THE RELEVANCE OF

Social Justice for Today's Therapists

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The #BLACKLIVESMATTER movement, born out of **racial violence** towards African-origin American and Canadian men and women, is not just an isolated social justice movement. This movement highlights **individual experiences of racism and inequity** with law enforcement. Racism is not only experienced in these venues, but in **daily life** experiences for many individuals and many racialized and marginalized communities.

Inequity influences not only one's daily experiences, but how one develops a career, how they respond to challenges, how they navigate systems, such as child welfare and criminal justice, and how they achieve education. Furthermore, popular messaging in social media, advertising, educational texts and history books continue to reinforce damaging stereotypes and assumptions about individuals' and communities' self-worth and achievement. These experiences of racism and inequity impact individuals' and communities' social-emotional and psychological functioning. As marriage and family therapists, we play a key role in assessing, treating and developing interventions for families and couples. Understanding the impact of racism and inequity and developing an equity lens in supporting families and couples demonstrates an ethical responsibility to the client and best practice.

According to research, experiences of racism and inequity lead to increased mental health issues including feelings of shame and inadequacy, depression, anxiety, paranoia, lower self-esteem, and stress levels (Etowa, Keddy, Egbeyemi & Eghan, 2007). Oppression influences job performance, career achievement, relationships, parenting challenges, chronic pain, and grief and loss (Etowa et al., 2007). The institutions which have supported families, such as child welfare, the criminal justice system, education system and similar have also contributed to oppression due to assumptions based on race and culture, oppressive policies and practices, institutional barriers, and restrictions. These institutions have also been responsible for interventions, which have been harmful to racialized families. Some examples include misdiagnosis of symptoms of paranoia for schizophrenia, children apprehended from their families due to experiences of poverty, and expectations for families to participate in services that are irresponsive to their needs. These experiences and more are harmful to the family unit, and contribute to mental health stress.

Anti-oppressive practice is the framework used for institutions to achieve inclusive and equitable practice. This practice framework is the model used now within educational systems, child welfare and private institutions to achieve equity within their organizational practice. As a marriage and family therapist, it is important to develop, adopt, and maintain such practice within your private or public setting. As well as advocate for equity with your clients. Understanding oppression is the first step. According to Mullaly: "What determines oppression is when a person is blocked from opportunities to self-development, is excluded from the

full participation in society, does not have certain rights that the dominant group takes for granted, or is assigned a second-class citizenship, not because of individual talent, merit, or failure, but because of his or her membership in a particular group or category of people" (2010, p. 40). As therapists, we often hear direct stories where our clients may have been followed home by the police and harassed, leading to an experience of trauma. We hear many clear examples of oppression. We, as therapists, are in a unique role to react differently from these experiences by supporting our clients by identifying and addressing these experiences of oppression for what they are.

An anti-oppressive practice framework seeks to identify, address, and assess institutional norms and assumptions on how it influences individuals' participation in society. This process is well detailed and includes processes such as respect for diversity, identifying stereotypes and prejudices, and developing a commitment to identity, power and privilege (Nzira & Williams, 2009).

On a practical level, using an anti-oppressive practice (AOP) in therapy to engage and treat racialized individuals will help develop accurate assessments and inform treatment plans. It will help improve engagement with the therapist, client motivation and change, and overall outcomes. As a therapist, we all seek to help motivate our clients to change through the therapeutic relationship. This relationship is often built on trust, expertise, and empathy. However, there are times when our clients have difficulty trusting our expertise and position because of past experiences of powerlessness within institutions and the authority of officers. It is important we are mindful of the client's experience of powerlessness in the context of racial violence and inequity.

As a therapist, I can pose questions to new clients that can help me understand their experiences of powerlessness and anticipate their challenges and barriers around developing a *trusting therapeutic* relationship. One example comes from working with African-Canadian young men involved in the criminal justice system. Many times, their behavior appears to convey anger and aggression, but upon further assessment, the youth are able to describe significant experiences of trauma from various forms, such as police brutality, poverty, isolation from community, grief/loss from losing friends to gun violence, loss from losing their parents to deportation, repeated school oppression due to hasty suspensions and repeated experiences of shame due to their behavior. However, this information does not always come readily from the youth. It was very important they develop a trusting relationship with the therapist that helps them feel safe to take the next step in their healing journey.

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AOP includes concepts such as power imbalances, cultural imperialism, and self-reflective practice. These concepts are critical pieces to anti-oppressive practice and developing institutional and individual change. These concepts are important to consider within the client-therapist relationship.

Power imbalances also refer to the experience of *white privilege*. An exercise in identifying white privilege was developed by Peggy McIntosh in, *Unpacking White Privilege* (1988). This tool helps therapists to identify and self-reflect upon the power in differentials which exist between the dominant group (white middle and upper class) and the subdominant group (generally marginalized communities).

The dominant group experiences privileges that are denied, restricted, or refused to the subdominant group within society. Even in the client-therapist relationship, the therapist holds privileges that are denied or restricted to the client. The same imbalance further exists within the client's daily experiences. When therapists belong to a member of a sub-dominant group, they also experience a power imbalance in the client relationship if the client belongs to a dominant group. It is important to note that these imbalances can often occur on a subconscious level. This may mean that within this therapeutic relationship, the client may not be aware of the power imbalance or the subtleties between themselves and the therapist.

As an African-Canadian therapist, I am distinctly aware that my experiences are many times not similar to the middle class white families I serve in my private practice. Being aware of these imbalances and identifying the imbalances which occur can direct the client to develop skills of empowerment, strength, self-efficacy and power. For example, I once completed an assessment with a middle class African-Caribbean woman who originally came to therapy for help managing anger. Upon further assessment, she shared that her anger developed while she worked in the

corporate field as a manager. She often felt excluded, dismissed, and isolated by her white middle class male colleagues. In this situation, there is the experience of white privilege, which has influenced the client's mental health, but also the power imbalance which exists within the therapeutic relationship. By encouraging this woman to discuss how her anger relates to power imbalances and white privilege, she is able to externalize her feelings of anger, reduce her shame around these feelings, and seek alternative ways to address and identify the impact of racism within her life.

Cultural imperialism refers to the belief and assumption that popular theory and modalities are best for all individuals, families, and couples. Some of these beliefs further oppress and subject the sub-dominant group to unnecessary hardship. For example, a family comes to therapy for support with their eight-year-old child who was recently diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). The family is adamant that they do not wish to medicate the child, and want to use alternate methods of intervention. While medications may be beneficial to support the child's behavior, respecting and supporting the family in their decision is anti-oppressive and strength-based. Strength based practice respects and honors the clients' ability to feel empowered to develop and identify the change they require within their lives. Understanding holistic healing approaches to mental health is an important practice. Encouraging, incorporating and supporting the clients' cultural understanding of mental health, the therapist further empowers and motivates the clients to direct their healing and their impetus for change.

Finally, **self-reflective practice** is a critical AOP practice that therapists are taught within their clinical practice training and graduate teaching. Issues such as transference and countertransference, ethical practice and guidelines are paramount within this practice. By using an anti-oppressive practice to self-reflection, the therapist is encouraged to further analyze and question whether he or she can recognize, identify and discuss race and equity within therapy; question whether interventions and treatment plans are consistent with and responsive to the client's cultural needs; and question whether he or she is replicating or responsible for experiences of oppression within the session. The therapist is further encouraged to reflect upon institutions which are oppressive to families and individuals.

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As an illustration, I often work with families involved with child welfare. On one such case, a family I worked with experienced significant difficulties working with me within the child welfare building. Through discussion with the parents, they shared with me that visiting with their children who lived in foster care was a shameful experience for them because the setting appeared institutional and they felt uncomfortable and anxious within the setting. This made it difficult for them to engage within the sessions because the building reminded them of not being able to care for their children and they felt anxious and scared for further repercussions if they made a mistake within the building. I advocated for the family to change the location of their visits to another building which appeared more home-like and was a private setting for the family. This appeared to work well, and the family felt comfortable to learn and grow with my interventions in this setting. I also had to take a step back to understand the barriers for this family and how I could support their growth, without judgment or assumptions.

As we continue to raise awareness of inequity and race-based violence, we will begin to develop a society focused upon inequity and inclusion, and designed to guide couples and families to achieve better outcomes. It is our ethical duty to ensure that our practice is inclusive and does no harm.

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