
Vulnerability and Strength — Giving Voice to the Voiceless

by Dennis Saleebey

This article examines the requisites of working with people who are interpersonally, institutionally, and politically oppressed and therefore vulnerable. To work successfully with them requires that we understand their vulnerability, appreciate their strengths and resources, and recognize the remarkable heroism of their daily lives. This insight is especially useful for professionals in the fields of health, mental health, public welfare, and family services.

Intricate relationships exist between the requisites of democracy and social justice and empowerment and personal dignity. Understanding these relationships may help us recognize who is vulnerable and what that means; the institutional elements of sustaining or subverting vulnerability; and the heroism of persons who must resist oppression to assert their autonomy, individually and collectively. Such work will also help clarify the obligations of the helping professions (including social work and healthcare institutions) who work in and among vulnerable populations.

Autonomy of the Oppressed

First, however, a critical distinction must be made between the vulnerability borne of oppression and autonomy borne of the relative freedom to make meaning of one's life, both as individuals and as cultures or classes. Vulnerability does not rule out autonomy, which reflects a degree of agency — the ability to define one's self and to act on that definition. Autonomy has a communal element. It flourishes best within the context of family, neighbors, friends, and cultural and

institutional supports. The assertion of the heroic in the lives of many vulnerable people is always an assertion, no matter how underdeveloped it might be, of their autonomy and agency.

Individualism is not autonomy, and the rampant individualism that characterizes our society is not my point. Individualism is a reigning sense in the dominant culture that the individual is the central element of the social order, and that an individual's agency is produced solely by his or her own efforts.

The question that engages us, then, is how to promote autonomy and "give voice to the voiceless" by developing their capacities, attending to their hopes and possibilities, and helping them summon the resources and reserves of the individual, family, and community. The strengths of individuals, families, and communities can be understood and better used by seeking out the heroic elements in the lives of the oppressed.

Who Are the Vulnerable? Who Decides?

Words that capture, in a meager way, the notion of vulnerability include the oppressed, the disenfranchised, the voiceless, the despised, the

marginalized, and “the other.” Paulo Freire (1973, 1996), argues that the oppressed, worn out by sickness and poverty, discrimination, cruelty, and torture, will eventually take on the view of their oppressors. They see themselves as lacking, at fault, weak, or not entitled.

Though oppressors themselves are dehumanized by the very dehumanization they practice, they eat and sleep well, and run the institutions of government and the marketplace. In addition, it is their language that dominates, persuades, and characterizes those who cringe under their practices. The vulnerable in Freire’s sense are those crushed in spirit, in consciousness, and in practice (the root word for oppression — *pressere* — means to crush).

Michel Foucault (1980) defines vulnerability by describing the inextricable relationship between knowledge and power. Those who have power because of their entrenchment in social institutions (e.g., in civic and commercial groups, healthcare, and education) know that their understanding, their language and lexicon reign supreme in the conduct of affairs. Their knowledge is privileged, and the knowledge of those who count less, who are defiled or live on the edges of society, is fugitive, disregarded, misunderstood, distorted, and suppressed. Those who cannot name their situation, themselves, their group, or their past are vulnerable.

In a recent report on the Pine Ridge reservation in South Dakota, home of an Oglala Sioux community, a reporter for NBC described the community. She said:

The high point of life here, called Carnival Week, is the start of every month when the aid checks come in. . . . Almost everyone spends some, or even all of the money, or barter food or sells cans for alcohol. . . . [And those who come back to the reservation, usually because they cannot manage life outside] succumb again to the ways of Pine Ridge — idleness and alcohol (quoted in Frazier 2000, pp. 226-227).

The residents of Pine Ridge were outraged. They wanted people to know the character and richness of life on the reservation and the inherent goodness and strength of its residents. Of course, they acknowledge the bleak side of living on the reservation — they live it — but the language of outsiders, the dominant voice in this report, had already framed the lens through which others will see Pine Ridge. The community, for example, has never used the term “carnival week.” Such misrepresentation is a common experience among

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vulnerable or oppressed people (but again, “oppression” and “vulnerability” are not the way groups refer to themselves — they are terms in an outsider’s language).

Edward Sampson (1993) provides yet another perspective. He notes how those in power and position often use various people to define themselves. That is, they take particular cultures and ethnicities, and poor people, women, gay men and lesbians, those with disabilities, and immigrants — and define them as “the other.” In the process of creating others, they create something serviceable to themselves; that is, the dominant “selves” use the term “other” to define who they are not. This process makes the other a thing to be used and then discarded. Toni Morrison (1992, p. 52) describes how the term “African-American” has become a serviceable

object constructed on behalf of the dominant white group's desired identity:

Africanism is the vehicle by which the American self knows itself as not enslaved, but free; not repulsive, but desirable; not helpless, but licensed and powerful; not history-less but historical; not damned but innocent; not a blind accident of evolution, but a progressive fulfillment of destiny.

For everyone or group defined as the other, what is said about them can become what is done to them. It becomes an ineluctable part of their self-identity. The words and actions used to describe them reflect a story of their lives — but not their story.

Remarkably enough, those who are vulnerable, often manage a life of infinite variety and color; and, in spite of the prevailing view, often stand up to dominant institutions and people who ignore or bedevil them, and say, "No more! This is who we are and this is how we will be treated." But for many, their own voices can be heard only in the family, neighborhood, or church, and not elsewhere: not in the hospital, the social service agency, the marketplace, the workplace, or the school.

If, then, we ask who are the vulnerable or the voiceless, and who decides, I think we know. We know them as people of color, or as members of the working class and the great army of poor people. Or they are the too many children, and the too many women, the gays and lesbians, and

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elders. Or they are latecomers or immigrants, or people with disabilities or those who suffer with mental illness, or prisoners. But their group identity may not be primary. Among them also are many who are dispersed among society: solitary souls who cannot define themselves, speak in

their own voice, or tell stories to establish the grounds of their uniqueness.

The vulnerable are individuals and groups who have few of the responsibilities, privileges, and joys of being agents on their own behalf or on behalf of their families and communities. The vulnerable are those who cannot articulate and act on their own values, make their own views known; or be recognized for their skills and competencies. Rarely can the vulnerable choose a course of action, refuse a disabling proposition, or act on another's behalf; and they are seldom, if ever, treated with dignity.

Social work's code of ethics does not speak of autonomy, but it does address the importance of respecting the inherent dignity and worth of the individual:

Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients' interest and the broader society's interest in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession (NASW, 1994, p. 3).

Clearly, the code's insistence on enhancing a client's capacity to address his or her own needs indicates the profession's concern for autonomy. If, further, we take as an essential human capacity the need and ability to make meaning, then autonomy is how we come to understand and act in the world around us. Hardly anyone makes meaning entirely on his or her own: instead, culture, the larger society, family, and history contribute to this project. Nevertheless, autonomy and agency center on the ability to make (in league with others), one's own meaning and to have those meanings understood, acknowledged, and heard by others.

Thus, as Robert Lindner said many years ago (1952): agency, or personal liberation — Lindner called it rebellion — includes the following qualities:

- awareness of one's situation and condition (i.e., what Freire calls conscientization — an intense consciousness raising);
- identification of and command over one's own powers, strengths, and assets;
- responsibility for having the tools and support to shoot for autonomy; and
- employment, that is, an engagement in something meaningful and purposeful beyond oneself.

These qualities are defined by the contexts in which people live and shaped by their various limitations, such as, physical or mental illness or disability. The context, the immediate environment in which a person lives and interacts, also makes a difference.

Consider the following case: Jack has a developmental disability and is an adult. There are many things he cannot do without help; however, Jack works as a custodian, keeps a bank account, plays miniature golf, and lives successfully with his brother who also has a disability. The person who sees Jack in a clinic or an emergency room, will be hard-pressed to imagine him doing these things because of his appearance and the difficulties he has communicating. But Jack, like the person seeing him in a vulnerable context, has degrees of awareness, identification, responsibility, and employment. Many, perhaps most people will not see Jack's virtues unless they are prepared to. This shortsightedness is true for all of us.

In treating people with disabilities, defects, diseases, and addictions, one often focuses on the diagnoses or designations they bear. These labels are easily used or misused to create a set of expectations for others — professionals and lay. In this way (and these are real people), May becomes a cancer victim; Tom becomes a child abuser; Tricia becomes a welfare, teenage mom;

Pat becomes a schizophrenic; and Kay becomes Bipolar.

But May is a professional athlete, a sister, a devout Catholic, a fiancée, and funny to boot. Tom is a mechanic, a father of four, a good provider, and has two close friends who know him as someone who struggles with "demons." Tricia has raised five children on her own; she is articulate,

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a really good mother who does not want to be a burden on her family, and quite an artist. Pat is a mother and wife; a psychiatrist, and a fine author who has devoted her last decade to promoting a recovery movement for people with severe and persistent mental illness. Kay is a psychologist and poet with the gift of care in her soul; she is also a mother, and she has done original research and writing on manic-depressive illness.

In the health and mental health professions, whether we mean to or not, we often confuse people with their diagnoses or their illnesses. More particularly, when we confront people who are different from us, say, those who are truly vulnerable, we add additional labels: they become resistant, manipulative, undesirable, different, difficult, noncompliant. Or more derogatively: they are a "crock," or a "pain in the butt." These designations occur more frequently among individuals with certain diagnoses or conditions: drug and alcohol abuse; HIV/AIDS, kidney disease, personality disorders, or is poor, or from a different culture. If such persons are not only different, but also defiant — demanding, for example, to be known for who they are and

to be given their due — these labels are more likely to stick.

In sum, people who are oppressed are, in a general sense, vulnerable. They are vulnerable because they cannot articulate their own meaning; their understanding, even their language, is appropriated or suppressed by others' ideologies, actions, institutions, and policies. This suppression makes the development of agency, both individual and communal, problematic and arduous. And, ironically, the vulnerable may begin to look like the stereotypes so beloved of their oppressors. This transformation is a result of labeling.

The Impact of Labels

Labels are words, words that come from those with the power to name. Names create imagery, imagery creates expectancies or orientations; orientations become part of behavior; and behavior may become part of one's identity — firmly lodged in the very marrow of one's being. Unchallenged, these expectancies become "theories" that govern what we do and that confirm the identities of those who bear the labels.

Many other diagnoses or labels have the same effect: schizophrenic, perpetrator, alcoholic, abusive parent, at-risk kid, emotionally disturbed child, heart patient (Type A personalities), and cancer victim. Susan Sontag (1988) wrote eloquently about the stigma of having cancer and HIV/AIDS, an infamy flowing from the fears of others, and the specter of death that these bring. In a word, theories too often obscure the complex reality before us and make us attribute traits, patterns, motives and even experiences to a person that are either untrue or susceptible to a more benign meaning. Most important, these markers turn us away from the capabilities and potential inherent in every one we see.

In other words, the penchant for labeling trumps agency and indigenous meaning-making. For example, the longer many clients are in the health, mental health, child welfare, or social service systems, the more difficult they are to help. Often that intractability is a result of the

negative symbols, words, images, designations that have grown like barnacles upon them, and other, confirmatory experiences.

Words can elevate and inspire or they can deflate, depress, and agitate. Whatever else they do, labels create expectations and help us and our clients form impressions of themselves. Labeling obscures the person behind the diagnosis because it ignores the sociocultural context of suffering and recovery or suffering and dying. It slights the strengths and capacities of the individual and the relevant environment (especially the family) and ignores the indigenous, cultural resources for transformation and healing within and around the individual, including the cultural view of death and dying.

Labeling disregards or even belittles the individual's own understanding. This disregard is regrettable because strengths, family, and cultural resources and meanings are the building blocks, the hallmarks of autonomy, or agency. Finally, it reflects and emboldens a power inequity between

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the expert provider and his or her client or patient that frustrates the possibility of restoration and regeneration inherent in the body, mind, and environment of the individual.

The power of labels turns on the power of words. As Joseph Conrad (1900, p. 185) wrote: "A word carries far — very far — deals destruction through time as bullets go flying through space." Labels create expectations in the patient or client, the healers, and the larger community. These expectations turn out to be extremely rugged blossoms. They affect others' responses to that person, and contrive role relationships in which it is extremely difficult for the person not to act in accordance with these expectations.

In the end, labeled individuals may begin to think of themselves as incapable or unwilling to get better or to follow through on treatment. In some cases, a clinician's initial expectations may serve as confirmatory biases that are then enshrined in charts and files, in staffings and

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conferences, and in informal contacts among professionals.

Despite our best intentions, attributions may continue to inform our impressions and undermine our critical thinking and careful reflection. While we are conducting our professional routines and conversations, we may be turning a case with considerable potential, or one wherein healing may take place (not a cure necessarily, but a transformation of one's quality of life) into one with little to recommend it. Of course, accurate diagnoses are beneficial, but given without proper assessment and attention to the person before you, they can rapidly deteriorate into labeling.

For example, imagine that you are a social worker in a school system. You learn that James, age fourteen, has spastic cerebral palsy, is frequently aggressive with peers and siblings, is two years below grade level in reading and arithmetic, and has parents who are rarely present in the home and not very supportive. It is tempting to plan a serious intervention immediately, and it certainly appears that you and James have much to accomplish. He and his family would seem to qualify for a variety of labels at this point. But to your credit you want to know more about James as a person.

You quickly discover (and James appreciates your interest) that he has had a paper route for over a year and does an outstanding job; that he

likes to write poetry and science fiction; that he has a close relationship with an aunt and uncle who live nearby; and that he is making steady progress in physical therapy (Wright & Fletcher, 1982). The picture changes dramatically. James still has cerebral palsy and is not doing well in school, and his parents are still detached, but you can begin to discern through his stories that he has a significant degree of motivation, some self-discipline, supportive relationships, and perseverance among other things. These strengths will ultimately be important assets in helping James contend with the insistent difficulties in his life.

The Power in People — Heroism

In spite of the costs of oppression and its toll — vulnerability — many individuals, communities, and cultures manage to sustain their meaning, the core of their agency and autonomy. This tenacity is what I mean by heroism. Appreciating and stimulating the heroic in clients or patients can help them confront their circumstances, marshal their positive and strong attributes, consort with their dreams and hopes, connect to outside resources and possibilities — and collaborate on a mutual project of singular importance to them (like getting well, or preparing for a "good" death).

Heroism is a generative idea. Generative ideas or themes are ideas, stories, concepts, values, myths, and experiences that generate new possibilities, new thinking, new directions. They are challenges to the canon, or cant, of convention. If they are potent and important, they will resonate with the urges, hopes, and experiences of all people, with the human condition and human nature. A true generative idea will overflow into your psyche and ultimately into your organization. Eventually, thanks to the power of such generative notions, a new possibility may spread into the community, into the institutions in which your clients or patients pass their time: schools, hospitals, churches, human service agencies, and the street.

So what is heroism? An old saying among Caucasus mountaineers is that "heroism is endurance for one moment more." It is true that many of the people we seek to assist have endured situations and conditions that stagger our minds and break our hearts. This endurance is the starting point for connecting to the heroic — we must find out how individuals have managed to survive.

I don't care if they are facing a court hearing, or look as though they were one step away from a prolonged hospitalization, even death. They have stayed alive; and even if they are mandated, they sit before you. How have they contrived to do this? In some community projects I have been involved in — for example, in public housing, where most of the things you hear about economically distressed communities has some truth — what is not seen or spoken of are the many families and individuals who fight everyday to exist with a degree of dignity and a glimmer of hope. They might be burdened with poverty or serious health problems, with not enough respite from the stress of life on the edge, or with drug addiction; but they are fighting for existence on the only terms they can accept, whether or not their struggle will be victorious. The struggle to exist with nobility and possibility is agentic: it reflects an individual's or group's efforts to be and to do.

Tapping into the energy, imagination, and will of clients to be heroic is to help people recover or command the power to change, using old skills and resources, and discovering or developing new ones. We don't know what people are capable of and, sometimes, they don't either. On the basis of a diagnosis, for example, we may think a person cannot be creative, cannot form a relationship, cannot use his or her intellectual powers in a variety of ways, cannot do a particular kind of work, cannot live independently in the community, or achieve a good quality of life with this illness. In many cases our judgment is wrong — we really cannot know whether a person's capacity. The reverse is true as well: on the basis

of many diagnoses, you cannot know whether a person can be creative, form relationships, use intellectual powers, or live independently.

The urge to be heroic is characteristic of most, if not all, people. That is, people live from an inner urge to transcend circumstances, to develop their powers, to overcome adversity, to stand up and be counted, to be a part of something that transcends the petty interests of self. It is a precious urge and often a fragile one. Liberation and empowerment are the heart of the professional's work with the vulnerable, and both liberation and empowerment are designed to unleash the heroic — human energy, critical thinking, challenges to the conventional wisdom, moral imagination, the humanitarian impulse, the ability to survive and surmount adversity, and the urge to health. This drive may occur within the parameters of one's daily life and be as simple as the willingness to try out new behaviors. It is the drive to entertain new ideas, escape the drudgery of oppressive work or abusive relationships, give help to a friend, volunteer in a community, or withstand stress or illness with dignity and resolve. It may be heroic simply to hold hands with those who are marginalized, isolated, or vilified.

But the heroic is, in the end, pegged on the lattice work of the practical. Here, then, are pragmatic steps to help practitioners engage the strengths and increase the heroism of their clients:

1. *Hear the voice, the story, the theory*, the ideas of the client and take them seriously; they may be the most important ideas around, even about physical illnesses, or the process of dying well.
2. *Adopt an attitude favoring resilience* — namely, foster a genuine belief that clients and their families can become what they hope for or move in a direction that is right for them. Even for one who is seriously ill, the issue is quality, not length of life.
3. *Believe in the clients' and one's own capacities and strengths* — which means accounting for, appreciating, affirming, and acting on these

strengths. In my experience, this attitude is essential for respecting and realizing clients' strengths, and the heroism of their daily lives. In other words, this tactic involves a double feedback loop: from you to client or patient; and from client or patient to you.

4. *Represent the clients' views, narratives, perspectives wherever possible* — during staffings, in-service trainings, grand rounds, newsletters, and bulletin boards.

5. *Challenge the views of your clients and families and the community* if such views demean or diminish their humanity or reduces them to a welter of neediness and problems.

6. *Celebrate clients' accomplishments and successes*, ritually and officially, personally and publicly. This validation is a very important element of community work.

7. *Invite clients to participate to the extent feasible* in the workings of the agency, the hospital, the association — ask them to be liaisons, advisors, mentors, participants, and tutors.

8. *Create organizational narratives that document both client and worker heroics*, capacities, leadership, ingenuity, accomplishments, and strengths. In my community, we sometimes create a photo album on walls and windows of people doing good things, of engagement in community projects, of accomplishment and celebration.

9. *Help foster an organizational culture* where conversation in the coffee room is not always about how awful things are going but occasionally about how awesome it is — especially with respect to the work staff and clients have accomplished together.

10. *Write records in a way that no one will mind if clients' read them*, and invite clients to read them — even amend them. One social worker I know always approaches family records as a mutual undertaking because it provides another dimension of relationship and trust. It also helps ensure that the records reflect the family's realities and the agency's theories.

Conclusion

It is time that we assert ourselves against the hegemony of the institutionalized word. For too long this word has characterized the "other" by itemizing and enumerating weaknesses, failures, and fallibilities, recounting defects and deficits, promulgating problems and predicaments. It is time to resurrect "agency" and "autonomy," and to celebrate the possible: that each one of us can do more, be more, see more than we think. I believe that if the work we do is chastened and leavened with belief in the dignity and autonomy of everyone, even our most vulnerable clients, and the ability to see them as they truly are, their strengths and resources will become apparent. Only then will we appreciate the real value of their heroism: it is a work that may become a critical mass in spinning this world on a different axis.

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