

More than being against it: Anti-racism and anti-oppression in mental health services

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Abstract

Anti-racism and anti-oppression frameworks of practice are being increasingly advocated for in efforts to address racism and oppression embedded in mental health and social services, and to help reduce their impact on mental health and clinical outcomes. This literature review summarizes how these two philosophies of practice are conceptualized and the strategies used within these frameworks as they are applied to service provision toward racialized groups. The strategies identified can be grouped in seven main categories: empowerment, education, alliance building, language, alternative healing strategies, advocacy, social justice/activism, and fostering reflexivity. Although anti-racism and anti-oppression frameworks have limitations, they may offer useful approaches to service delivery and would benefit from further study.

Keywords

anti-racism, anti-oppression, ethno-racial groups, racism, mental health, service provision

Introduction

Many organizations providing mental health services to racialized communities claim to use “anti-oppression” or “anti-racism” frameworks of practice or philosophy and many research papers on mental health and racism call for anti-racist actions and anti-racist mental health services. Accordingly, it is important to

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understand the meanings of anti-racist and anti-oppressive claims and their implications for service provision (Across Boundaries, 2007, 2009; Derman-Sparks & Phillips, 1997; Fernando, 2003, 2005; King, 2000; Peacock & Daniels, 2006). This article presents a comprehensive literature review on anti-racism and anti-oppression philosophies of practice in mental health. We focus on what it means to “be” anti-racist, to “do” anti-racism or anti-oppression, how to work within such frameworks and how they translate into mental health and social services delivery. The review is relevant for service providers working with racialized groups or collaborating with agencies using anti-racism or anti-oppression as their main philosophies of practice since it highlights the issues of power imbalance often inherent to service provision and emphasizes the importance of self-reflexivity and awareness for mental health professionals who work with racialized groups. In a Canadian context of increasing immigration and fast-changing demographics, this literature can inform efforts to be more responsive to people from racialized groups who experience mental illness. Those individuals have to navigate a service system that works from a dominant discourse, leaving very little space for alternative frameworks that challenge racism and oppression embedded in the system. This dominant discourse, better described as the “medical model,” tends to individualize causes of illness and uses biomedical approaches to treatment, thus overlooking structural, social, and cultural factors which influence mental health (Tew, 2002).

In order to frame our review within the mental health field, we will provide a brief overview of how racism is defined, some facts and figures on mental health and visible minorities in Canada, and briefly describe the impact of racism on mental health and how racism is embedded in mental health and social services. We then present how anti-racism and anti-oppression are conceptualized and the strategies used within these frameworks as they are applied to service provision. We conclude by presenting the main critiques and limitations of the two philosophies.

To identify relevant and comprehensive articles, we conducted a search in the main databases in social sciences, humanities, and medical sciences using “anti-racist,” “antiracism,” “anti-oppression,” and “philosophy,” “framework,” “practice” or “theory.” Searching for these concepts as keywords within article abstracts produced a large number of documents. We have selected for this review only those articles that give a broad understanding of these concepts and provide a conceptual and theoretical foundation that allows us to capture how they are defined in intellectual discourse. We searched for articles published after 1990, but added key articles and critical documents written before that date identified from the articles’ bibliographies.

What is racism?

Racism is a multifaceted and multidimensional form of oppression (Delgado & Stefancic, 2001; Saloojee, 2003) that is widely prevalent and embedded in many

spheres and institutions of social life (King, 2000). As Derman-Sparks and Phillips (1997) put it, racism

encompasses a web of economic, political, social, and cultural structures, actions, and beliefs that systemize and ensure an unequal distribution of privilege, resources, and power in favor of the dominant racial group and at the expense of all other racial groups. (1997, p. 9)

According to Saloojee (2003), “racism is both an ideology and a set of practices. As an ideology racism seeks to both legitimate the inequality faced by racialized groups and proclaim the superiority of the racial group that constitutes the status quo” (2003, p. 3). Racism as a specific form of oppression creates binary thinking, or a dichotomy, that places White people in a privileged position and people of color in an oppressed position based on their race (Dominelli, 2008). Racism as the result of power imbalances can diminish social inclusion since it leads to “incomplete citizenship, undervalued rights, undervalued recognition and undervalued participation” (Saloojee, 2003, p. 4).

Racism can be seen on a continuum, going from subtle forms of discrimination to explicit oppression (Richmond, 2001). Some authors argue that racism tends to be more and more subtle, disguised, and covert than its blatant form, making it hard for victims of racism to clearly recognize its manifestations (Bell, 1996; Noh, Kaspar, & Wickrama, 2007). Covert forms of racism include what has been called “microaggressions” (Constantine, 2007; Masko, 2005; Sue et al., 2007). Sue et al. (2007) define microaggressions as “brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group” (2007, p. 273). Because of their more subtle and ambiguous nature, microaggressions are harder to identify and act upon and can engender confusion in their victims (Bell, 1996). Racism can also encompass other forms of oppression that go beyond the notion of race to include culture, language, religion, and the different ways that people live and dress (Dominelli, 2008; Fernando, 2003, 2010). Fernando (2010) points out that “race is perceived as physical, culture as sociological and ethnicity as psychosocial” (2010, p. 7). Race is related to physical appearance, culture is about social behavior, ways of being, attitudes and how people live, and ethnicity refers to a mix of race and culture in terms of background, heritage, and sense of belonging (Fernando, 2010). Ethnicity includes a subjective feeling of belonging where culture and/or race play a part in the various ways individuals define themselves. Racism in anti-racism and anti-oppression literature thus goes beyond the sole notion of race to encompass oppression towards cultural and ethnic groups, even though anti-racism as a social movement was more concerned with issues of Black people in its early stage.

Racism then takes differences in physical attributes to determine differences in behavioral, intellectual, or any other spheres of human life (Dei, 1996; Dei & Asgharzadeh, 2001; O’Neil, 2009; D. R. Williams & Harris-Reid, 1999).

Pinderhughes (1979) notes in his seminal article on stereotyping that: "Once falsely positive or falsely negative attitudes and beliefs about people develop, relationships, social structures, and the environment are modified wherever possible into a contrived reality that expresses, perpetuates, and seems to validate the false beliefs" (1979, p. 36).

Dominelli (1992, 1997, 2008) described three main forms of racism that interact with each other: individual, institutional, and cultural racism. *Individual racism* refers to prejudicial behavior toward racial groups. *Institutional racism* is defined as the public legitimation of racial exclusion within social institutions and/or legislation. *Cultural racism* is defined by Dominelli (1992) as "the values, beliefs and ideas usually embedded in our 'common sense,' which endorse the superiority of white culture over others" (1992, p. 165). Authors talk about institutional racism when racial oppression is embedded in social institutions and policies that engender different opportunities for some racial or ethnic groups (Quinones Rosado & Barreto, 2002; Richmond, 2001). As Dalal (2008) mentions, despite the fact that liberal democracies are based on social justice and equality, some groups are far worse off than others in many spheres. Racism thus provides the context for social exclusion and domination (Dominelli, 1997; Pierce, 1995).

Ethno-racial groups and mental health in Canada

In Canada, 18% of the population was born outside the country (Beiser, 2005) and 16.2% belongs to a visible minority group (Arundel & Associates, 2009). Around 96% of people from visible minorities live in large urban areas where many face social exclusion and a high incidence of poverty (Across Boundaries, 2009; Arundel, 2009). It is estimated that 81% of people from visible minorities in Canada perceive that they have experienced discrimination because of their race or ethnicity (Arundel, 2009). Racism's impact on labor participation and equity is illustrated by the fact that racialized groups in Canada earn less, have little job security, a higher rate of unemployment, are overrepresented in low-paid jobs and have a higher poverty rate (Arundel, 2009; Richmond, 2001; Saloojee, 2003). For example, as Beiser (2005) mentions, in Canada, "more than 30% of immigrant families live below the officially defined poverty line during their first 10 years in Canada" (2005, p. S38). Ill mental health among minorities in Canada is closely associated with poverty and low education and the deterioration of health status for immigrants is mostly observed after their arrival in Canada (Beiser, 2005; De Maio & Kemp, 2010). Immigrants in Canada, particularly those from non-European countries, also tend to underutilize mental health services (Whitley, Kirmayer, & Groleau, 2006).

The impact of racism on health and health service use

Canadian data on the impact of racism on mental health and health equity are consistent with the international literature (Fernando, 1988; Gary, 2005;

Hopton, 1997; King, 2000; Krieger, 2003; Nazroo, 2003; Noh, Beiser, Kaspar, Hou, & Rummens, 1999; Pierce, 1995; Primm et al., 2010; Turner & Kramer, 1995; D. R. Williams & Harris-Reid, 1999). As Turner and Kramer (1995) explain:

ethnic minorities are subjected to stressors directly related to minority status: discrimination in education and occupation; assaults upon self-esteem that arise out of low status within society; relative lack of access to health care; segregation in isolated communities that are prone to social disorganization. (1995, p. 8)

Racism therefore has multiple and pervasive impacts on well-being, self-esteem, and self-confidence (Edwards, 2006; Naidoo, 1992; Saloojee, 2003). As Brown (2003) mentions, "Racial stratification produces mental health problems to the extent it generates stressful circumstances and cognitive states conducive to emotional distress" (2003, p. 295). Pierce (1995) compares the impacts of racism to stress generated by terrorism and torture, where victims constantly have to deploy defensive and adaptive strategies to face oppression, domination, and victimization that could lead to psychological exhaustion. Similarly, according to Comas-Diaz (2007), "constant exposure to racism increases behavioral exhaustion, psychological affliction, and physiological distress" (2007, p. 96). Finally, racism as a form of oppression can be internalized with negative outcomes for people who suffer from it (Krieger, 2003). As Quinones Rosado and Barreto (2002) put it, "internalized oppression can lead oppressed people to doubt their very selves, their inherent worth as human beings" (2002, p. 67). Other literature supports a strong association between the experience of discrimination and adverse health outcomes (Bahm & Forchuk, 2008; Brown, 2008; De Maio & Kemp, 2010; Franklin, Boyd-Franklin, & Kelly, 2006; McKenzie, 2003; D. R. Williams, 2003; D. R. Williams & Williams-Morris, 2000). Despite these findings, there is a paucity of research and theoretical analyses on the role of race and racism on adverse mental health outcomes, especially in relation to their mechanisms and pathways to mental ill health (D. R. Williams, 2003).

Regarding service use, racism can create barriers to accessing mental health services among racialized groups, including lack of information about these services, economic constraints, cultural mistrust, and communication problems (Beiser, 2005; Constantine, 2007; Fernando, 1988; Laroche, 2000). Takeuchi, Uehara, and Maramba (1999) mention that ethnic minority groups' access to mental health services is limited and that they "are less likely to use mental health services than whites" (1999, p. 552). Whitley et al. (2006), in their study using qualitative interviews with Afro Caribbean immigrants in Montréal, reported a reluctance to use mental health services based on three main themes: a perceived overwillingness of doctors to rely on medications; a lack of time or dismissive attitude from physicians; and a belief in the value of nonmedical interventions, both spiritual or religious and traditional folk medicine. Stigma within racialized communities towards individuals suffering from mental ill health may be another reason for their reluctance to use mental health services, a phenomenon that Gary (2005) refers to as "double stigma."

Racism in mental health and social services

Ethnicity, race, and culture are important considerations for mental health services, as inattention to their role in shaping manifestation of mental health problems, the meaning ascribed to symptoms, approaches to healing, and available support networks may contribute to systematic patterns of misdiagnosis and inappropriate treatment (D. R. Williams & Harris-Reid, 1999). The American Psychiatric Association (2010) has elaborated a position statement that clearly recognizes the detrimental impacts of racism on mental health and the impacts of racially biased attitudes on service provision and treatment. Yet racism remains prevalent and embedded in both social services and health services (Dominelli, 1997; Fernando, 1988, 2003; Fleming & Wattlely, 1998; Sue et al., 2007). Some authors report that Black people are more often given a diagnosis of schizophrenia compared to their White counterparts (Fernando, 1988, 2003, 2010; Wheeler, 1994). This may result, in part, from a dominant biomedical approach which tends to put the emphasis on biological causes of illness, giving less importance to social and contextual issues (Arredondo & Rosen, 2007; Fernando, 2010; Larson, 2008; Strawbridge, 1994; Takeuchi et al., 1999; Tew, 2002). In terms of treatment, Turner and Kramer (1995) suggest that ethnic minority clients are more likely to be hospitalized and treated with pharmacotherapy than to receive psychotherapy.

Fernando (1988), Knowles (1996) and Turner and Kramer (1995) argue that as a social institution and as a set of practices, psychiatry perpetuates racist assumptions in its methods of evaluation, observation, research, and treatment. Since psychiatry starts from a White point of view on normality and what deviates from it (diseases), Fernando (1988) maintains that

the lack of precision and objectivity in designating psychiatric categories results in slippage of meaning whereby categories become stereotypes. Thus, psychiatry is comfortable in dealing with, and in, stereotypes; the result is that stereotypes present in society – such as racial stereotypes of black people – are incorporated into its “machine” with no difficulty. (1988, p. 46)

Hence, generalizations become problematic because research based on racial groups “is perceived as being applicable to those groups alone, while research based on white people is incorporated into mainstream psychiatry as being applicable to everyone” (Fernando, 1988, p. 54).

Clearly racism as an explicitly recognized factor affecting health and well-being has to be addressed by health and social services because ignoring it may have detrimental effects on individuals and communities (Krieger, 2003). Despite the important impact of racism on mental health and health equity, however, most mental health professionals have little knowledge and guidelines on how to explore the consequences of racism in clients' lives (Masko, 2005).

Some community-based mental health or social service agencies have built programs and services that address issues of oppression and racism, using

anti-oppression and anti-racism as philosophies of practice (Across Boundaries, 2007, 2009; Ali, 1996; Fernando, 2005; Peacock & Daniels, 2006). As more agencies adopt elements of this approach, knowledge of anti-racism and anti-oppression strategies can be useful in fostering development of appropriate services and supports for racialized groups.

What is anti-oppression?

Oppression can be defined as “a system of domination that denies individuals dignity, human rights, social resources and power” (Dominelli, 2008, p. 10). Anti-oppression is therefore a theory that guides practitioners’ actions in the social service and the health field that specifically tackle problems of power and access to resources (Harlow & Hearn, 1996). As Dalrymple and Burke (1995) put it, “anti-oppressive practice, then, means recognizing power imbalances and working towards the promotion of change to redress the balance of power” (1995, p. 15). Mallinson (1995), on the other hand, defines anti-oppressive practice as “a set of ideas that taken together have the purpose of conveying and promoting sound practice that concerns the promotion and maintenance of equality, rights, equity, wellbeing, and independence through positive structural and personal initiatives” (1995, p. 67).

An anti-oppression framework then is a counter-discourse to the medical or bio-psycho-social model (Larson, 2008) and stipulates the importance of connecting all forms of oppression as a struggle strategy for equality within social structures and institutions (C. Williams, 1999). As Larson (2008) states, anti-oppressive practices are based on the following premises:

a clear theoretical and value base that promotes egalitarianism and power sharing; an understanding of one’s social location and how it informs relationships and practice behaviors; a challenge to existing social relationships in which powerful groups maintain power and influence over less powerful groups; and specific practice behaviors and relationships that minimize power imbalances and promote equity and empowerment for users of service. (2008, p. 42)

As Tew (2002) explains, anti-oppressive practices put the consumer’s perspective at the forefront:

anti-oppressive practice starts with the experience of service users, and maintains a concern with those factors which may be diminishing people’s sense of esteem or value, or constraining their personal, social, economic opportunities. It places questions of stigma, power, inequality and internalized oppression firmly on the working agenda – not as issues and definitions to be imposed on people, but as areas to be drawn out through processes of joint exploration. (2002, p. 146)

An anti-oppression framework is then by definition a very wide and ambitious project driven by social justice, hence it is difficult to conceptualize precisely

(Wilson & Beresford, 2000). When defining anti-oppressive practices, Dalrymple and Burke (1995) make explicit the importance of including, engaging, and supporting consumers in every phase of service delivery (from assessment to final evaluation) in order to respond adequately to the needs they identify for themselves. This principle of “minimal intervention” (Dalrymple & Burke, 1995) aims to ensure that professionals do not decide on what specific groups might need in order to promote choice and empowerment.

What is anti-racism?

Anti-racism can represent a social movement as well as a set of practices and discourses aimed at tackling the whole spectrum of ways and sites where racism is embodied (Hamaz, 2008). Bonnett (2000) provides a comprehensive definition of anti-racism as “forms of thought and/or practice that seek to confront, eradicate, and/or ameliorate racism” (2000, p. 4). An anti-racism framework then is a specific strategy within the wider spectrum of anti-oppression practices (Butler, Elliot, & Stopard, 2003; Dei, 2005) that explicitly focuses on privilege and power relations embedded in social institutions in relation to the social construction of racial categories (Bonnett, 1993; Dalal, 2008; Dei, 1996, 2000; Gould, 1994; Strawbridge, 1994), what Bonnett (1993) refers to the “process of racialization.” Dominelli (2008) defines anti-racism as “a state of mind, feeling, political commitment and action to eradicate racial oppression and transform unequal social relations between black and white people to egalitarian ones” (2008, p. 28).

Many authors agree that anti-racism has to confront the core aspects of racism: its institutional, individual, and cultural dimensions (Derman-Sparks & Phillips, 1997; Dominelli, 1992; Kailin, 1994; Keating, 2000). When applied within the health and mental health fields, an anti-racist framework looks at the impact of racism on health and mental health and also makes explicit the notion of “internalized racism” and its possible impact (Keating, 2000) including the tendency to reject one’s culture and one’s self (Derman-Sparks & Phillips, 1997). Furthermore, as Thompson (2008) puts it, “where people begin from a position of inequality, a uniform approach will serve only to reinforce such inequalities. . . . So we need to ensure that the focus is on equal outcomes, rather than uniformity of treatment” (2008, p. 104).

Anti-oppression and anti-racism frameworks then share many theoretical features. The difference between these frameworks lies in the fact that the former does not predefine oppression from a specific category or mechanism, whereas the later takes race/racism as the point of entry in its analysis of oppression, power, and privilege (Dei, 2000, 2005; Dei & Asgharzadeh, 2001; Larson, 2008). Since anti-racism, like anti-oppression, is a broad project geared towards social change at different levels, its specific strategies or critical ingredients are hard to capture (Gillborn, 2006; Rebollo-Gil & Moras, 2006). As a result, despite their potential usefulness in informing a more responsive service delivery system, the literature on how anti-oppression and anti-racism frameworks can be implemented in practice is very sparse (Larson, 2008).

The following section aims to provide some insight on how anti-racism and anti-oppression frameworks are applied. These perspectives are not mutually exclusive. The approaches stem from a variety of disciplines (education, social work, psychology, critical theory, etc.), and the discussion is organized by dominant themes.

How do anti-racism and anti-oppression translate into programs and practices?

Empowerment

One main component of anti-racism and anti-oppression in practice is empowerment of service users. This is accomplished by involving service users in decisions that concern them within all the components of care (e.g., programs, policies, and agenda setting) (Arredondo & Rosen, 2007; Gould, 1994; Hopton, 1997; Larson, 2008; Peacock & Daniels, 2006; Tew, 2002; Wheeler, 1994) and by validating their life experience, pride, belief systems, and strengths (Dominelli, 2008; Edwards, 2006; Fleming & Wattley, 1998; D. R. Williams & Williams-Morris, 2000). Racialized communities have many strengths manifested in supportive families, strong spiritual practices and beliefs. They have developed coping strategies and resources to cope with individual racism (Brondolo, van Halen, Pencille, Beatty, & Contrada, 2009). Mobilizing clients' strengths and resources are key components of empowerment. Empowerment specifically aims at assisting service users in gaining more control over their lives, in meeting their needs, having their voices heard, and helping them gain the tools to challenge power and develop a strong positive identity (Dalrymple & Burke, 1995; Peacock & Daniels, 2006). A good anti-racist and anti-oppression strategy, therefore, builds equal relationships with service recipients by minimizing the power imbalance between providers and clients, and by developing an "expertise geared towards servicing individuals and groups who define for themselves the provisions they need" (Dominelli, 1997, p. 159). Wheeler (1994) mentions that from a mental health research perspective, doing research with and about Black people can also be a way to empower them, and it can indeed contribute to much needed change, provided these professionals feel safe and secure in the workplace

one of the greatest benefits which could come out of doing black research is the provision of data which can be used by black pressure groups, in conjunction with black health and social service professionals, to lobby for changes and to help set the agenda for services which they see as important. (1994, p. 57)

Education

Dei (1996) defines anti-racist education as

an action-oriented strategy for institutional, systemic change to address racism and the interlocking systems of social oppression... Anti-racism education explicitly names the issues of race and social difference as issues of power and equity rather than as matters of cultural and ethnic variety. (1996, p. 25)

Anti-racism is committed to educating people about the notions of race, racism, and the position of privilege held by White people (Across Boundaries, 2009; Ali, 1996; Franklin et al., 2006; van Leeuwen, 2007). Anti-racism education also encompasses the examination of individual and institutional racism by learning the historical roots of racism, its definitions, its manifestations within institutions, its impacts on poverty, the job market and on the treatment of visible minorities in the media (Kailin, 1994). As Dei (1996) points out, anti-racist education has to integrate the perspectives of people from many sites of oppression in order to achieve social change:

All progressive forces need to be included in the production, validation and dissemination of a critical anti-racism knowledge of social change. The inclusion of multiple voices from multiple social locations is one powerful way to rupture the institutional structures of society and to address questions of social credibility, fairness, justice and equity. (1996, p. 18)

Describing specific activities led by an organization in the United States working within an anti-racism philosophy of practice, Santas (2000) reported that the organization's framework had four main components: defining and undoing racism; teaching the history of racism; developing leadership to overcome domination and gain independence; and multidirectional accountability. As Dominelli (1997) mentions, "besides making connections between the different forms of racism and their interaction with each other, anti-racism awareness training helps individuals to acquire confidence in 'owing' or becoming accountable for their own actions" (1997, p. 74).

Finally, anti-racism values and promotes alternative ways of knowing and producing knowledge by giving voice to lived experiences and resistance (Dei, 1996). But teaching and promoting anti-racist strategies is in itself not enough without embarking on a journey to change social structures, policies, and attitudes (Across Boundaries, 2009; Dominelli, 1997). That is, knowledge and awareness without action cannot in themselves be considered anti-racist.

Building alliances

Establishing and developing community alliances, collaborations, linkages, coalitions, and partnerships with other oppressed groups is an important component of an anti-racist and anti-oppression strategy (Across Boundaries, 2009; Arredondo & Rosen, 2007; Dei, 2005; Dominelli, 1997; Franklin et al., 2006; Lloyd, 2002; O'Brien, 2009). Building networks of people and groups working for oppressed

people can provide support and political visibility to efforts to challenge power (Dalrymple & Burke, 1995). Building alliances then can be a powerful tool in changing perceptions, racist discourses, and practices at multiple levels. As Dominelli (2008) explains; “Resistance involves links with others through networks, campaigns and other forms of direct action to create circles of resistance at the personal, institutional and cultural levels” (2008, p. 205).

In the mental health field, alliances may facilitate the development of services specifically geared towards racialized minorities. As Fernando (2003) suggests,

there are two strands in the struggle for change in the mental health field. First, there is the direct approach in highlighting injustices and deficiencies in the services, and second, the development of projects by and for black and minority ethnic communities. (2003, p. 54)

Strengthening Black communities and promoting ethno-specific projects and services that are managed by people from the community is an anti-racist way to respect people’s culture and value their ways of dealing with mental health issues.

Language

Working within an anti-racism framework involves the use of language that does not stigmatize or reproduce oppressive forms of power (Hopton, 1997; Larson, 2008). Anti-racism and anti-oppression avoid the use of titles, ranks, or positions that can put a distance between clients and service providers, hence producing a more egalitarian relationship (Larson, 2008). Avoidance of titles and ranks needs to be negotiated, however, to help support the development of trust and a strong working alliance. Practices that are language sensitive (Arredondo & Rosen, 2007), which avoid the use of labels and judgments and that focus on people’s strength instead of on pathology, are also crucial for anti-racist and anti-oppression advocates (Larson, 2008). In the mental health field, Fernando (1988) suggests that diagnosis should be used carefully and the emphasis should be on exploring the client’s viewpoint and culture; “a psychiatric diagnosis should be seen as a part of a statement about a patient in a social context rather than a designation for an attribute or peculiarity within the patient” (1988, p. 183). Institutional, as well as individual languages have to be explored in order to determine if they reinforce or resist racism embedded in language usage (Boushel, 2000). Fernando (2003) further suggests that an anti-racist psychiatry should use a language that users can understand and that makes sense of their specific ways of experiencing distress.

Also related to language, other anti-racist and anti-oppression strategies in service delivery are the use of interpreters (Dominelli, 1997; Fernando, 1988), the use of professionals from the same ethno-cultural background who can facilitate mutual understanding (Fernando, 2005; Takeuchi et al., 1999; Turner & Kramer, 1995) and the use of translated documents for people who do not speak or read the primary language of service providers (Dominelli, 1992). The practice of using

interpreters may not appeal to all clients, as some individuals may be reluctant to share their stories with people from their own community, but it should be an available option when appropriate.

Alternative healing strategies

Anti-oppression distances itself from the “medical model,” (which tends to use medication and related treatment modalities) in favor of holistic approaches to service provision (Fernando, 2010; Lefley, 1999). Tew (2002) defines holism as a way “of reclaiming the whole person from the partiality of a purely medical definition” (2002, p. 147). Holism is therefore closer to a “social model” of mental “distress” than the dominant individualistic medical model of mental “illness.” As Tew (2002) argues: “a social model which locates distress in its social context should seek to include all significant others as part of the ‘action system’ working towards recovery” (2002, p. 151). Promoting, developing and proposing a vast array of healing strategies is, according to Larson (2008), a way of injecting alternative discourses into the dominant model of care. Therefore, other holistic approaches to treatment may be included in an anti-racist mental health services system, like Chinese traditional medicine, Indian Ayurveda, African approaches, and yoga, in order to promote philosophies of healing that are responsive to the diversity of human experiences and worldviews (Comas-Diaz, 2007; Fernando, 2003, 2010; Larson, 2008; Quinones Rosado & Barreto, 2002). Psychiatry is based on Western individualistic values which “emphasize the attainment of personal autonomy as desirable while in other cultures and in anti-oppressive services the emphasis may be on harmony and interdependence” (Fernando, 2003, p. 137).

Advocacy, social justice/activism

Advocating for disenfranchised groups or people involves guiding them without interfering with their needs and claims. As Dalrymple and Burke (1995) explain, “Advocacy ensures that people are able to make informed and free choices. Advocacy is about advising, assisting and supporting. It is not about pressurizing or persuading, which would be disempowering” (1995, p. 69). Defending the rights of minorities is a crucial practice component within anti-oppression and anti-racism, “to support, through direct service and advocacy, those in society who have become disenfranchised, marginalized, and oppressed” (Arredondo & Rosen, 2007).

Anti-oppression and anti-racism both share the goal of reaching social change, a change defined by those who suffer from oppression, based on the needs they have identified for themselves (Dalrymple & Burke, 1995). As Arredondo and Rosen (2007) put it, “enacting social justice leadership involves active listening, more truth-telling, having difficult dialogues, risk-taking, and applying collective empowerment strategies to combat systems of oppression” (2007, p. 453). Furthermore, public social action that aims at reaching racial equity is a crucial aspect of anti-racism practices (Rebollo-Gil & Moras, 2006).

Promoting policies that tackle discrimination and resisting explicitly anything that can be perceived as racism are also anti-racist strategies (Ahmed, 2008; van Leeuwen, 2007). Delgado and Stefancic (2001) suggest some strategies that can be included within an anti-racism framework, such as supporting the critical deconstruction of the concept of race, increasing the visibility of minorities in the media, pressuring the criminal justice system to stop racist practices, pushing for more inclusive immigration policies, and continuing the battle for equity and economic democracy. For example, professionals in the field can get actively involved in changing policies at the organizational level in order to implement and promote equal-opportunity policies (Dominelli, 1997; Franklin et al., 2006; Gould, 1994) and by speaking up against everyday racism and its manifestations in forms such as jokes, songs, and conversations, to name a few (Bonnett, 2000).

Finally, some authors note the importance of hiring, training, and recruiting people of color in organizations that serve different racial groups (Dominelli, 1992; Fernando, 1988; O'Brien, 2009; Takeuchi et al., 1999). As Fernando (1988) states, "ethnic minority patients/clients need professional staff at all levels with whom they could identify at a personal level" (1988, p. 116).

Fostering reflexivity

Critical self-knowledge and self-examination are essential in order to understand the dominant system, one's place and role in it, and how it can be challenged (Bonnett, 2000; Dalrymple & Burke, 1995; Dominelli, 2008; O'Brien, 2009). Some authors point out that without any individual changes, institutional and cultural changes are almost impossible, as a level of reflexivity, awareness, and acknowledgment of one's social position is necessary to achieve social justice and inclusion and to combat racism and oppression (Dei, 1996; Dominelli, 1997, 2008). By learning anti-racist and anti-oppression strategies, individuals have to make explicit their social locations (as oppressed or oppressors) (Rebollo-Gil & Moras, 2006) in order to understand their role in the system of oppression/privilege. People engaged in anti-racism also have to acknowledge their values and histories (Razack, 1999), as well as their feelings and inner thoughts in relation to their contacts with people from other cultures (Fernando, 1988; van Leeuwen, 2007). Strawbridge (1994) argues that White people have to engage in the fight against racism; "white people must accept responsibility for racism because racism is fundamentally a problem of white society and as such implicates all white people" (1994, p. 5).

Anti-racism encourages people of color to regain pride in their identity and history by a self-reflexivity of their own racial background (Bonnett, 1993). "Building self-awareness, acknowledging one's own belief system and internalized racism, is an important aspect of the process of developing anti-racist approaches to practice" (Butler et al., 2003, p. 276). On the other hand, exploring one's whiteness, the advantages attached to it, and the constructed superiority of the White dominant group is essential to reach a better understanding of institutional racism

(Butler et al., 2003; Rebollo-Gil & Moras, 2006). Since White people mostly benefit from racism and have access to more resources, they have to question, challenge, and eradicate the racist structures that benefit them at the expense of people of color (Dominelli, 1997). More specifically, it has been suggested that professionals in the mental health field should constantly monitor their possible racist biases as they may interfere with service provision (Turner & Kramer, 1995).

Critiques of anti-oppression and anti-racism frameworks

Some authors suggest that an anti-racist framework is not enough in itself to capture the whole spectrum of experiences related to oppression because it limits the comprehension of oppression to a single component (Butler et al., 2003; Gilroy, 1990; Harlow & Hearn, 1996; Keating, 2000). As Keating (2000) argues, a narrow anti-racist framework “implies that racism is a system that operates independently from other systems of oppression and domination... What is absent from anti-racist theory is how racism intertwines or intersects with sexuality, gender, class and other forms of oppression” (2000, p. 83). Similarly, Delgado and Stefancic (2001) write that “many races are divided along socioeconomic, political, religious, sexual orientation, and national origin lines, each of which generates intersectional individuals” (2001, p. 55). They further argue that anti-racism holds the risk of silencing other marginalized voices that do not fit within the Black/White dichotomy (Delgado & Stefancic, 2001). Furthermore, according to Macey and Moxon (1996), the confusion of anti-racism is due to its “failure to analyze racialized relations within broader sociological theory which takes into account the interplay of political, economic, ideological and historical forces” (1996, p. 301). That is, anti-racism does not encompass the many possible ways racism can be experienced by individuals and all the other factors that influence visible racial minorities negatively, like economy, ideology, liberalism, immigration, scapegoating, reduction of the welfare state, and xenophobia (Macey, 1995).

Anti-racism can thus be seen as a paternalistic approach to protect those who suffer from racism by a kind of internalized superiority (Santas, 2000). Others have argued further that anti-racism is atheoretical and limited because it fails to conceptualize and differentiate race, ethnicity, color, and culture as fluid constructs and reifies the terms in fixed, homogenous categories (Macey, 1995). From that perspective, anti-racism fails at its social change task because it reinforces stereotypes by emphasizing differences between groups (Macey, 1995; Macey & Moxon, 1996). As Jeffery (2005) argues, anti-racism by its theoretical nature is removed from practice, especially in the field of social work where anti-racism is part of the training curriculum but hard to apply in practice within a profession that tends to reproduce whiteness. Using an anti-racist framework in research can be problematic because when research results do not confirm the assumptions of an anti-racist standpoint, the validity of those very outcomes and the methods used for the research may be questioned (Hammersley, 1995). A related critique of anti-racism is that it is not a scientific theory of change, but a social justice

enterprise that aims at changing the structural foundations of society, with a clear political agenda and a predetermined site of entry (race/racism). Because of these theoretical weaknesses, it has been argued that anti-racism may not be the conceptual framework of choice to tackle oppression related to race or ethnicity (Macey & Moxon, 1996). For example, C. Williams (1999) mentions that in the UK, anti-racism as a framework of practice in social work is decreasing in popularity at the expense of a broader anti-oppression framework.

In contrast to anti-racism, which takes racism as the crucial form of oppression and might therefore be too limited, anti-oppression runs the risk of being too general, thus masking important debates about specific forms of oppression and discrimination (C. Williams, 1999). Kailin (1994) mentions that compared to anti-oppression, anti-racism is more precise, targeted, and in tune with concepts such as power and domination because its claims are directly connected to the notions of race and class. Other authors, on the other hand, argue that the broader nature of anti-oppression frameworks can lead to policies and strategies that tackle more than one single aspect of human experience, thereby encompassing many forms of oppression (Macey, 1995; Macey & Moxon, 1996). As Macey and Moxon (1996) mention,

the reasons for moving towards anti-oppressive, rather than simply anti-racist social work, are not only practical, but theoretical and philosophical. Many issues of contemporary concern involve the intersection of such divisions as class, race and gender . . . It moves from a narrow, exclusive focus on racial oppression to a broader, more inclusive understanding of the links between various forms and expressions of oppression. (1996, p. 309)

Other critics suggest that an anti-oppression framework is a form of professional knowledge (derived from people in a dominant position) and professionals, even with the best intentions, may not be the best to judge what counts as oppression (Wilson & Beresford, 2000). Users or consumers (those impacted by oppression) are rarely involved in the development of anti-oppressive practices and proponents of such a framework rarely acknowledge their own roles in possibly contributing in various systems of oppression by their privileged positions (Larson, 2008; Wilson & Beresford, 2000).

Last, but not least, both anti-racism and anti-oppression philosophies run the risk of perpetuating a stereotype that racialized groups are powerless victims on whom action must be taken, rather than promoting a strengths-based approach that places equal emphasis on people's strengths and ways of coping, and on showcasing success stories and role models.

Conclusion

Despite their limitations and critiques, anti-racism and anti-oppression as philosophies of practice have the potential to bring positive changes to mental health

service delivery. Racism is a powerful form of oppression that has real consequences for racialized groups, who face structural barriers and challenges to their health and well-being. Racism and oppression, more than being manifested by a few individuals, are alive and embedded in the mental health and social services systems. Some organizations serving racialized groups frame their actions and practices in anti-racist and anti-oppressive philosophies in order to be more responsive to the populations they serve. These two frameworks are ambitious social projects advocating for racialized groups and addressing the issue of racism and oppression in mental health and social services.

Anti-racism and anti-oppression are distinct from discourses on cultural competence, pluralism, and diversity that celebrate multiculturalism without tackling the power dynamics related to race. As Dei (2005) points out,

the pleasant poetry of ‘diversity’ and ‘multiculturalism’ would suggest that when we learn about each others’ differences, we will learn to appreciate and celebrate what might otherwise be perceived as threatening and unknowable. But these naïve interpretations of difference do not implicate power relations or internalized oppression in the equation. (2005, p. 141)

The celebration of diversity therefore masks the notions of equity, access to resources, barriers, racism, and oppression under the umbrella of freedom and justice that are supposedly inherent to a multicultural society (Dalal, 2008; Saloojee, 2003). The paradigm of multiculturalism does little to promote ethno-specific programs (Lo & Chung, 2005) and to shed light on the structural root causes of racism. Instead of celebrating diversity, anti-racism and anti-oppression seek to “identify, challenge and change the values, structures and behaviours that perpetuate systemic racism and other forms of societal oppressions” (Dei, 2000, p. 41). Anti-racism and anti-oppression both have the advantage of explicitly addressing crucial issues that permeate service provision and society at large.

The literature in support of anti-racism and anti-oppression interventions remains very scant. There is an urgent need for further in-depth description of programs that operate from an anti-racist or anti-oppressive framework. Our review allowed us to highlight and identify the suggested key ingredients at play within these two frameworks, but what is missing are explicit program theories that account for successful interventions that can be replicated in other settings. The main ingredients identified in these frameworks include: empowerment, education, alliance building, language, alternative healing strategies, advocacy for social change, and fostering reflexivity. However, there is still a need to document how these frameworks and approaches interact with one another to bring about individual well-being and the betterment of society. Future research related to these two philosophies can fill that gap in knowledge by providing comprehensive program descriptions, elucidating program theories of change, documenting success stories of people using these services, and by evaluating interventions operating within anti-racism and anti-oppression philosophies. Further attention could also

be paid to the situation and experiences of racialized mental health professionals who must work in environments where racism and discrimination are rampant.

This review was limited to broadly defining anti-racism and anti-oppression and their main components in practice. It did not include description of other paradigms used in developing services for racialized groups. Furthermore, we did not examine resilience factors that may be helpful in understanding how people from minority, minoritized, or racialized groups cope with mental illness. The literature on anti-racism and anti-oppression seems polarized around the domination/oppression axis, leaving very little room to strategies deployed by people of color when facing adversity. Oppression and discrimination can also engender creative opportunities to cope with its consequences (Brondolo, 2009; Noh & Kaspar, 2003; Warner, 2008) but more research is needed to capture these coping mechanisms and strategies in order to foster and promote people of color's strengths and resilience (Edwards, 2006; Sue et al., 2007).

How to improve mental health care for racialized groups remains an important question to address. Whether to produce specific services for particular groups or to increase the capability of mainstream services to offer appropriate care has been hotly disputed. The Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees' report (1988), *After the Door Has Been Opened*, concluded that specific services for each ethno-racial group was not viable and mainstream services must improve but that specific services should be set up where there is a particular need.

Rather than considering either/or approaches in service planning, important questions might be, "How can we integrate anti-racism and anti-oppression approaches into mainstream care? How can we use the knowledge and experience of these frameworks to develop a more responsive, effective, and equitable service system?" This review, more than plainly describing concepts and philosophies of practice, implicitly brings out tensions that exist in the system of care, namely the risks of fragmenting and dividing a system already hard to navigate, but also its limits to serve adequately a diverse population using comprehensive approaches to healing.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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