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

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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 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, mass 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 (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, mass incarceration) problems. When applied to socio-structural determinants of health (e.g., stigma, substandard housing, lack of access to employment and

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health care), critical consciousness may present a model for achieving health equity (Barr, 2014; Chronister & 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 mass 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 healthcare 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 (e.g., Macias, 2017).

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 healthcare than their white counterparts (Boardman & Alexander, 2011; Jackson, Knight, Rafferty, 2010). Specifically, African Americans are 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) than their white counterparts (James, Hartnett, & Kalsbeek, 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 under-recognized 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 & Mohammed, 2009; Williams, Neighbors, & Jackson, 2003). Underlining the pervasive influence of racism, blacks in the U.S. are more likely to have chronic illness or disability when controlling for age and income (Mead et al., 2008; Barr, 2014). 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 (Mead, 2008; Barr, 2014). 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 (Mead et al., 2008; Barr, 2014). 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

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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, James, Yamout, & Baker, 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 & Ocampo, 2005; Carter, 2007) that can greatly compromise psychological and physical health and wellbeing (Brown-Reid & Harrell, 2002; Clark, Anderson, Clark, & Williams, 1999; Jackson et al., 1996) and contributing to crime, substance use, and related health risk behaviors (Franklin & Boyd-Franklin, 2000; Franklin, Boyd Franklin, & Kelly, 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, Kiefe, Williams, Diez Roux, & Gordon-Larsen, 2006; Carter, 2007; Speight, 2007). Moreover, negative, self-destructive, and maladaptive coping styles may develop to manage toxic stress (Windsor Benoit, & Dunlap, 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 & Des Jarlais, 2009; Des Jarlais, McCarty, Vega, & Bramson, 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 & Phelan, 1995; Williams, Yu, Jackson & Anderson, 1997) and critical consciousness (CC) has been deemed the antidote to external and internalized oppression (Watts et al., 1999; Windsor et al., 2014a; Windsor et al., 2015b). The way to interrupt this viral cycle of

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oppression is to: 1) build anti-bodies, 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; Peterson, 2014; Rappaport, 1981; Wallerstein &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 & 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., 2014). Unfortunately, from the beginning of academic study through career specialization, U.S.-based social workers are siloed in either the micro or macro practice method (Androff & 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 & McPherson, 2014; Austin, Anthony, Knee, & Mathias, 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 & 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 & McPherson, 2014; Austin, Coombs & Barr, 2005; Lane, Chiarelli-Helminiak, Bohrman, & Lewis, 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 & 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, & 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

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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, 2017b). 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 & MacPhail, 2002), domestic violence (Chronister & McWhirter, 2006), and substance use (Windsor, Jemal, & Benoit, 2014a), scholars have reinterpreted CC to have various conceptualizations (Baker & Brookins, 2014; Diemer, Rapa, Park, & Perry, 2014; Jemal, 2017a; Watts, Diemer & Voight, 2011). For example, scholars have used conflicting definitions and assessments of the CC construct (Baker & 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; Windsor et al., 2015b). 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

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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 & MacPhail, 2002; Diemer & 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 & 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 Figure 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 Figure 2):

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 sociopolitical and cultural environment to identify the contextual factors and relationships necessary for change (Carlson, Engebretson, & Chamberlain, 2006; Chronister, Wettersten, & Brown, 2004; Houser & Overton, 200; Watts & Abdul-Adil, 1999); (2) competencies that allow the individual to interact with others and with their environment to transform personal and social realities (Diemer & Blustein, 2006; Diemer, Kauffman, Koenig, Trahan, & Chueh-An, 2006; Getzlaf & Osborne, 2010); and, (3) a sense or assessment of the impact of the problem on

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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, Diemer, & Voight, 2011). Awareness is a social analysis and conceptual grasp of the different axes along which inequity contributes to the identified problem (Watts & Flanagan, 2007; Thomas et al., 2014). 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 & 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 Figure 3 and Table 2). The critical (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 (1973) work that outlined the three stages of consciousness: magical consciousness, naïve consciousness, and critical consciousness. The magical stage was characterized by 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 (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 (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 for problems and/or the 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

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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 blame 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 (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 U.S. 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 (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, Bibeau, Steckler & Glanz, 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 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, Ezeofor, Smith, Welch, & Goodrich, 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

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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; Corning & Myers, 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 & Johnson, 1992; Schnittker et al., 2011). Treatment of oppressed individuals and families in isolation from their sociopolitical contexts ignores the influence of oppressive forces on the daily experiences of these individuals (Dunlap & Johnson, 1992; Windsor, Benoit, & Dunlap, 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 (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 socioecosystem (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, Wettersten, & Brown, 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 & McPherson, 2014) and community-centered clinical practice (Austin, Coombs & Barr, 2005), TC is individually and community focused; concerned with eradicating 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 & Barr, 2005). The final model of TC assesses whether individuals are at the denial, blame or critical consciousness 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).

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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 (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 & Brookins, 2014; Diemer et al., 2014; Ginwright & 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 (Mullaly, 2002; Chronister & McWhirter, 2006). Oppression manifests in limited access to opportunities and resources (Ho, 2007; Jemal, 2016), while privilege provides relatively unfettered access to opportunities and resources (Berman & Paradies, 2010; Buhin & 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 & Engen, 2016; Haight, Gibson, Kayama, Marshall, & Wilson, 2014). The U.S. 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, Holmberg, Warren, & Wong, 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 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 (1973) work, but not incorporated in the current CC conceptual models; 4) the TC construct incorporates Bronfenbrenner's (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

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(see Figure 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 socio-structural 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 & 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 sociopolitical development, or for theorized dimensions of CC, such as critical reflection. When analyzing their data, Chamberlain 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 sociopolitical and economic systems. In the third stage, the pre-critical stage, individuals question the usefulness of previous strategies to deal with injustice. In stage four, 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, 1975), models of personal development, and the stages of grief model (Kübler-Ross, 1969). Level One 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 Two 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

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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 & 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 Three, Critical Consciousness, during which the individual comes to accept ideas that would have been 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, 1970), 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 & 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, Transformative Consciousness (TC). Influenced by Paulo Freire's (2000) critical consciousness (CC) framework, 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 & MacPhail, 2002), interpersonal violence (Chronister & 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 & 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

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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, Pinkard, & Davidson, 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, community and social dysfunction and, ultimately, health inequities (Barr, 2014; Link & Phelan, 1995). Critical consciousness has been deemed an antidote to the social determinants of inequitable health outcomes (Watts, Griffith, & Abdul-Adil, 1999) and is used to assist marginalized populations in coping with, healing from and resisting dehumanizing contexts (Windsor, Jemal, & Benoit, 2014a). However, there is ample evidence that the construct of CC has conceptual limitations and requires clarification for theoretical and practice purposes (Baker & 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 & 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 healthcare and service providers to reduce stigma and improve quality of and access to care. A TC approach can help social workers educate

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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 healthcare professionals, from social workers to pediatricians, form collaborative partnerships for anti-oppressive work in their communities (Jutte, Miller, & Erickson, 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 & 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 & 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 & Jemal, 2015; Garcia et al., 2009; Sakamoto & Pitner, 2005).

Thus, Transformative Consciousness intersects micro and macro practice. In doing so, it overcomes the micro/macro divide that currently dominates social work education, practice, and research in the U.S. – 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 & 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 U.S. 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, Kang, & Fraser, 2014); and, as a result, faculty struggle with how to integrate difficult content in the classroom setting (Lane et al., 2017; Garran et al., 2014). 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 anti-privilege 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 & Mizrahi 2014), and unjust systems require transformation (Androff &

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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.

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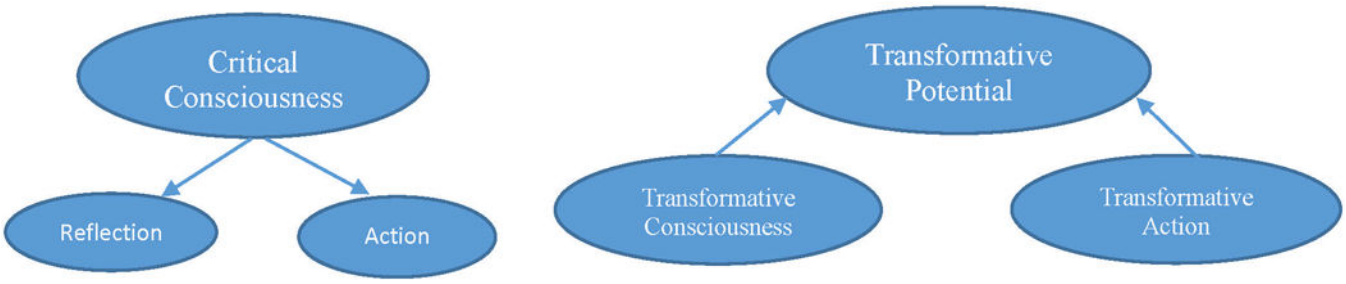

Figure 1.

Conceptual models of CC and TP. The figure illustrates the dimensions of CC and TP for comparison.

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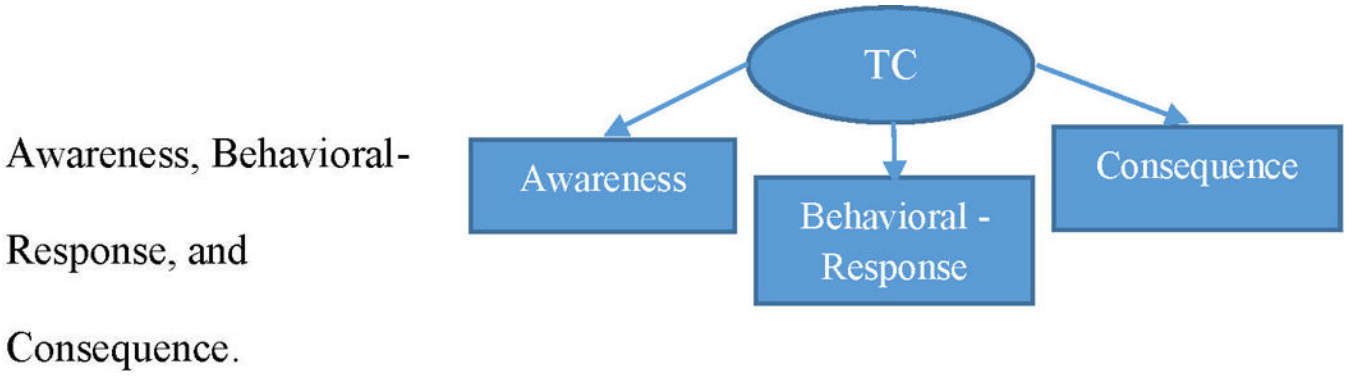

Figure 2.
Domains of Transformative Consciousness. This figure illustrates the three hypothesized domains of Transformative Consciousness.

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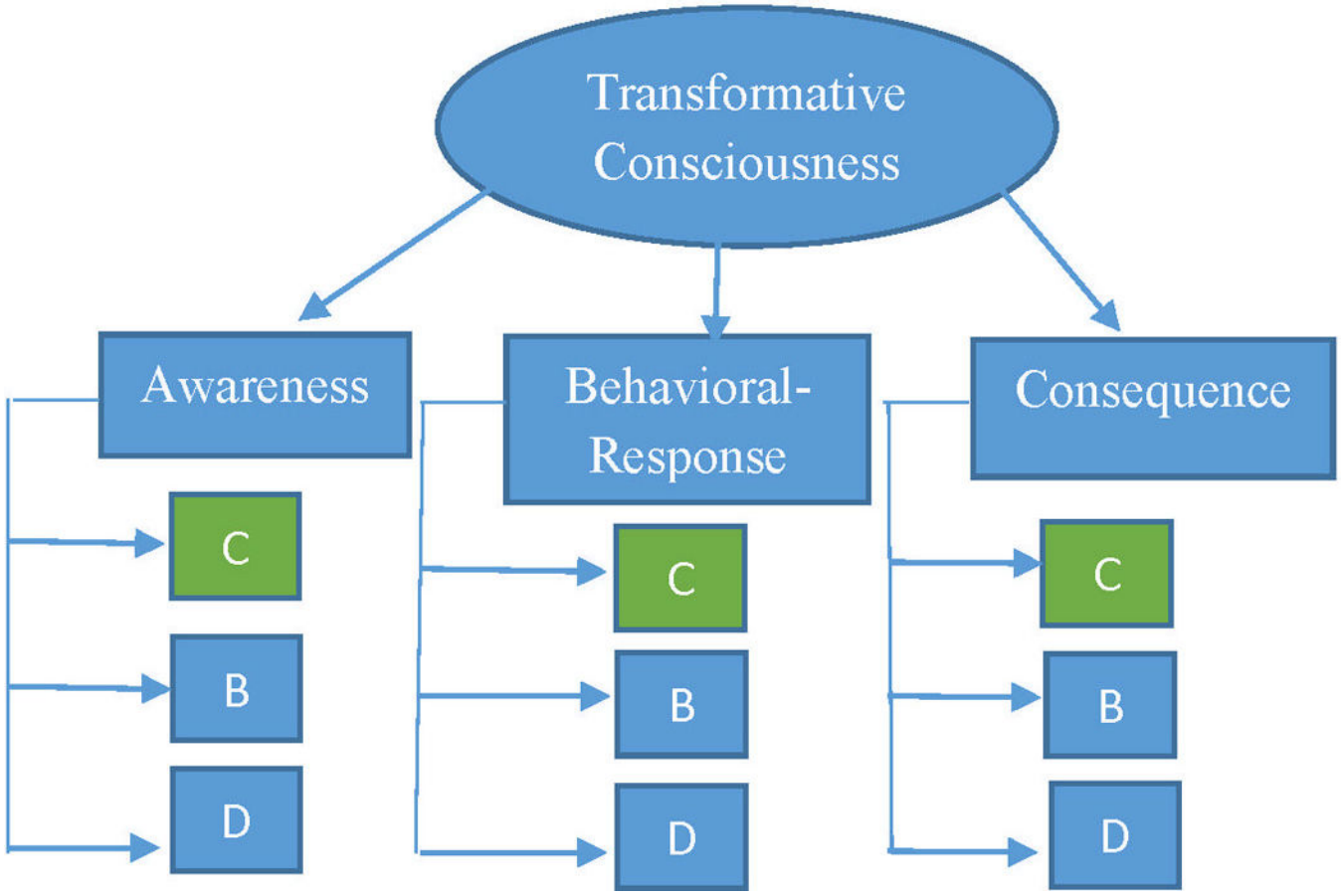

Figure 3.
Conceptual model of TC. This figure illustrates the three levels of each domain of TC. C = critical. B = blame. D = denial.

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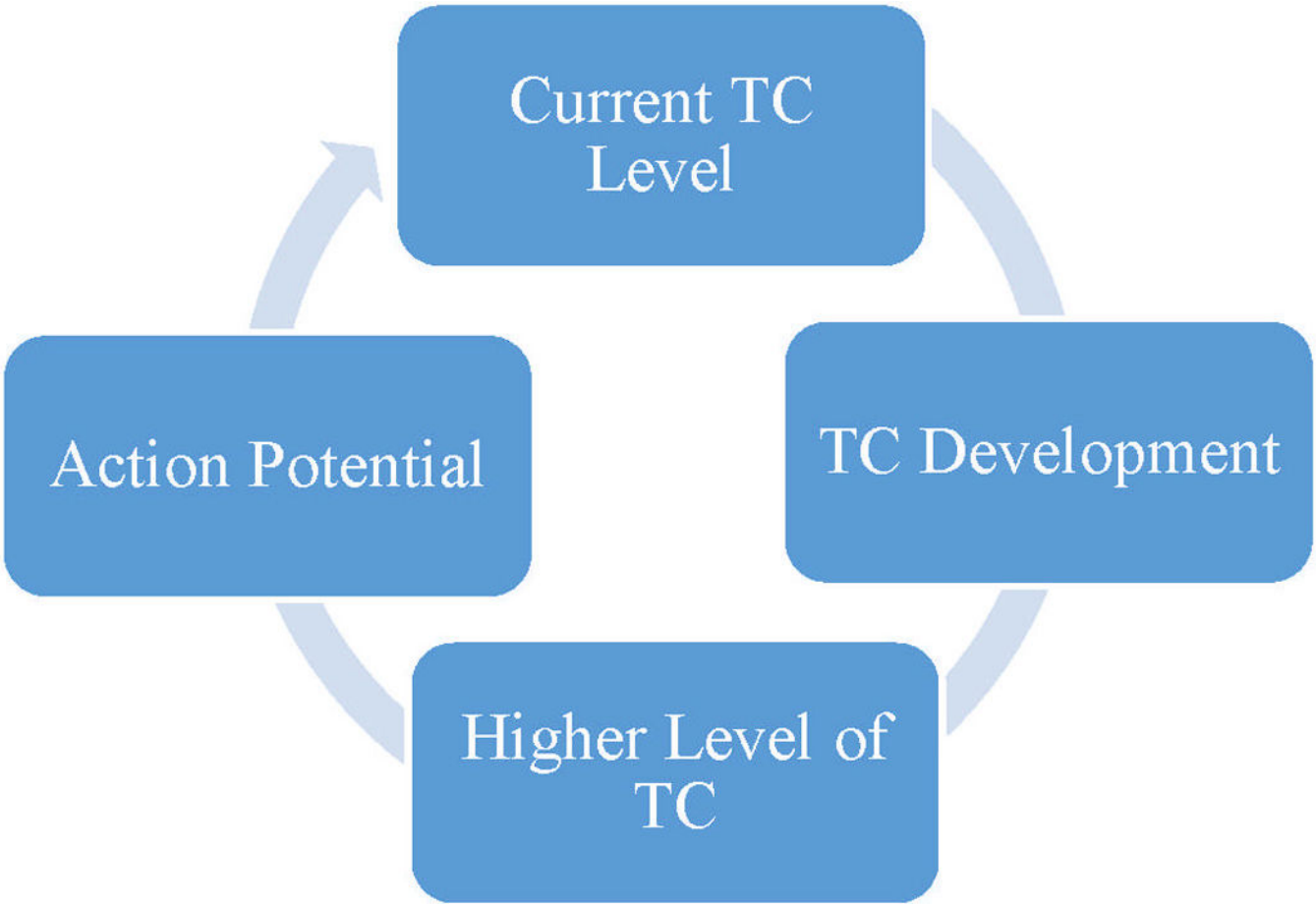

Figure 4.
The cyclical, teleological transformation process. This figure illustrates how TC development leads to action potential to change one's environment, impacting current TC level.

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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 & Overton, 2000; Watts &Abdul-Adil, 1999
Behavioral-Response	Consciousness of potential actions to challenge health inequities within sociopolitical environments.	Diemer & Blustein, 2006; Diemer et al., 2006; Getzlaf & 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, Diemer, & Voight, 2011

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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).

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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 blames individuals to the exclusion of all other systemic factors or social forces of identified problems that shape of people's lives.	The consideration of a response (action or verbal) that addresses the perceived blameworthy individual(s) for the problem and/or the 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 for identified problems and/or the 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.

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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.

Note. Adapted from Bronfenbrenner (1977).

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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 underlie 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 blames 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.

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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 conflicts 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 informs action.
	Stage 6: Liberation	Based on the integration of new and old ideas, micro and macro factors, the individual can discern the roots of their thinking and the factors influencing consciousness.