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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.
Keywords: Research, Anti-Oppressive Practice, Music Therapy, Feminist, Critical Analysis, Ethical, Social Justice
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, et al, 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 establishment 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 individualised 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, et al., 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 PhD, 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 practices1. Oppression has been described in multiple contexts and in relation to many professions. For example, Deutsch’s (2005) 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 medicalisation 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). Focussing 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 favour conservative and quieter traditions of therapy that

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1 The authors thank Prof. Dr Susanne Metzner for the encouragement to examine the tenets of oppression in order to better understand and explain how anti-oppressive practices might be developed and enacted in research
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 Langenberg (2002), Priestley (1994), De Backer and Van Camp (1999), Pavlicevic (1999), Nygaard Pedersen (1999), Smeijsters and Van Den Berk (1995), and Metzner (1999) 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 individualised medicalised 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 practices 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
with a way of addressing how privilege is shaping, defining, and decreasing the potential positive impact of our work. As music therapists, the authors suggest that the minority status of their profession within healthcare allows them to provide unique reflections to the wider community of more dominant practices that consider power differentials and imbalances. We can only offer this when we are prepared to examine our own practices. Consideration of and critical examination about music therapy practices for potential abuses of power becomes the lens through which all research actions can be processed. Research envisioned in this manner is intended to contribute to and create the ethical robustness required toward attaining a more socially just future for all.


Beyond pedagogy and social work, anti-oppressive practice has been gaining
traction in a number of other human services professions including with medical doctors (Thesen 2005), nurses (Martin & Younger 2000, Flood et al, 2006, Barnes & Brannelly 2008, MacDonald 2008), psychology (Campbell 2011), sociology (Scott 1999), anthropology (Gunaratnam 2008), and in particular, within disability studies (Gilbert et al, 2007).

Developing processes to address ever-present power inequities is the goal of contemporary critical inquiry in this space. As Barton wrote “Research is a social act. As such, it involves interactions and relationships with a range of individuals and groups which entail ethical, procedural and political issues” (Barton 2005, p. 317). In their research, Boog et al, (2003) recommended “Scientific social research which is participatory and practice-oriented, which aims to find solutions to social problems and to emancipate individuals and group confronted with such problems,” (p. 419). In agreement, community-based participatory action researchers, Schmittdiel, et al, (2010) explained that without such measures, research often leads to “interventions that are not sustainable in real-world environments,” (p. 256). In their research, Potts and Brown (2005) concluded that

Various emancipatory and critical social science research methodologies … are potential allies in doing anti-oppressive research … we must learn to discern when principles of participation and social action are being misused, and to careful about how we use these methods in our work (p. 281).

Potts and Brown (2005) examined feminist research, Freirian emancipatory or
participatory research, indigenous paradigms, narrative methods, ethnographic methods, heuristic methods, grounded theory methods, phenomenological methods, discourse analysis, critical ethnography, life histories, narratives, and autobiography models for congruencies and cautioned that anti-oppressive researchers need to consistently engage in critical reflection to reconceptualize research practices. They argued that

Anto-oppressive research is not methodologically distinctive, but epistemologically distinctive … to transform research into an anti-oppressive practice, then it is the epistemological underpinnings (e.g., relationships of the knower, the know, and those who want to know) that are key … these principles (e.g., social justice, shifting power to insiders, community building, working for change) that we need to look for in our critical reading of research (p. 283).

Disabilities Studies is a post-modern approach to research that developed out of activism in the 1990’s by those labeled disabled. Disabilities Studies have taken on the historical activist phrase, *Nothing about us without us* (Charlton 1998). A review of the development of Disabilities Studies will provide a representational example of how the researchers’ perspectives can change when challenged to address privilege.

Danieli and Woodhams (2005) reported that in the past, the common view of disability was that

Disability was caused by impairments located in the body, i.e. a medical model of disability, rather than adopting an ontology, which sees disability as resulting from
collective social and environmental factors located outside the body, i.e. a social model (p. 283).

They explained that historically, non-disabled people with no first-hand knowledge of disability conducted disability research. Such research privileged a positivistic approach perpetuating an individualistic medical model while claiming to be objective and value neutral and the research produced ran the risk of bearing little resemblance to the true needs and values of the participants.

…[t]he social model [of disability research] views disability as socially constructed and thus it is societal and cultural norms that transform the person with impairment into a ‘disabled’ person, (Mercieca & Mercieca 2010, p. 80).

They continued “Disability is currently measured in terms of how far it is from ability and how severe. Disability is also measured in relation to social structures, in terms of power and oppression” (p. 88). This privileged lens of perception of disability assumed by many researchers affected all subsequent understanding. For example, Bigby and Frawley (2010) reported on the rare inclusion of service user voices stating,

Seldom … does research that claims to be inclusive give detailed descriptions of the involvement of people with an intellectual disability, their roles, contribution, the challenges encountered, or the support provided (p. 54).
Danieli and Woodham’s research (2005) proposed that the solution to emancipatory research methodological dilemmas was “for disability writers to continue to take lessons from the feminist methodological debates, namely, to adopt more eclectic critical methodologies,” (p. 293). Feminist Participatory Action Research (FPAR) integrated feminist theories and participatory action research methods with a focus on specifically addressing power inequities, particularly gender bias, through the process of creative research partnerships, (Ponic et al, 2010). Ponic et al (2010) elaborated the process of creating *power-with* relationships rather than more typical *power-over* standards stating,

> Power-over approaches to academic-community partnerships will not bring us any closer to dismantling patriarchal and other oppressive traditions to more adequately address [] health issues. Rather, cultivating *power-with* relationships, in all their messiness and complexity, has provided us with an important starting point, (p. 333).

Feminist philosophy, theory, and research practices have been represented in music therapy publications for over three decades. The following review will elaborate the links between music therapy and feminism. In 2006, Wheeler (2006) reviewed music therapy publications using feminist models of research and feminist principles revealing a wide range of studies that can be described as feminist music therapy research including Heineman (1982), Curtis (1990), Rolvsjord (2004a, 2004b), Rolvsjord et al (2005), York (2006), and York and Hearns (2005). Next, Wheeler (2006) reported on music therapy research that incorporated feminist principles: Cassity and Theobold (1990), and Whipple

Within the timeframe of Wheeler’s review, there were two other publications investigating music therapy and feminism. Curtis (1996) completed her doctoral dissertation, which explored women’s voices in feminist music therapy and Hadley and Edwards (2004) explored the relationship of feminist theory to the discourse(s) within music therapy.

Subsequent to Wheeler’s (2006) review further research in feminist music therapy has been published. In 2006, Rolvsjord (2006) incorporated feminist psychology in her therapeutic empowerment model, Resource-Oriented Music Therapy, in 2007, Edwards and Hadley (2007) summarized the contributions of the Feminist Perspectives in Music Therapy into a journal publication, and in 2011, Hahna (2011) described feminist music therapy pedagogy, broadening this lens to include creative arts therapies in 2013 (Hahna 2013). In 2012, Curtis published two articles researching feminist music therapy, one addressing the topic of music therapy and social justice through a description of her own personal journey (2012a) and the second (2012b) extending the feminist dialogues in music therapy of Hadley (2006) and Edwards and Hadley (2007). Although feminist theory remains a foundational force within anti-oppressive practices because of “the ongoing misunderstanding and misapproporitig of the term feminism and … increasing curiosity about such paradigms as anti-imperialism, anti-racism, critical post-modernism,
post-structuralism, post-colonialism, disability studies, and other partners in social justice” (Baines, S. 2013, p. 1), a term that was both more semantically specific and socially understandable and acceptable was sought.

The result of that search for communicative clarity was found in *Anti-Oppressive Practice*. Anti-oppressive practice recognizes the value of multiple theoretical positions which are unified by the concerns of power relations, the role of research within a social frame, and the ways in which dynamic criticality can shape and support research challenging orthodoxies within dominant discourses. Anti-oppressive practice seeks to respectfully combine these theoretical positions for deeper social justice. The first piece of writing specifically referring to anti-oppressive practice in music therapy was by Baines, S. (2013). However, within the field of music therapy, there are a number of post-modern approaches that resonate with the principles of anti-oppressive practice. Some of these approaches are discussed below.

context of world peace” (p. 3). Boxill petitioned music therapists in addition to providing ethical music therapy practice to commit to work in the community for lasting peace. In subsequent publications, Kenny (2005), Vinander (2008), Vaillancourt (2009, 2011, 2012), and Baines, S. (2013) have furthered the work of Boxill researching the links between music therapy, peace work and work for social justice. Following this research, several other post-modern theoretical positions that utilized a politicized client-centered approach involving a social justice critique to address power-inequities developed concurrently in music therapy. These included Resource-Oriented Music Therapy (Rolvsjord 2004b, 2006, 2010), Music-Centered Music Therapy (Aigen 2005, Brandalise 2009), Culture-Centered Music Therapy (Stige 2002a), and Community Music Therapy (Bunt 1994, Ruud 1998; Baines, S. 2000/03, Baines & Danko 2010, Kenny & Stige 2002, Ansdell 2002, Pavlicevic & Ansdell 2004, Stige 2002b, Stige and Aaro 2012). Each of these approaches has value and merit and all have moved the field of music therapy forward politically but each engenders concern about semantic vagueness in the nomenclature of the approach. Regrettably, the terms used to name these practices do not readily describe the practice, potentially leading to confusion on the part of service users, which decreases the political potential of the work.

Other researchers in music therapy have been exploring theories that address specific functions of privilege. Post-colonialism is an example of this work. Although some argue that post-colonialism does not exist and that a preferred term would be anti-colonialism, according to Stige (2004), Kigunda (2003) initiated the post-colonial dialogue in music therapy with his work on culturally grounded music therapy practices in Kenya. Subsequently, Pavlicevic (2004), Nzewi (2002, 2006), and Akumbo (2009),
examined African traditions in relationship to music therapy, referencing a post-colonial framework. Elwafi (2008) described the integrative role of arts and culture in traditional Maori ways of healing and Miyake’s (2008) research indicated that music therapists need to give increased consideration to socio-cultural perspectives.

Critical Race Theory is another field being researched in music therapy to address the on-going adverse effects of white male privilege. Hadley (2012) explored the links between music therapy and race using an indepth interview process and compiled a compelling book of personal narratives of race in music therapy practice. Her authors shared accounts about their experiences of race in their music therapy training, as practitioners and as trainers illuminating aspects of how racial bias can interfere with ethical music therapy practice. Concurrently, Veltre and Hadley (2012) researched how feminist and anti-racist analysis intersect with music therapy practices.

Privilege is also at work in the area of gender and sexuality, which without a strong political analysis can likewise adversely affect ethical practice. Hadley’s (2013) research determined that “queer theory is a field of critical theory that challenges essentialist notions of sexuality” (p. 6). She contended that sexual identities are complex, fluid, and socially constructed. In order to increase their criticality and awareness music therapists benefit from reflection on their personal experiences of sexual identity within a political context. Subsequently, Hadley differentiated queer theory from sexuality studies. She distinguished that “Sexuality studies theorists explore the concept of sexuality” (Hadley 2013, p. 6) and how it relates to social justice. The respectful recognition of these theories provides another basis for anti-oppressive practice.

In his review of methodological approaches, Davis provided a valuable point of
reference remarking that exploring methodological pluralism is not a new idea (Davis 2009). Toward that contextualization, Nicholls (2009) wrote that

Researchers need to engage with reflexive evaluation of collective and negotiated design, data collection and data analysis to consider the interpersonal and collective dynamics during the research process, and any effects that the research may potentially have into the future. Additional political and relational layers of reflexivity are essential for a researcher to critically evaluate empowerment and participation in a counter-colonial context (p. 119).

Critical reflection is not just about reframing situations and stories, but challenging and changing dominant power relations and structures, and operationalizing progressive social change strategies at the interpersonal level (Morley 2008).

From their research, Potts and Brown (2005) proposed that anti-oppressive research is social justice and resistance in process and outcome, anti-oppressive research recognizes that all knowledge is socially constructed and political, and the anti-oppressive research process is all about power and relationships. Becoming anti-oppressive can be uncomfortable and means constantly reflecting on how one is being constructed and how one is constructing one’s world.

In reviewing music therapy research, Edler et al, (2012) reported that a focus on theory appeared to be timely, given the burgeoning of research in the field. However, this emphasis on theory needs to be tempered with political awareness unlike in a text on ethical research in music therapy (Farrent et al, 2011), which made no mention of
preferred theoretical models. Rather, the publication concentrated on ethical research development practices to create ethical research. There is no question this focus is essential but without a political analysis, true ethicality is questionable. In 1988, D. Baines stated the importance of analyzing for oppression, arguing that without engaging in this manner, elements of the dominant ideology undoubtedly become incorporated in undesired and unrecognized ways, (Baines, D. 1988, p.1). Twenty-five years later, in 2013, Hadley repeated this caution; “dominant narratives have a way of rebuilding themselves constantly even when being dismantled” (Hadley 2013, p. 8). Hadley (2013, p. 7) encouraged us to examine how our approaches to research reinforce dominant paradigms rather than unintentionally, corrupting research with oppressive elements.

The quest to liberate … research from oppression is based on the assumption that any intervention or research project, regardless of the benevolent and progressive nature of its goals and intentions may replicate the structural conditions that generate oppression (Strier 2007, p. 859).

Integrating of anti-oppressive practices within research processes can work to address oppression embedded within questions of participation, developing the research question, recruitment, consent, and further steps of the research process. Traditional, objective research techniques will not work to excavate the working of a phenomenon the privileged were carefully taught not to recognize within themselves and cultural systems (McIntosh 2012). Critical theories seek to expose and therefore create an impetus for action against subjugation (Hadley 2013). Employing an anti-oppressive practice
approach to research and practice ensures the highest ethical standard can be the measure of future results. The ultimate aim of research therefore is to expose and dismantle oppression and increase the relevance and practice of social justice within all systems in healthcare.

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