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Anti-Oppressive Practice: An Integral Component of a Graduate Curriculum

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Anti-Oppressive Practice: An Integral Component of a Graduate Curriculum

Abstract

To be fully prepared to work within an increasingly diverse society, CSD students need to learn more about oppression, racism, equity and inclusion in addition to learning about cultural differences. In this article, a model of Anti-Oppressive Practice (AOP) developed as an integral part of a CSD graduate education curriculum is presented. Rooted in theoretical models including Critical Race Theory and Critical Disability Theory, the AOP curriculum includes eight modules, with each module defining relevant language, introducing concrete action step strategies, and giving students opportunities to practice these steps. Topics include forms of bias, systemic racism, oppression, cultural competence and cultural humility, deficit vs. strength-based models, inclusion and ableism in CSD. Numerous examples of how AOP has been threaded throughout the CSD curriculum in academic and clinical courses are provided.

Keywords

Anti-Oppressive, Curriculum

Authors

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Introduction

A few years ago, the new president of our graduate school for health professions implemented a program as part of the orientation activities for all students. It has become known as the PPP event, which stands for Power, Privilege, and Positionality. Every entering group of new students since then has participated in this learning experience. On our website, PPP is described as "a program intended to create dialogue and reflection on Power, Privilege, Positionality and their connections to the health professions," (MGH Institute of Health Professions, n.d.). Students are assigned a series of readings for them to learn the meaning of these terms in a healthcare educational context as well as website resources and videos to explore. As an example, in 2020 one of the required videos was a short documentary called *Explained: Racial Wealth Gap*, narrated by New Jersey Senator Cory Booker that focused on the racial wealth gap in America between Blacks and Whites, (Klein et al., 2018). After completing their pre-work, the institute community (students, faculty and staff) participated in an afternoon of discussions with outside speakers and panelists about the relationship of power, privilege, and positionality to health providers and their patients or clients. Scheduling the PPP event as the first experience on campus that students have was a deliberate choice to underscore the values of our institution with respect to social justice, equity, diversity, and inclusion, what we call JEDI issues. All faculty and staff are strongly encouraged to participate each year and some also serve as trained facilitators, along with 2nd and 3rd year student volunteers.

Recognizing how powerful this orientation event has been for students, the Communication Sciences and Disorders (CSD) Department sought additional ways that this conversation could continue into the CSD academic and clinical curricula. In this article we talk about several unique initiatives that have subsequently been incorporated into the curriculum of core courses and clinical educational practicum courses within our onsite clinical center. Primary among these initiatives are concepts and practical strategies related to anti-oppressive practice (AOP), (Burke & Harrison, 1998; Campbell, 2003; Kumashiro, 2000). Specifically, we describe how we have changed student assignments, clinical operational processes, and the selection of educational materials within our onsite clinical center to better adhere to an AOP Framework. All students spend their first two semesters of clinical education onsite in our center, so infusing this framework into clinical practice is a powerful way for students to become justice-oriented practitioners.

Speech-language pathology is a field dominated by White women. The American Speech-Language-Hearing Association (ASHA), using data from 2018, stated that less than 9% of their members, associates, and affiliates were racial minorities (ASHA, 2019). However, therapists' caseloads are becoming more diverse each year, as the population in the US increases in diversity (Frey, 2020). Therefore, it is critical to train professionals who have the knowledge and skills necessary to become exemplary leaders in providing education and health care within this increasingly diverse society.

ASHA has long espoused that cultural competence is a requirement of speech-language pathologists (SLPs). Learning specifics about different cultures and how to respond appropriately, and generally respecting and accepting cultural differences are essential for providing quality care. Yet, persistent inequities in healthcare access and outcomes necessitate reexamining how to better train practitioners to be equipped to both understand systemic

issues and address them. Despite cultural competence requirements for SLPs, many SLP graduates do not feel well prepared to work with clients who are non-White and/or minoritized-language speakers (Farrugia-Bernard, 2018; Guiberson & Atkins, 2012; Kritikos, 2003; Parveen & Santhanam, 2020;). SLPs who are not sufficiently prepared to work with clients with marginalized identities can contribute to inequities in healthcare and education by making clinical choices which further marginalize groups of people (Farrugia-Bernard, 2017). As systemic racism and oppression of marginalized groups continue to make headlines, there are calls for explicit discussion and examination within education and healthcare systems (Acosta & Ackerman-Barger, 2017). SLPs must ensure that social justice, equity, anti-racism, diversity and inclusion are no longer considered special topics or niche interests. Instead, we must develop a framework for clinical practice which puts cultural humility and anti-oppression at the forefront.

We recognize that many graduate programs in CSD are currently engaging with similar issues related to JEDI and how to provide effective education for students to become the culturally humble, sensitive, and justice-oriented practitioners our world requires them to be. The AOP discussion in this article is just one pathway among many that addresses this need.

What is Anti-Oppressive Practice (AOP)?

Several disciplines including social work, education, and psychology have developed frameworks which seek to address issues of equity and inclusion, including anti-oppressive education, anti-racist education and global citizenry. However, until recently, there were few SLP resources and literature addressing social justice and anti-oppression beyond considerations of increasing awareness of diversity and inclusion (Franca & Harten, 2016; Horton-Ikard et al., 2009; Stockman et al., 2004). In seeking models relating to cultural humility, Critical Race Theory (CRT), or anti-racist practices specific to CSD, the dearth of resources specifically for speech-language pathology led our academic department to develop our own model, rooted in the research from other fields.

Our application of AOP requires a combination of theoretical understanding and concrete action steps. To contextualize the need for these steps, clinicians first must have a working understanding of racism and oppression. A foundational tenant of CRT is that racism is a common, ordinary aspect of American society and as such can only be effectively confronted by powerful and purposeful "color conscious" actions (Stefancic, 2017). Once clinicians have the skills necessary to see the intersecting and racialized identities of their clients, they can better implement concrete steps to increase inclusion and belonging for marginalized identities and make more responsive assessment and intervention choices. Color consciousness also requires awareness of Whiteness and its relationship to normativity and power (Stefancic, 2017.) According to Burke and Harrison (1998), understanding the connected nature of power and social difference is crucial if we are to fight against oppression in our work with clients.

Our model of AOP intends to equip healthcare practitioners to address inequity, racism, and oppression. To do so, clinicians must develop an understanding of oppression, an orientation toward continued learning, compassion for others, and concrete actions. Rooted in theoretical models including CRT and Critical Disability Theory (Annamma et al., 2013), AOP acknowledges and seeks to address marginalization and inequities (see Table 1).

Table 1

Foundational theories for AOP

Foundational Theories	Summary
Critical Race Theory (CRT)	A cross-disciplinary approach to examining and confronting structural racism. CRT theorizes that racism is embedded within society and supports strategies such as race consciousness, contemporary orientation, centering the margins, and praxis (Ford & Airhihenbuwa, 2010).
Disability Critical Race Studies (Dis Crit)	An approach to examining the interplay between racism and ableism (Annamma et al., 2013).
Cultural Humility	An orientation toward continuous learning, openness to the other (i.e., other people, perspectives, values, cultures, experiences), critical self-reflection, and a personal commitment to correct systemic inequities (Tervalon & Murray-García, 1998).
Anti-Oppressive Education	Strategies for addressing various types of oppression within the education field (Kumashiro, 2000).

The AOP curriculum includes eight modules, with each module defining relevant language, introducing concrete action step strategies, and giving students opportunities to practice these steps. Topics include bias, systemic racism, oppression, cultural competence and cultural humility, deficit vs. strength-based models, inclusion, and ableism in CSD. Nearly as important as the content itself is the method of instruction. Some students can be resistant to learning about racism and privilege (DiAngelo, 2018; Oluo, 2018). However, research indicates that classroom exposure to concepts of diversity can better prepare future clinicians to challenge beliefs held about clients (Romanello & Holtgrefe, 2009). To increase the likelihood of students being receptive to the content of AOP, several pedagogical approaches are embedded into the design of the curriculum. First, given the sensitive nature of the topics, care is taken to create a safe and supportive environment, including setting community agreements for discussions and emphasizing the need for establishing a growth mindset (Dweck, 2006). Students interact with content via a combination of lectures, workshops, and multi-media products including research articles and podcasts. Modes of instruction include active learning and asynchronous reading and reflection. The eight modules are embedded into a first-year graduate clinical seminar course, which focuses on developing pediatric speech and language clinical knowledge and skills (see Table 2). By threading AOP throughout this year-long course, students are repeatedly exposed to the tenets associated with the curriculum.

Table 2

The 8 Modules of AOP

Title of Module	Content Topics	AOP Strategies to Increase Self Knowledge	Examples of Clinical Application
AOP: An Introduction	Orientation to Diversity Wheel (Hopkins, 2016) and Social Determinants of Health Ethnographic interviewing	Assessment of one's own cultural competency and identities Establish personal growth goals	Complete ethnographic interview with standardized patients Complete pre-brief/debrief
Deficit Thinking: Bias in Assessment Measures	Inclusion and equity in assessment Norms across various populations Personalized and contextualized analysis of assessment results Difference vs. disorder in assessment	Establish checklists for analyzing one's own bias in content and interpretation of assessment results	Complete assessment of Spanish-speaking child with Mexican heritage using computer-based simulated case Complete pre-brief and debrief
Linguistic Bias	Bias in referential labels and subjective behavioral descriptors Potential pitfalls for clinicians, including inspiration porn and saviorism	Identify coded language Speak about clients in humanizing ways	Write behavioral descriptions using objective language Complete diagnostic report of simulated case
Developing Goals: Difference vs. Disorder	PPP in intervention planning and access Understanding disorder and difference Intercultural communication	Identify functional/appropriate intervention goals Include family goals/concerns and community contexts	Complete treatment plan for simulated case
Promoting Inclusion Through Literacy	Inclusion versus marginalization Types of bias in materials Steps of a bias review	Utilize measures to analyze assessment and teaching materials for bias	Conduct a review of materials using the Washington Model (Washington Office of the State Superintendent of Public Instruction, 1996)
Oppression: What Is It?	Various forms of oppression Racism, prejudice and discrimination	Understand one's own PPP Understand history of oppression in the US/world	Attend PPP orientation event at start of program
Addressing Implicit Bias	Causes of implicit bias Relationship between implicit bias and disparities	Assess self for internalized bias and implement strategies to reduce bias in self	Reconsider and reevaluate own growth goals Complete reflection on change across time
Ableism in CSD	Basic concepts from Critical Disability Theory Understanding strengths-based perspective	Understand and participate in/with disability communities Attend institutions' accessibilities workshops	Evaluate simulated client report using algorithm proposed by Braun et al. (2017) for strengths-based language

AOP in the Curriculum

The content covered in the AOP curriculum is integrated into many aspects of CSD students' clinical and academic education. At the beginning of every course and clinical rotation, faculty and students work together to create a set of "Community Agreement" guidelines. The agreement is a crucial step towards establishing an inclusive learning environment and creating a brave space where all voices are respected; mistakes and disagreements can be aired and seen as learning moments; and emotions arising when discussing difficult topics are acknowledged and valued in the group learning process. Some of the guidelines put forth include the assumption that all persons in the room have positive intentions, and that 'I' statements should be used when commenting, along with using inclusive language.

Shared models such as Social Determinants of Health (Artiga & Hinton, 2018) and Johns Hopkins University's Diversity Wheel (Johns Hopkins University Diversity Leadership Council, 2016) are utilized across courses and clinical experiences in the onsite clinical practice center. The center brings together students from across the health professions to learn and practice in teams and to deliver essential care to the local community, comprising a range of diverse neighborhoods. CSD students see clients and their families on a weekly basis and services are provided free, with no insurance or private pay requirement. To increase client diversity to better align with the center's JEDI goals, community recruitment is prioritized to areas in which access to services is limited. Recruitment information can be provided in two languages (English and Spanish). To further enhance the intake process for new clients seeking services, there is a bilingual intake coordinator who aids families in navigating the referral process. In addition, the center has access to an interpreter service representing a variety of languages so intervention can meet the linguistic needs of clients and their families.

Anti-oppressive practices are integrated into all aspects of clinical practice from initial case history interviews to assessment and treatment plan development. In the initial stages of working with clients and families, students utilize a client profile template to help them organize and interpret assessment information. As a graphic organizer for categorizing complex information, the template supports clinical thinking by assisting students in seeing patterns in their data and supporting inferential thinking. The template consists of sections for categorizing contextual information (environmental and personal factors) as well as client speech, language, and literacy strengths and challenges. The section for contextual factors, modeled after the WHO International Classification of Function, Disability and Health (World Health Organization, 2002), occupies the top portion of the template, providing space for students to document potential sources of systems-level oppression (environmental factors) and the client's social identities (personal factors). As part of the template, we include the Johns Hopkins University diversity wheel image and a summary table of social determinants of health (Artiga & Hinton, 2018). See Appendix A for an example of a client profile template focusing on literacy skills. Prioritizing contextual factors and providing these images creates a common basis for integrating and bridging discussions from the academic classroom into clinical application. The template structure brings reflections of power, privilege and positionality to the forefront, and in conjunction with community agreements, keeps clinical instructors and students accountable yet supported in discussing topics that can elicit pain or discomfort.

Ethnographic interviewing (Westby, 1990; Westby et al., 2003) is introduced in academic coursework and translated into practice in clinic. This form of interviewing provides a case history

process that identifies meaningful cultural values held by clients and their families and can be a bridge to providing culturally sensitive and anti-oppressive care. During the initial client and family visit to the center, students complete an ethnographic interview with the expected student outcome being to summarize the client's background, environmental considerations and client/family goals through active listening and open-ended questioning. As part of the AOP curriculum, the practice of these interviewing skills was conducted in a lab utilizing standardized patients (SPs). In preparation for the lab, students attended a class centered on the family and client interview process and respecting values and backgrounds. Students then completed independent work that included readings, videos, and an assignment requiring them to develop questions for a simulated child's family member. The simulated client was a Spanish-speaking school-age child of Mexican heritage. Meetings were held with our standardized patient coordinator, and a pool of SPs representing Asian, Black, and White racial identities was determined. Each SP was provided a script regarding their simulated child's lived experience, and students worked in pairs to interview the family member. Following established procedures for conducting simulations, a pre-brief and debrief were completed, and students completed a reflection activity.

AOP also involves choosing intervention materials that are affirming for the client's identity, allowing them to see themselves, their family, and community in a positive context. Children's books are often used as intervention materials to address a range of goals targeting communication. AOP with respect to children's literature was addressed in three inter-related ways: (1) evaluating and updating the children's book library; (2) evaluating and updating decodable books used specifically in structured literacy intervention; and (3) creating active learning opportunities for graduate students to assess books for bias. The children's book library, much of which was acquired through donations, was surveyed by graduate assistants using the Washington Model for Evaluation of Bias Content in Instructional Materials, (Washington Office of the State Superintendent of Public Instruction, 1996). As a result, many outdated books portraying harmful stereotypes were removed (see, for example, Ishizuka & Stephens, 2019). The department provided funds to purchase newer books featuring characters with non-dominant social identities, often written and/or illustrated by authors from minoritized populations (see The Conscious Kid). Graduate students also used the Washington Model checklist to conduct a bias review on books as a small group activity. Currently, faculty and students together are developing an updated version of the Washington Model to conduct a bias review of decodable books (books which target accurate 'sounding out' of familiar phonics patterns.) The aim is to collect data regarding how many decodable books across various publishers represent minoritized identities compared to dominant identities and how many contain biases such as tokenism, stereotypes, or erasure, versus representing minoritized social identities in affirming ways. This information will be used to advocate for improved and expanded offerings from publishers to ensure that readers encounter motivating and identity-affirming texts from their earliest reading experiences.

Another addition to the AOP clinical curriculum was the introduction of a shared reading. Like others have done for similar reasons, (DasGupta, 2006; Laws & Chilton, 2013; Mahendra et al., 2005), we selected: *A Spirit Catches You and You Fall Down*, (Fadiman, 2018.) This book illustrates the complexity between Western medicine and the cultural values and understanding of a Hmong refugee family from Laos. The book was divided into

sections and students were given guided questions to reflect upon in clinical team meetings over four weeks. These assignments provided a powerful narrative approach that led to enlightening discussions about the impact of a lack of cross-cultural understanding and communication on caring for patients who hold differing beliefs and ideals.

Conclusion and Next Steps

The field of speech-language pathology acknowledges that cultural and linguistic competence is as important to the successful provision of services as are scientific, technical, and clinical knowledge and skills (ASHA, 2016). Looking through an anti-oppressive practice lens can lead us to see in a new way. What is a 'disorder' and what is a 'difference'? How might the word 'pathologist' in our titles cause us to think and act in biased ways? How can an anti-oppressive lens focus our research attention differently and potentially lead us on new paths? How should a person-centered philosophy like AOP, concerned with reducing the deleterious effects of structural inequalities upon peoples' lives cause us to reconsider and revamp our current systems of research, practice, and student education? (Kumashiro, 2000.)

This year the CSD Department sponsored an "exit" Power, Privilege, and Positionality professional development event for faculty and graduating students. Our two invited speakers, Dr. Shameka Stanford and Dr. Tracy Conner, are leaders in the field on topics central to anti-oppressive practice. Dr. Stanford's work as a forensic SLP and on the school to confinement pipeline (Stanford, 2020) and Dr. Conner's work as an experimental linguist studying AAE, dialect, difference, and social justice (Conner, 2020) give us excellent examples of anti-oppressive research and practice and how AOP principles can and should lead our field in new directions.

Next steps in our AOP curriculum development include extending and integrating the content beyond the core curriculum and into advanced electives, creating faculty and clinical supervisor training modules, and developing clinical seminars for second year students that focus on teaching AOP-based advocacy skills to empower our graduates to create systems-based change in their post graduate careers.

Anti-oppressive practice requires that we educate our graduate students and ourselves to do more than have a sensitivity to apparent ethnic or cultural 'differences.' AOP argues that what is needed is practice that challenges and changes structures of inequality at every level. The teaching of anti-oppressive practice leads us to the understanding that we must continue to move towards models of anti-oppressive education in our communication sciences and disorders programs. We must examine ourselves and our teaching practices and acknowledge that many of the ways that we traditionally educate our students may yet still involve oppressive education methods. We must stand with our students and others who experience oppression, marginalization and other forms of injustice and come to the fight with humility, striving to do better to promote equity for our students and for the people that we serve as a profession.

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Appendix A
Client Profile Template

Contextual Factors

Environmental Factors (e.g., school, family, social determinants, etc.)	Personal Factors (e.g., behavior, temperament, motivation, etc.)

Language Strengths and Weaknesses

Receptive Language and Cognition
Expressive Language
Articulation and Phonology
Pragmatics

Social Determinants of Health Factors Include:

Economic Stability	**Education**	**Community and Social Context**
Employment	Literacy	Social integration
Income	Language	Support systems
Expenses	Early childhood education	Community Engagement
Debt	Vocational training	Discrimination
Medical bills	Higher education	Stress
Support		

Neighborhood and Physical Environment	**Food**	**Health Care System**
Housing	Hunger	Health coverage
Transportation	Access to healthy options	Provider availability
Safety		Provider linguistic/cultural competency
Parks		Quality of care
Playgrounds		
Walkability		
Zip code / Geography		

Diversity Factors Include:

Age	Political Belief
Race / Ethnicity	Family
Gender Identity or Expression	Organizational Role
Sex	Language / Communication Skills
National Origin	Income
Sexual Orientation	Religion
Mental / Physical Ability	Appearance
Education	Work Experience