incorporates Bronfenbrenner's (Bronfenbrenner 1994) Social Ecological Systems Theory; and (5) the TC framework explicitly incorporates both sides of systemic inequity (i.e., privilege and oppression) and persons with privileged identities.

Process of Transformative Consciousness Development

The TC construct focuses on the aspect of a person's consciousness needed to transform oppressive social realities. There are two distinct processes of TC: (1) the process of moving from lower levels of TC to a higher level of TC, and (2) the interaction process through which TC impacts one's action potential to change their environment. That is, TC encompasses one's level of consciousness (i.e., critical, blame, or denial) *and* capacity to undergo a specific teleological transformation process themselves, ending at a level of consciousness (i.e., CTC) where they can then transform oppressive situations and contexts (see Fig. 4). "As people become increasingly critical," Alschuler describes, "they move from a position of passivity, pessimism, victimization, and acceptance of the status quo to a role of collaboration in actively creating situations that are more just, liberating, and loving" (Alschuler 1986, p. 493). Research seems to suggest a cyclical relationship between the two transformation dynamics within the TC concept, such that development of CTC cultivates action potential to make equitable changes within the sociostructural environment, and that potential for action promotes increased TC (Thomas et al. 2014; Zaff et al. 2010).

Transformative consciousness development relates to the individual's own transformation from uncritical to critical levels of consciousness within the TC framework. The development of CTC involves people moving through a series of stages or levels of consciousness (Campbell and MacPhail 2002) to increase their transformative potential, culminating in critical action. Scholars have identified development processes for constructs similar to the CC construct, such as socio-political development, or for theorized dimensions of CC, such as critical reflection. When analyzing their data, Carlson and colleagues (2006) proposed a four-stage understanding of critical reflection: (1) passive adaptation, (2) emotional engagement, (3) cognitive awakening, and (4) intention to act. Similarly, Watts et al. (1999) developed a five-stage model of sociopolitical development. In the first stage, the acritical stage, individuals have a "just world" perspective and are unconscious of systemic inequities in access, resources, and power. In the adaptive stage, the individual recognizes systemic inequity, but may feel powerless to change socio-political and economic systems. In the third stage, the pre-critical stage, individuals question the usefulness of previous strategies to deal with injustice. In stage 4, the critical stage, individuals learn more about social justice which may encourage persons to become change agents. In the final stage, the liberation stage, individuals become change agents for social justice and act to address systemic inequity.

The process of progressing from denial or blame levels of consciousness to critical transformative consciousness includes progressing through several hypothesized levels and stages (see Table 6). These stages are informed by other developmental models such as Margaret Mahler's stages of child development (Mahler et al. 1975), models of personal development, and the stages of grief model (Kübler-Ross 1969). Level 1 is non-critical/denial and is composed of two stages. At stage 1, the individual takes what they believe as what they know, and the knowledge is without question. There is nothing outside of their beliefs. At this stage, there is a strong tendency for confirmatory bias in that the subconscious draws the person's attention to experiences, information, and circumstances that confirm what the individual already believes. Contradicting information is filtered out and only that which conforms to existing beliefs is introduced to the individual's belief system. Stage 2, discovery, is characterized by conflict, anger, resistance, and doubt. At this stage, a person shows increased sensitivity to the idea that there are other perspectives and ideas and is conflicted about exchanging beliefs. This awareness of conflicting beliefs may be precipitated by a cognitive-emotional crisis in which the person's belief system clashes with another and introduces doubt. Level 2 is pre-critical and is composed of stages 3 and 4. In stage 3, there is a strong urge for system justification and cognitive dissonance to retain the original belief system while simultaneously not rejecting the conflicting belief system. The individual may also recognize the lack of evidence supporting current perspectives, but may feel that certain beliefs are incapable of being changed. In stage 4, the person differentiates between beliefs and determines which beliefs to keep and which to discard. The manifestations of this process are likely to impact behavior because the person may need to negotiate new boundaries based on beliefs. At this stage, there is the possibility for "the person either to withdraw or become reactionary (to fear the new), or to pursue change for change's sake (to fear the old)" (Kirkwood and Kirkwood 1989, p. 38) which could impact the extremity of behaviors. This stage is also characterized by nostalgia for the old belief system. Stage 5 marks the beginning of level 3, critical consciousness, during which the individual comes to accept ideas that would have been

Table 4 Socio-ecosystem levels

Intrapersonal	Pertains to the self; includes the processes that exist within a person, from biological functions to internal thoughts, attitudes, emotions, and beliefs
Interpersonal	Includes all interactions and communications between individuals
Microsystem	Includes interactions between groups of individuals that are closely related to an individual or within the individual's immediate surroundings, such as family, friends, peers, colleagues, neighbors, and other people with whom the individual has direct interactions
Mesosystem	Includes interactions between different parts of a person's microsystem (e.g., family, schools, jobs, and neighborhoods) in which the microsystems exert influence upon each other
Exosystem	Includes interactions between institutions (e.g., education system and criminal justice system) in which the individual plays no role in the decision-making process or the construction of experiences; but the interaction has a direct or indirect impact on the individual level and/or the microsystems to which the individual belongs
Macrosystem	Includes the socio-political environment, culture, norms, values, laws, attitudes, and ideologies of the society in which a person lives
Chronosystem	The patterning and cumulative effects of events and transitions manifesting overtime or throughout the life course as well as socio-historical circumstances that shape the individual's context and the context for the other socio-ecosystems

Adapted from Bronfenbrenner (Bronfenbrenner 1977)

completely overlooked in stage 1. The individual reconciles the usefulness of previous strategies in consideration of the new ideas. In stage 6, within the CC level, the person may begin to practice action in accordance with newfound beliefs, reinforcing and allowing new beliefs to replace old ways of thinking. This liberation phase allows the person to transform from object to subject (Freire 2000), as they perceive and pursue their capacity to act upon, create, and transform their world rather than be acted upon as an object. Kirkwood and Kirkwood reiterate that

> Critical consciousness is not superficial, but seeks to go into, to go under, to understand, to go to the roots of, to unveil, to investigate, and is willing to test its findings. It is open to revision, seeks to avoid pre-conceptions, accepts responsibility, and is dialogical rather than polemical. Engages in communication which is the collaborative search for truth. (Kirkwood and Kirkwood 1989, p. 38)

Ideally, the person resolves the struggle of how they will choose to exist in this world in accordance with their new beliefs.

Future Research

This paper offered a conceptual model of a new construct, TC. Influenced by Paulo Freire's (Freire 2000) CC framework,

Table 5 The levels of TC within the awareness domain at two socio-ecosystem levels

	Denial	Blame	Critical
Intra	The lack of critical thought and insight about how social-structural forces impact the intrapersonal experience that underlies the identified problem and/or shape people's lives	An understanding of causal factors that blames perceived intrapersonal processes to the exclusion of all other systemic or social forces for identified problems and/or the shape of people's lives	The consideration of thought(s) and insight about the influence of socio-structural forces on people's thoughts, feelings, and behaviors that shape people's lives or the identified problem
Inter	The lack of critical thought and insight about how social-structural forces impact experiences between individuals that underlie the identified problem and/or shape people's lives	An understanding of causal factors that blames perceived interpersonal processes to the exclusion of all other systemic or social forces that underlie the identified problem and/or shape people's lives	The consideration of thought(s) and insight about the influence of socio-structural forces on people's interpersonal experiences that shape people's lives or the identified problem
Macro	The lack of critical thought and insight about social-structural forces that underlie the identified problem and/or shape people's lives at the macro level	An understanding of causal factors that blames individual processes to the exclusion of macrosystemic factors that underlie the identified problem and/or shape people's lives	Critical thought and insight about systemic inequities that underlie the identified problem and/or shape people's lives
Chrono	The lack of critical thought and insight about social-structural forces that underlie the identified problem and/or shape people's lives over time	An understanding of causal factors that blame individual processes to the exclusion of social-structural forces that underlie the identified problem and/or shape people's lives over time	Critical thought and insight about systemic inequities that underlie the identified problem and/or shape people's lives over time

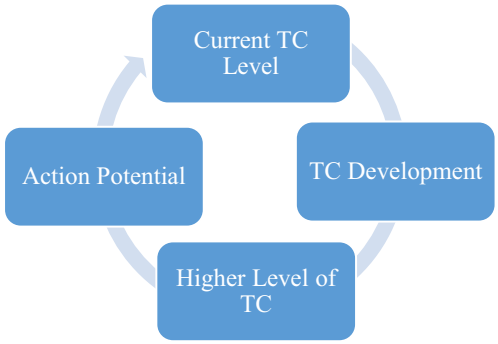

Fig. 4 The cyclical, teleological transformation process. How TC development leads to action potential to change one's environment, impacting current TC level

transformative consciousness can be used to advance an agenda of health equity. It is important to note that the proposed conceptual model has not been tested, and testing is needed to identify the effectiveness of this model to address health inequities. However, CC theory has been used in research addressing health disparities—such as interventions to reduce HIV risk (Campbell and MacPhail 2002), interpersonal violence (Chronister and McWhirter 2006), and substance misuse (Windsor et al. 2014a). Accordingly, CC is associated with a host of desirable individual-level outcomes among marginalized people (Hatcher et al. 2010), for example, healthier sexual decision-making among South African youth of color (Campbell and MacPhail 2002); reduction of substance misuse among adult African American men and women with recent incarceration history (Windsor et al. 2014a); and mental health improvements among urban adolescents (Zimmerman et al. 1999). Changes at non-individual levels resulting from CC development at the individual level are difficult to ascertain, due to the dearth of measures that can assess the impact of individual-level variables on community-level outcomes (Friedman et al. 2013). Thus, to be able to test the proposed model, the next step is to develop and test a *scale* of the TC construct. This has been done and will be forthcoming in future publications. Future research includes further theoretical clarification and development of TC and the broader framework of transformative potential. Future research will determine if the domains of TC—awareness, behavioral-response, and consequence—are distinct domains and are necessary. Moreover, the use of only three of the seven socio-ecosystems explored may be sufficient: interpersonal, mesosystem, and macrosystem (Speight 2007). However, the literature supports retaining the chronosystem because historical context offers insight into the power dynamics used to promote and maintain health inequities (Reich et al. 2008). Future research would also examine which domains of TC—awareness, behavioral-response or consequence, working either in concert or isolation—account for changes in health outcomes. For example, high levels of critical awareness may be more important for changing individual behavior and developing motivation to navigate perceived structural barriers. However, critical levels of behavioral-response or understanding consequences may engender agency or self-efficacy that lead individuals to feel responsible for making change. Research of this kind will identify the effectiveness of this model at addressing health inequities and will pinpoint which domains are most responsible for predicting certain health outcomes.

Conclusion

Building from a CC philosophy, social determinants of health are fundamental causes of disease leading to individual,

Table 6 Levels and stages of transformative consciousness development

Levels of transformative consciousness	Stages of transformative consciousness	Nature of transformative consciousness development
Level 1: Non-critical/denial	Stage 1: Blind belief	When the individual takes what they know as all-being. Beliefs are unconscious and automatic. To vet information before it is integrated into one's belief system, the subconscious mind generates resistance when retained information and knowledge from past experiences conflict with the new information and/or experience being presented. Information that confirms belief system is automatically accepted and never questioned
	Stage 2: Discovery	The individual develops a consciousness of conflicting perspectives usually precipitated by a confrontation or challenge.
Level 2: Pre-critical blame/credit	Stage 3: Duality	The individual attempts to find ways to hold countering beliefs while struggling to maintain pre-existing beliefs in the face of contradicting information or experience
	Stage 4: Contemplation	The individual begins to recognize that their beliefs had a beginning and can also have an end
Level 3: Critical consciousness	Stage 5: Integration	Individuals develop an attitude of complacency regarding the conflict and asymmetry of consciousness. Individuals integrate new and old ways of thinking that inform action
	Stage 6: Liberation	Based on the integration of new and old ideas and micro and macro factors, the individual can discern the roots of their thinking and the factors influencing consciousness

community and social dysfunction and, ultimately, health inequities (Barr 2014; Link and Phelan 1995). Critical consciousness has been deemed an antidote to the social determinants of inequitable health outcomes (Watts et al. 1999) and is used to assist marginalized populations in coping with, healing from, and resisting dehumanizing contexts (Windsor et al. 2014a). However, there is ample evidence that the construct of CC has conceptual limitations and requires clarification for theoretical and practice purposes (Baker and Brookins 2014; Diemer et al. 2014; Jemal 2017a; Watts et al. 2011). To address these conceptual limitations, this paper introduced a new construct, transformative consciousness, grounded in the CC literature.

The TC framework can be applied to various health-related issues (e.g., substance abuse, HIV risk behaviors, gender-based violence, environmental racism, crime). For example, the TC framework could be applied to HIV risk behaviors among African American women, by exploring whether intergenerational patterns and oppressive messages affect sexual socialization of African American adolescent females resulting in low self-esteem and body shaming. TC interventions could help repair damaged relationships between in-group members with marginalized status, thereby increasing opportunities for sharing life-saving information—such as information about pre-exposure prophylaxis (PrEP), an HIV prevention strategy before encountering HIV; and post-exposure prophylaxis (PEP), an HIV prevention strategy after encountering HIV. Since powerlessness is linked to disease and empowerment linked to health (Wallerstein and Bernstein 1988), these theoretical contributions can be tested and used to inform practice and research targeting marginalized populations to promote multi-systemic change.

Besides aiding the oppressed to overcome external and internalized oppression, TC-based interventions could increase TC among health care and service providers to reduce stigma and improve quality of and access to care. A TC approach can help social workers educate themselves, their colleagues, their students, and their clients about oppressive social structures (Barrett 2011). In this way, TC is an effective health education and prevention model that promotes health in all personal and social arenas. The development of TC may help service providers and health care professionals, from social workers to pediatricians, form collaborative partnerships for anti-oppressive work in their communities (Jutte et al. 2015). Social workers with critical transformative consciousness will resist acting as agents of social control in the enforcement of the status quo perpetuating inequity (Mullaly 2002; Sakamoto and Pitner 2005; Windsor et al. 2014a). Moreover, they will not assist marginalized individuals in maintaining their status as oppressed individuals by facilitating conformity with oppressive societal norms and practices (Mullaly 2002). Social workers with CTC could (1) address oppressive sociopolitical contexts; (2) create therapeutic alliances that validate the client's reality and experiences; (3) help clients navigate oppressive systems of care, while simultaneously acting to change those systems; (4) recognize and challenge personal biases and the biases of others; and (5) take collaborative action with communities to address socio-structural determinants of health inequities (Hernandez et al. 2005; Garcia et al. 2009; Mullaly 2002; Sakamoto and Pitner 2005). This process includes holding themselves accountable for reflecting on power dynamics; continuously examining how personal biases, assumptions, and normative values influence perceptions of differences between individuals; owning one's contributions to social injustice; and developing partnerships that forge a war on oppression and privilege rather than against individuals trapped in marginalized statuses (Smith and Jemal 2015; Garcia et al. 2009; Sakamoto and Pitner 2005).

Thus, transformative consciousness intersects micro and macro practices. In doing so, it overcomes the micro/macro divide that currently dominates social work education, practice, and research in the USA—a divide which ultimately diminishes the profession's commitment to human rights and social justice, since most, if not all, social problems require complex and sustained intervention at all levels of social work practice (Rothman and Mizrahi 2014). To ensure the profession overcomes the false micro/macro dichotomy, social work faculty must incorporate core social work values within the curriculum and develop pedagogical skills and strategies to teach social justice issues effectively (Lane et al. 2017). Social work educators based in US institutions are entrusted to help students apply their "understanding of social, economic, and environmental justice to advocate for human rights at the individual and system levels; and engage in practices that advance social, economic, and environmental justice" (Council on Social Work Education [CSWE] 2015, p. 8). However, faculty development pertaining to issues of oppression and privilege is often inadequate at many institutions (Garran et al. 2014); and, as a result, faculty struggle with how to integrate difficult content in the classroom setting (Lane et al. 2017). One factor may be the faculty's lack of CTC or the institution's lack of support. To cultivate effective learning opportunities, the administration's commitment to anti-oppression and antiprivilege issues must be an academic priority (Garran et al. 2014). Aligned with the field's professional and ethical mandate, transformative consciousness and human rights-based practices require both sides of social work practice: individuals and families have the right to health and support with alleviating difficulties in social functioning (Rothman and Mizrahi 2014), and unjust systems require transformation (Androff and McPherson 2014). Transformative consciousness may prove necessary to move persons in the direction of anti-oppressive individual and collective action to overcome and dismantle socio-structural oppression, thereby creating a healthy and just society in which the human right to health is not only attainable, but all inclusive.

References

Abdulrahim, S., James, S. A., Yamout, R., & Baker, W. (2012). Discrimination and psychological distress: does whiteness matter for Arab Americans? *Social Science and Medicine, 75*(12), 2116–2123. https://doi.org/10.1016/j.socscimed.2012.07.030.

Androff, D., & McPherson, J. (2014). Can human rights-based social work practice bridge the micro/macro divide? In K. R. Libal, S. M. Berthold, R. L. Thomas, & L. M. Healy (Eds.), *Advancing human rights in social work education*. Washington, DC: Council on Social Work Education.

Alexander, M. (2010). *The new Jim Crow: Mass incarceration in the age of colorblindness*. New York, NY: The New Press.

Alschuler, A. S. (1986). Creating a World Where It Is Easier To Love: Counseling Applications of Paulo Freire's Theory. *Journal of Counseling & Development, 64*(8), 492–496.

Arasteh, K., & Des Jarlais, D. C. (2009). At-risk drinking and injection and sexual risk behaviors of HIV-positive injection drug users entering drug treatment in New York City. *AIDS Patient Care & STDs, 23*, 657–661. https://doi.org/10.1089/apc.2009.0027.

Austin, M. J., Coombs, M., & Barr, B. (2005). Community-Centered Clinical Practice. *Journal of Community Practice, 13*(4), 9–30.

Austin, M. J., Anthony, E. K., Knee, R. T., & Mathias, J. (2016). Revisiting the Relationship Between Micro and Macro Social Work Practice. *Families in Society: The Journal of Contemporary Social Services: 2016, 97*(4), 270–277. https://doi.org/10.1606/1044-3894.2016.97.33.

Baker, A. M., & Brookins, C. C. (2014). Toward the development of a measure of sociopolitical consciousness: listening to the voices of Salvadoran youth. *Journal of Community Psychology, 42*(8), 1015–1032. https://doi.org/10.1002/jcop.21668.

Barr, D. (2014). *Health disparities in the United States: social class, race, ethnicity, and health* (2nd ed.). Baltimore: The John Hopkins University Press.

Barrett, J. (2011). Multicultural social justice and human rights: strategic professional development for social work and counseling practitioners. *Journal for Social Action in Counseling and Psychology, 3*, 116–122.

Berman, G., & Paradies, Y. (2010). Racism, disadvantage and multiculturalism: towards effective anti-racist praxis. *Ethnic and Racial Studies, 33*(2), 214–232.

Boardman, J. D., & Alexander, K. B. (2011). Stress trajectories, health behaviors, and the mental health of black and white young adults. *Social Science & Medicine, 72*(10), 1659–1666. https://doi.org/10.1016/j.socscimed.2011.03.024.

Borrell, L. N., Kiefe, C. I., Williams, D. R., Diez-Roux, A. V., & Gordon-Larsen, P. (2006). Self-reported health, perceived racial discrimination, and skin color in African Americans in the CARDIA study. *Social Science & Medicine, 63*(6), 1415–1427. https://doi.org/10.1016/j.socscimed.2006.04.008.

Bradley, M., & Engen, R. (2016). Leaving prison: a multilevel investigation of racial, ethnic, and gender disproportionality in correctional release. *Crime and Delinquency, 62*(2), 253–279.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist, 32*(7), 513–531. Retrieved 12/21/15 from http://cac.dept.uncg.edu/hdf/facultystaff/Tudge/Bronfenbrenner%201977.pdf.

Bronfenbrenner, U. (1994). Ecological models of human development. In International Encyclopedia of Education, Vol. 3, 2nd Ed. Oxford: Elsevier. Retrieved from http://www.psy.cmu.edu/~siegler/35bronfebrenner94.pdf.

Brown-Reid, T. L., & Harrell, J. P. (2002). Racist experiences and health outcomes: An examination of spirituality as a buffer. *Journal of Black Psychology, 28*(1), 18–36. https://doi.org/10.1177/0095798402028001002.

Bryant-Davis, T., & Ocampo, C. (2005). Racist incident-based trauma. *The Counseling Psychologist, 33*, 479. https://doi.org/10.1177/0011000005276465.

Buhin, L., & Vera, E. M. (2009). Preventing racism and promoting social justice: person-centered and environment-centered interventions. *Journal of Primary Prevention, 30*(1), 43–59. https://doi.org/10.1007/s10935-008-0161-9.

Campbell, C., & MacPhail, C. (2002). Peer education, gender and the development of critical consciousness: participatory HIV prevention by South African youth. *Social Science & Medicine, 55*(2), 331–345.

Carlson, E. D., Engebretson, J., & Chamberlain, R. M. (2006). Photovoice as a social process of critical consciousness. *Qualitative Health Research, 16*(6), 836–852. https://doi.org/10.1177/1049732306287525.

Carter, R. T. (2007). Racism and psychological and emotional injury: recognizing and assessing race-based traumatic stress. *The Counseling Psychologist, 35*(1), 13–105.

Chronister, K. M., & McWhirter, E. H. (2006). An experimental examination of two career interventions for battered women. *Journal of Counseling Psychology, 53*(2), 151–164.

Chronister, K. M., Wettersten, K. B., & Brown, C. (2004). Vocational research for the liberation of battered women. *The Counseling Psychologist, 32*(6), 900–922. https://doi.org/10.1037/0022-0167.53.2.151.

Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist, 54*(10), 805–816 http://dx.doi.org.proxy.wexler.hunter.cuny.edu/10.1037/0003-066X.54.10.805.

Council on Social Work Education (2015). *Educational policy and accreditation standards*. Retrieved from https://www.cswe.org/getattachment/Accreditation/Accreditation-Process/2015-EPAS/2015EPAS_Web_FINAL.pdf.aspx.

Des Jarlais, D. C., McCarty, D., Vega, W., & Bramson, H. (2013). HIV infection among people who inject drugs: The challenge of racial/ethnic disparities. *American Psychologist, 68*(4), 274–285. https://doi.org/10.1037/a0032745.

DiAngelo, R. (2011). White fragility. *International Journal of Critical Pedagogy, 3*(3), 54–70.

Diemer, M. A., & Blustein, D. L. (2006). Critical consciousness and career development among urban youth. *Journal of Vocational Behavior, 68*(2), 220–232. https://doi.org/10.1016/j.jvb.2005.07.001.

Diemer, M. A., Kauffman, A., Koenig, N., Trahan, E., & Hsieh, C. A. (2006). Challenging racism, sexism, and social injustice: support for urban adolescents' critical consciousness development. *Cultural Diversity and Ethnic Minority Psychology, 12*(3), 444–460. https://doi.org/10.1037/1099-9809.12.3.444.

Diemer, M. A., Rapa, L. J., Park, C. J., & Perry, J. C. (2014). Development and validation of the critical consciousness scale. *Youth & Society, 49*(4), 1–23. https://doi.org/10.1177/0044118X14538289.

Dunlap, E., & Johnson, B. D. (1992). The setting for the crack era: macro forces, micro consequences (1960–1992). *Journal of Psychoactive Drugs, 24*(4), 307–321.

Flynn, A., Holmberg, S., Warren, D., & Wong, F. (2016). *Rewrite the racial Rules: building an inclusive American economy* (p. 92). Roosevelt Institute. Retrieved from http://rooseveltinstitute.org/wp-content/uploads/2016/06/Structural-Discrimination-Final.pdf.

Franklin, A. J., & Boyd-Franklin. (2000). Invisibility syndrome: A clinical model of the effects of racism on African-American males. *American Journal of Orthopsychiatry, 70*(1), 33–41.

Franklin, A. J., Boyd-Franklin, N., & Kelly, S. (2006). Racism and Invisibility. *Journal of Emotional Abuse, 6*(2-3), 9–30.

Freire, P. (1973). *Education for critical consciousness*. NY: Continuum.

Freire, P. (1975). Cultural action for freedom. Retrieved from http://www.thinkingtogether.org/rcream/archive/110/CulturalAction.pdf Harvard.

Freire, P. (2000). *Pedagogy of the oppressed (30th anniversary ed)*. New York: Continuum (original work published 1970).

Friedman, S. R., Sandoval, M., Mateue-Gelabert, P., Rossi, D., Gwadz, M., Dombrowski, K., Smyrnov, P., Vasylyeva, T., Pouget, E. R., & Perlman, D. (2013). Theory, measurement and hard times: some issues for HIV/AIDS research. *AIDS and Behavior, 17*(6), 1915–1925. https://doi.org/10.1007/s10461-013-0475-3.

Garcia, M., Kosutic, I., McDowell, T., & Anderson, S. A. (2009). Raising critical consciousness in family therapy supervision. *Journal of Feminist Family Therapy, 21*(1), 18–38. https://doi.org/10.1080/08952830802683673.

Garran, A. M., Kang, H., & Fraser, E. (2014). Pedagogy and diversity: enrichment and support for social work instructors engaged in social justice education. *Journal of Teaching in Social Work, 34*(5), 564–574. https://doi.org/10.1080/08841233.2014.952868.

Gebo, K. A., Fleishman, J. A., Conviser, R., Reilly, E. D., Korthuis, P. T., Moore, R. D., Hellinger, J….HIV Research Network (2005). Racial and gender disparities in receipt of highly active antiretroviral therapy persists in a multistate sample of HIV patients in 2001. Journal of Acquired Immune Deficiency Syndromes, 38(1), 96–103. doi: https://doi.org/10.1097/00126334-200501010-00017.

Getzlaf, B. A., & Osborne, M. (2010). A journey of critical consciousness: an educational strategy for health care leaders. *International Journal of Nursing Education Scholarship, 7*(1), 1–15.

Ginwright, S., & James, T. (2002). From assets to agents of change: Social justice, organizing, and youth development. *New Directions for Youth Development*, (96), 27–46. https://doi.org/10.1002/yd.25.

Goodman, R. M., Speers, M. A., McLeRoy, K., Fawcett, S., Kegler, M., Parker, E., et al. (1998). Identifying and defining the dimensions of community capacity to provide a basis for measurement. *Health Education & Behavior, 25*(3), 258–278.

Green, B. H. (2009). Exploring the relationship between racial factors and critical social analysis among a group of African American youth. Psychology Theses. Paper 67. Retrieved from http://digitalarchive.gsu.edu/cgi/viewcontent.cgi?article=1063&context=psych_theses.

Haight, W., Gibson, P. A., Kayama, M., Marshall, J. M., & Wilson, R. (2014). An ecological-systems inquiry into racial disproportionalities in out-of-school suspensions from youth, caregiver and educator perspectives. *Children and Youth Services, 46*, 128–138. https://doi.org/10.1016/j.childyouth.2014.08.003.

Hatcher, A., de Wet, J., Bonnell, C. P., Strange, V., Phetla, G., Proynk, P. M., Kim, J. C., et al. (2010). Promoting critical consciousness and social mobilization in HIV/AIDS programmes: lessons and curricular tools from a South African intervention. *Health Education Research, 26*(3), 542–555.

Hernandez, P., Almeida, R., & Dilan Del-Vecchio, K. (2005). Critical consciousness accountability, and empowerment: key processes for helping families heal. *Family Process, 44*(1), 105–119. https://doi.org/10.1111/j.1545-5300.2005.00045.x.

Ho, K. (2007). Structural violence as a human rights violation. Retrieved from http://projects.essex.ac.uk/ehrr/V4N2/ho.pdf.

Houser, N. O., & Overton, S. (2001). Reconciling freedom and control in the early grades: toward a critical consciousness for a freedom of choice. *Theory & Research in Social Education, 29*(4), 582–616. https://doi.org/10.1080/00933104.2001.10505958.

Jackson, J. S., Knight, K. M., & Rafferty, J. (2010). Race and unhealthy behaviors: chronic stress, the HPA axis, and physical and mental health disparities over the life course. *American Journal of Public Health, 100*(5), 933–939. https://doi.org/10.2105/AJPH.2008.143446.

James, S. A., Hartnett, S. A., & Kalsbeek, W. D. (1983). John Henryism and blood pressure differences among black men. *Journal of Behavioral Medicine, 6*(3), 259–278.

Jemal, A. D. (2016). Transformative consciousness: conceptualization, scale development and testing (unpublished doctoral dissertation). Rutgers University, NJ.

Jemal, A. (2017a). Critical consciousness: a critique and critical analysis of the literature. *Urban Review., 49*(4), 602–626. https://doi.org/10.1007/s11256-017-0411-3.

Jemal, A. (2017b). The opposition. *Journal of Progressive Human Services: Radical Thought and Practice (JPHS), 28*(3), 134–139. https://doi.org/10.1080/10428232.2017.1343640.

Jones, B. A., Reams, K., Calvocoressi, L., Dailey, A., Kasl, S. V., & Liston, N. M. (2007). Adequacy of Communicating Results From Screening Mammograms to African American and White Women. *American Journal of Public Health, 97*(3), 531–538.

Jutte, D. P., Miller, J. L., & Erickson, D. J. (2015). Neighborhood adversity, child health, and the role of community development. *Pediatrics, 135*(Supplement, S57), 48–57. Retrieved 9/20/16 http://pediatrics.aappublications.org/content/135/Supplement_2/S48.full.

Kirkwood & Kirkwood (1989). Living adult education. Retrieved 2/2/16 from https://www.sensepublishers.com/media/619-living-adult-education.pdf.

Krieger, N. (1999). Embodying inequality: a review of concepts, measures, and methods for studying health consequences of discrimination. *International Journal of Health Services, 29*(2), 295–392.

Kübler-Ross, E. (1969). *On death and dying*. New York: Macmillan.

Lane, T. Y., Chiarelli-Helminiak, C., Bohrman, C., & Lewis, T. (2017). The teachable moment: engaging students in social justice movements. *Social Work Education, 36*(4), 359–372. https://doi.org/10.1080/02615479.2016.1268120.

Link, B. G., & Phelan, J. (1995). Social conditions as fundamental cause of disease. *Journal of Health and Social Behavior, 35*, 80–94.

Macias, K. (2017). Black women are dying from pregnancy and childbirth at alarming rates due to structural racism. *Daily KOS* Retrieved from https://www.dailykos.com/stories/2017/12/7/1722255/-Black-women-are-dying-from-pregnancy-and-childbirth-at-alarming-rates-due-to-structural-racism?detail=emaildkre.

Mahler, M., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant: symbiosis and individuation*. New York: Basic Books.

Maton, K. I. (2008). Empowering Community Settings: Agents of Individual Development, Community Betterment, and Positive Social Change. *American Journal of Community Psychology, 41*(1-2), 4–21.

McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly, 15*(4), 351–377.

Mead, H., Cartwright-Smith, L., Jones, K., Ramos, C., Woods, K., & Siegel, B. (2008). Racial and ethnic disparities in U.S. healthcare: a chartbook. The Commonwealth Fund. Retrieved from http://www.commonwealthfund.org/~/media/files/publications/chartbook/2008/mar/racial-and-ethnic-disparities-in-u-s–health-care–a-chartbook/mead_racialethnicdisparities_chartbook_1111-pdf.pdf.

Mullaly, B. (2002). *Challenging oppression: a critical social work approach* (p. 232). Don Mills: Oxford University Press.

Murray, R. (2011). Social injustice and the problem of cross purposes. *Journal of Social Philosophy, 42*(2), 153–172.

Mustakova-Possardt, E. (1998). Critical consciousness: an alternative pathway for positive personal and social development. *Journal of Adult Development, 5*(1), 13–30.

National Association of Social Workers (NASW). (approved 1996, revised 2017). Code of ethics of the National Association of Social Workers. Retrieved 3/1/18 from https://www.socialworkers.org/LinkClick.aspx?fileticket=ms_ArtLqzeI%3D&portalid=0.

National Economic & Social Rights Initiative (NESRI) (2017). What is the human right to health and health care? Retrieved 7/17/17 from

https://www.nesri.org/programs/what-is-the-human-right-to-health-and-health-care

Nichol, S. N. M. (2004). "We make the road by walking:" reflections on the legacy of white anti-racism activism. In J. Harvey, K. A. Case, & R. H. Gorsline (Eds.), *Disrupting white supremacy from within: white people on what we need to do* (pp. 188–211). Cleveland: The Pilgrim Press.

Paradies, Y. (2006). A systematic review of empirical research on self-reported racism and health. *International Journal of Epidemiology, 35*(4), 888–901.

Rappaport, J. (1981). In praise of paradox: A social policy of empowerment over prevention. *American Journal of Community Psychology, 9*, 1–25. https://doi.org/10.1007/BF00919275.

Reich, S. M., Pinkard, T., & Davidson, H. (2008). Including history in the study of psychological and political power. *Journal of Community Psychology, 36*(2), 173–186. https://doi.org/10.1002/jcop.20229.

Rothman, & Mizrahi. (2014). Balancing micro and macro practice: a challenge for social work. *Social Work, 59*(1), 91–93.

Sakamoto, I., & Pitner, R. O. (2005). Building critical consciousness in anti-oppressive social work practice: disentangling power dynamics at personal and structural levels. *British Journal of Social Work, 35*(4), 435–452.

Schnittker, J., Massoglia, M., & Uggen, C. (2011). Incarceration and health of the African American community. *Du Bois Review, 8*, 1–9.

Shin, R. Q., Ezeofor, I., Smith, L. C., Welch, J. C., & Goldrich, K. M. (2016). The development and validation of the contemporary critical consciousness measure. *Journal of Counseling Psychology, 63*(2), 210–223.

Shonkoff, J. P., Garner, A. S., & The Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, and Section on Developmental and Behavioral Pediatrics. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics, 129*(1), 232–246. https://doi.org/10.1542/peds.2011-2663.

Smith, V., & Jemal, A. (2015). Addressing the health of formerly imprisoned persons in a distressed neighborhood through a community collaborative board. *Health Promotion Practice, 16*(5), 733–744. https://doi.org/10.1177/1524839915588293.

Speight, S. L. (2007). Internalized racism: one more piece of the puzzle. *The Counseling Psychologist, 35*(1), 126–134. https://doi.org/10.1177/0011000006295119.

Stokols, D. (1992). Establishing and maintaining healthy environments: toward a social ecology of health promotion. *American Psychologist, 47*(1), 6–22.

Thomas, A., Barrie, R., Brunner, J., Clawson, A., Hewitt, A., Jeremie-Brink, G., & Rowe-Johnson, M. (2014). Assessing critical consciousness in youth and young adults. *Journal of Research on Adolescence, 24*(3), 485–496. https://doi.org/10.1111/jora.12132.

Wallerstein, N., & Bernstein, E. (1988). Empowerment education: Freire's ideas adapted to health education. *Health Education Quarterly, 15*(4), 379–394. https://doi.org/10.1177/109019818801500402.

Wallerstein, N., & Bernstein, E. (1994). Introduction to community empowerment, participatory education, and health. *Health Education Quarterly, 21*(2), 141–148.

Watts, R. J., & Flanagan, C. (2007). Pushing the envelope on youth civic engagement: a developmental and liberation psychology perspective. *Journal of Community Psychology, 35*(6), 779–792. https://doi.org/10.1002/jcop.20178.

Watts, R. J., Griffith, D. M., & Abdul-Adil, J. (1999). Sociopolitical development as an antidote for oppression—theory and action. *American Journal of Community Psychology, 27*(2), 255–271.

Watts, R. J., Diemer, M. A., & Voight, A. M. (2011). Critical consciousness: current status and future directions. In C. A. Flanagan & B. D. Christens (Eds.), *Youth civic development: work at the cutting edge. New Directions for Child and Adolescent Development, 134,* 43–57. https://doi.org/10.1002/cd.310.

Williams, D. R., & Mohammed, S. A. (2009). Discrimination and racial disparities in health; evidence and needed research. *Journal of Behavioral Medicine, 32*(1), 20–47.

Williams, D. R., Yu, Y., Jackson, J., & Anderson, N. (1997). Racial differences in physical and mental health: socioeconomic status, stress, and discrimination. *Journal of Health Psychology, 2*(3), 335–351. https://doi.org/10.1177/135910539700200305.

Williams, D. R., Neighbors, H. W., & Jackson, J. S. (2003). Racial/ethnic discrimination and health: findings from community studies. *American Journal of Public Health, 93*(2), 200–208.

Wilper, A. P., Woolhandler, S., Boyd, W., Lasser, K. E., McCormick, D., Bor, D. H., & Himmelstein, D. U. (2009). The health and health care of US prisoners: results of a nationwide survey. *American Journal of Public Health, 99*(4), 666–672.

Windsor, L., Benoit, E., & Dunlap, E. (2010). Dimensions of oppression in the lives of impoverished black women who use drugs. *Journal of Black Studies, 41*(1), 21–39. https://doi.org/10.1177/0021934708326875.

Windsor, L., Jemal, A., & Benoit, E. (2014a). Community wise: paving the way for empowerment in community reentry. *International Journal of Law and Psychiatry, 37*(5), 501–511. https://doi.org/10.1016/j.ijlp.2014.02.023.NIHMS576112.

Windsor, L., Pinto, R., Benoit, E., Jessell, L., & Jemal, A. (2014b). Community wise: addressing oppression to promote individual and community health. *Journal of Social Work Practice in the Addictions, 14*(4), 405–420. https://doi.org/10.1080/1533256X.2014.962141.

Windsor, L., Jessell, L., Lassiter, T., & Benoit, E. (2015a). Community wise: a formative evaluation of a community based health intervention. *International Public Health Journal, 7(1)*, 79–90 NIHMSID 714802.

Windsor, L., Jemal, A., & Alessi, E. J. (2015b). Cognitive behavioral therapy: a meta-analysis of race and substance use outcomes. *Cultural Diversity and Ethnic Minority Psychology, 21*(2), 300–313. https://doi.org/10.1037/a0037929.

Wise, T. J. (2010). *Colorblind: the rise of post-racial politics and the retreat from racial equity.* San Francisco: City Lights Books.

Zaff, J., Boyd, M., Li, Y., Lerner, J. V., & Lerner, R. M. (2010). Active and engaged citizenship: Multi-group and longitudinal factorial analysis of an integrated construct of civic engagement. *Journal of Youth and Adolescence, 39*, 736–750. https://doi.org/10.1007/s10964-010-9541-6.

Zimmerman, M. A., Ramirez-Valles, J., & Maton, K. I. (1999). Resilience among urban African American male adolescents: A study of the protective effects of sociopolitical control on their mental health. *American Journal of Community Psychology, 27*(6), 733–751. https://doi.org/10.1023/A:1022205008237.