Considering the ways in which anti-oppressive practice principles can inform health research

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ABSTRACT

All research that investigates therapeutic practice should be conducted with the aim to develop and support good procedures of inquiry. An anti-oppressive practice approach within health research provides a way to systematically examine research procedures and motivations to increase the potential that the resultant research will yield ethical and just results. In this paper two music therapy researchers consider how anti-oppressive practices can address *real life* problems and be applicable to *real life* situations; from questions of participation, to developing the research question, recruitment, consent, and further steps of the research process. The goal of this paper is to examine issues arising when considering anti-oppressive practices and healthcare research practices from the perspective of the authors' experience of music therapy research.

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Introduction

All discourse, whether universalistic and/or particularistic, must be subject to contestation, so that we are held accountable for the thinking that we articulate in our writings, and so that we do not reinforce much of the taken for granted assumptions about the world, (Sewpaul, 2007, p. 398).

As a *practice*, research requires attention to its history, its contemporary workings, and its future potentials in order that it can remain lively and engaged with contemporary issues. Otherwise research practices and choices can risk becoming calcified into a series of unremarked tropes. Anti-oppressive practice orientations within research offer a lens by which analysis of the worldview, assumptions, and motivations of the researcher can occur. The researcher pays attention to their experience and understanding in relation to power dynamics, and in particular *privilege*. Privilege refers to the power and higher status disproportionally afforded to some groups within culture (Pease, 2010). For example, in almost all, if not all societies, able-bodied people are afforded more accessibility to physical spaces, professional opportunities, and education than disabled people resulting in a power differential where able-bodied people are more privileged than people who have disabilities. In particular, anti-oppressive practices have developed to address white male privilege and the inequities that

result from the unremarked advantage of white maleness (Kimmel & Ferber, 2003; McIntosh, 2003).

Historically, research across many disciplines has evolved in a culture of privilege, in particular that which has been described as *white male privilege* (McIntosh, 2003). This can be observed in multiple ways. Research protocols, informed consent and data collection procedures, discussion of results, and subsequent conclusions have operated within this consensus. Numerous sources from past decades recounted a history of abuse and oppression within many aspects of health research, from various medical practices to psychological theories. For example, the effect of privilege within the construct of deviance was researched (Erickson, 1966). Dual norms of mental health for males and females based on sex-role expectations were studied exposing that the norms for healthy person and males were the same but did not match the norms for healthy females, which closely resembled those of a healthy child. In order for women to fulfill their designated role in the dominant culture, they were not allowed to function as healthy adults (Broverman, Broverman, Clarkson, Rosencrantz, & Vogel, 1970). Further research documented abuse of women in the name of therapy. Women who did not conform to rigid sex-role expectations of the dominant culture were then labeled mentally ill, ostracized in the community, medicated, and warehoused in institutions (Chesler, 1971). The politics of therapy have been researched exploring the distribution of power within therapeutic process revealing that therapy practice needed to evidence more political awareness (Halleck, 1971). By remaining *neutral* in an oppressive situation, psychiatry became an enforcer of establish-

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ment values and laws (Steiner, 1974) rather realizing the radical psychiatry position that for individuals to be free, society must be free (Wyckoff, 1974). Radical anti-psychiatrists and labeling-theory sociologists demonstrated convincingly that both diagnosis and treatment in psychiatry are founded on ethical judgments and social demands whose content is sometime reactionary and controversial (Sedgewick, 1982). Models of moral development were critiqued as based on a male ideal reporting how this de-valued elements of moral development that are part of women's experience (Gilligan, 1979). Egalitarian approaches to therapy where the therapist used self-disclosure to state their bias and ideology and invited feedback and evaluation were encouraged (Greenspan, 1983) while the Diagnostic and Statistical Manual of Mental Disorders was revealed as sexist and racist (Kaplan, 1983). Traditional therapy often individualized experiences, focusing on symptoms and challenges without addressing the social structures that have given rise to the person's difficulties. These inequities reflected in all aspects of life leading to stress on those of non-dominant status were examined in the politics of mental health (Banton, Clifford, Frosh, Lousada, & Rosenthall, 1985). Feminist therapy arose as a consequence of deficiencies in mainstream therapies, which reflected biases against women (Ballou & Gabalac, 1985). Society established norms of what it meant to be a *good* member of that society and what it meant to be a *bad* one defining success and failure revealing that ultimately, society held most tenaciously to values essential for the continuation of the privileged (Pallone, 1986).

Privilege continues to be a consideration in contemporary research (Potts & Brown, 2005). For example, a researcher potentially gains from the research participant's involvement through increased status as a scholar by achieving a Ph.D., by being published, or by receiving grant funding based on the findings of the research. However, many research processes require input from participants, the gain for whom might not be obvious, or may not even be present. Often, the participant is anonymous, thanked but not credited, and their contribution in terms of time and effort can go unnoticed and unrewarded. Investigations that use anti-oppressive practices offer researchers a way of looking at their work that is both inclusive and also political. The shift in language and practice in many areas of social research can be encapsulated by the move from treating respondents as *subjects* to involving them as *participants* (Kemp, 2001). Using the anti-oppressive practices lens, participants are viewed as colleagues in the research process and treated as a valued voice in the research collective.

Since oppression can be present in the context of any aspect of healthcare practice including research practices, to progress the theme of this paper the concept of oppression will be briefly explored in order to better define and delineate the characteristics of anti-oppressive practices.[1] Oppression has been described in multiple contexts and in relation to many professions. For example, Deutsch's (2006) research highlighted elements of repeated, widespread, systemic injustice whereas Dong and Temple (2011) focused on denial of rights and dehumanizing unjust treatment. Oppression and repression are fed and supported by the state's dominant ideology and its security forces and sociocultural norms, values, and practices (Kucukaydin, 2010).

The medical model is the primary philosophy currently at work in therapeutic and healthcare services. In his description of the development and regularization of the professions of counseling and psychotherapy, Murphy (2011) wrote that "The medicalization of distress serves the interests of those who favour maintaining

the dominant medical model paradigm and that which its proponents deem *appropriate, effective and efficient*," (p. 228). Focusing on the authors professional practice site of music therapy, it can be argued that where the state ignores possible benefits for service users of certain treatments such as music therapy, oppression of the socially radical and creative is occurring in order to favor conservative and quieter traditions of therapy that have hitched themselves in tandem to the medical model. Power is ubiquitous: it exists in all practice settings and even with the best of intentions we can cause harm (Prilleltensky, 2008). Because music therapy is practiced in a system structured by the medical model, oppression can come into play through the brokering of power in all aspects of service delivery and in the privileging or silencing of certain theoretical perspectives.

Beginning to address the absence of criticality in theoretical positioning within various music practices including music therapy, music education, and community music, Edwards (2011) queried "How is the balance of this emerging dichotomy of the proposed ubiquitous *goodness* of music and its constituent potential for stress or harm negotiated and incorporated into practices around music therapy?" (p. 96).

Isenberg (2012), concluded in a study of harm in music therapy practice that "If we are not talking about harm, then perhaps we are also not doing as much good as we can" (p. 76). She provided a detailed account of possible ways in which music therapists may harm their patients and suggested music therapists can do harm in ways that are typical to all therapeutic practices. Isenberg (2012) addressed music therapy specific concerns for *doing harm* reviewing related research by De Backer and Van Camp (1999), Langenberg (2002), Metzner (1999), Nygaard Pedersen (1999), Pavlicevic (1999), Priestley (1994) and Smeijsters and Van Den Berk (1995) to support her thesis. Isenberg and her sources all encouraged us to sincerely examine our power to harm as well as to help. As Edwards and Hadley (2007) reported

> It is increasingly clear that the therapist is not the benign *helper*, but rather an active being who is undertaking a social and political work. First, this occurs because the helper believes that by belonging to a particular professional occupation and orientation, s/he is capable of prompting and supporting change in others. Second, by believing that such interventions are necessary, required, and helpful the helper is obliged to take particular actions. When the authors write about these interactions and experiences in music therapy we are not separate from them, but rather are actively engaged in their construction, interpretation, and consequently their meaning, (p. 202).

Practitioners in all facets of healthcare practice, including research practices, benefit from self-reflective analysis to address the potential of their actions for harm. In order to do this effectively, we must extrapolate beyond traditional ethical terms to deeply and consistently engage in critical examination and analysis of our own worldviews and political perspectives. For example, a researcher in the field of obesity may benefit from the alarm caused by claims that obesity is out of control, or has the potential to cause future catastrophic burden on healthcare systems in the developed world. By blaming overweight individuals for being uncontrolled in their eating, healthcare solutions are able to advocate an individualized medicalized patient treatment model. By avoiding wider social impacts for the issue that many more people are overweight in the developed world currently than in the past the healthcare researcher potentially colludes with a medical model which cannot attribute this change beyond an individual blaming perspective.

Anti-oppressive practice offers us a politicized framework to decrease potential negative effects for healthcare clients when the contemporary worldview in healthcare research rarely considers of the potential for harm. Anti-oppressive practice provides us

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