Social Justice Implications for MFT: The Need for Cross-Cultural Responsiveness

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> Discourse without action is dangerous because it creates the impression that progress is taking place when in fact only the words have changed. (Prilleltensky, 1997)

Multicultural sensitivity, cultural responsiveness, and cultural humility are all forms of historical determinism in order to respond to perplexing social realities of disenfranchised and oppressed groups' experiences with high prevalence of social disparities. Such disparities have been well-documented across significant domains of life. For example, ethnic minorities underutilize mental health service compared to white populations (Pole, Gone, & Kulkarni, 2008) and experience significant cultural bias regarding the process of their treatment (Schulman et al., 1999).

This chapter offers a framework for supporting and including a social justice perspective in family therapy praxis by discussing a vision of social justice that is true to the needs of families we serve. As authors of this chapter, we both have studied social sciences (first author in Iran, India, and the USA and the second author in Iran and the USA) and are academicians, researchers, and practicing clinicians and have seen the complexity of relational issues cross-culturally. We both have dealt with different kinds of social, political, and relational injustices when we lived abroad but believed that these issues are more related to the developing world's cultural context in terms of lack of sustainable laws, collectivistic values, and scarcity of resources. However, we have been shocked and then greatly motivated to examine and discuss issues related to social justice, diversity, and human suffering that are continuously and contextually happening in the USA and have tried to do a critical analysis of these phenomena. We both have extensively researched, written, and presented about lack of a social justice framework within the realm of psychotherapy in the USA and abroad. Therefore, in this chapter, we attempt to offer specific ideas about a paradigm shift in thinking about the inclusion

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S. Singh Poulsen, R. Allan (eds.), *Cross-Cultural Responsiveness & Systemic Therapy*, Focused Issues in Family Therapy, https://doi.org/10.1007/978-3-319-71395-3_1

of diversity and social justice in practice to help clinicians understand multicultural clients' dilemmas and challenges.

First, it is critical to acknowledge that the experience of chronic stress for ethnic minorities is positively associated with health disparities caused by sociopolitical factors such as perceived racism, neighborhood poverty, family stress, acculturative stress, and maternal depression (Djuric et al., 2008). Compared to white Americans, racial and ethnic minorities report a significantly lower level of overall health. Such experiences occur due to the existing gap caused by lower socioeconomic status, lower education level, living in poverty-stricken neighborhoods, lower rates of employment, lack of access to healthcare, and providers' bias (Bahls, 2011). Further, due to chronic stress caused by daily experiences of discrimination, the prevalence of diabetes and hypertension is significantly higher among different oppressed groups such as African-Americans, Hispanics, and Native Americans (Kaholokula, Iwane, & Nacapoy, 2010; Williams & Neighbors, 2001). The US Census Bureau report revealed that 19% of African-Americans did not have any form of health insurance compared to the general population in the USA, while 20% of African-Americans are more likely than whites to experience significant mental health symptoms and diagnoses (Health and Human Services Office of Minority Health, 2012).

Furthermore, perceived discrimination and racism have been indicated as significant contributors to unhealthy coping mechanisms such as alcohol and substance use, smoking, improper nutrition, and rejection from receiving necessary medical care (Lee, Ayers, & Kronenfeld, 2009; Peek, Wagner, Tang, & Baker, 2011). Lesbian, gay, bisexual, and transgender (LBGT) individuals also experience higher risk for psychiatric disorders compared to heterosexual individuals because of higher levels of discrimination (Lehavot & Simoni, 2011; McCabe, Bostwick, Hughes, West, & Boyd, 2010).

Additionally, acculturation stress among immigrants has shown to be negatively associated with ethnic identity and self-esteem (Marin, 1993), academic achievement and depression (Cuellar, Bastida, & Braccio, 2004), psychological adjustments (Smith & Khawaja, 2011), racial micro-aggression/racism (Araújo-Dawson, 2009), substance abuse Segura, Page, Neighbors, Nichols-Anderson, & Gillaspy, 2003), and emotional well-being (Caldwell, Couture, & Nowotny, 2010). Immigrant women reported more significant experiences with depressive symptoms compared to US-born women in general (Tillman & Weiss, 2009).

Classism and Capitalism: The Forbidden Words in the Therapy Room

Despite all the cliché and infantile attack on psychoanalysis reductionism, Sigmund Freud was among the earliest professionals who realized the limitations of psychotherapy within larger social systems. He claimed that "the vast amount of

neurotic misery which there is in the world, and perhaps need not be" (Freud, 1914, p. 165). Freud was expressively disappointed for not having served the poor people. He argued that in the future "society must have an awaken[ed] conscience toward its disadvantaged citizens where treatments will be free" (p. 165). Ironically, in our current academic discourses and research practices, the issues of poverty, classicism, and economic injustices have been significantly overlooked.

Generally speaking, every individual has inherited a membership within a social class. Such category predominantly shapes and impacts individual and family experiences. Social class significantly influences human well-being either physically or psychologically (Dillaway & Broman, 2001). McDowell (2015) argues that "Social class influences the range and types of choices available to each of us, how we define ourselves, our values and expectations, and the way we organize our day-to-day lives" (p. 13). Despite the importance of the interconnectedness between social class and families' psychosomatic well-being, limited attention has been paid to these issues. The very mundane and apologist arguments of privileged therapists are that we are not economists and that it is beyond the scope of our practice. Yet, a momentary gaze into empirical evidence of economic hardship of modern age can expand our limited horizon related to the mental health hygiene in the age of economic disparities.

In the USA, 15% of people are living under the poverty line (Wolff, 2012). The top 1% of the American population earn approximately more than 38 times compared to the bottom 90% which means the top 1% accumulation is 184 times that of the bottom 90% (Saez, 2015). The income of the top 1% bracket has skyrocketed by 256% between 1979 and 2007, while the bottom 90% have experienced a very minimal growth of average income by 16.7% during the same historical period (Mishel, Gould, & Bivens, 2015), and 43.1 million people (13.5%) live below the poverty line. Among those individuals, 14.5 million (19.7%) are children under the age of 18, and 4.2 million (8.8%) are elderly 65 and older (Proctor, Semega, & Kollar, 2016).

There is a plethora of empirical studies revealing the significant impact of one's socioeconomic status on overall mental and physical health. More precisely, the poorer you are, the unhealthier you become. Faris and Dunham (1939) conducted one of the earliest studies to examine the connection between socioeconomic stress and mental health. The result indicated the prevalence of significant mental illness among the poorest neighborhood in Chicago. This was a groundbreaking study that led to other similar empirical studies including Hollingshead and Redlich (1958) in New Haven, Connecticut, and Srole et al. (1977) in Midtown Manhattan. The findings of these studies consistently convey the same concept that lower social class contributes to a higher rate of health issues both at individual and community levels. In these articles, classism is approached not only as a form of social attitude for both therapist and clients but also as a form of "social oppression" (Smith, 2005) that impacts and shapes individuals' lives negatively.

Psychotherapists are predominantly unconscious about their axiological position regarding class (Chalifoux, 1996).

Such lack of awareness can easily function as a form of countertransference called "fear of the poor" (Javier & Herron, 2002, p. 26) which leads many therapists to fail to build a meaningful relationship with their poor clients. Lorion (1974) argues that therapists' "negative attitudes" toward poor clients are potentially the most significant factors for treatment failures with this population. Jones (1974) echoes Lorion's perspective and proposes therapists' reluctance to work with poor clients as "the expression of an ugly class bias" (p. 309) (as cited in Smith, 2005). Unfortunately, a three-decades' fast-forward of clinical work with clients from lower socioeconomic status is not promising. For instance, Saris and Johnston-Robledo (2000) found a common theme after conducting a content analysis called "Poor Women Are Still Shut Out of Mainstream Psychology." Furnham (2003) claims that "the most important topics in poverty research have been almost totally neglected by psychologists" (p. 164). Regardless of researchers' intentionality, the research on poverty and mental health has mystified such unhealthy relationship through what Moreira (2003) calls "the medicalization of poverty" and Read et al. (2004) has called the "colonization of the psychosocial by the biological." Smith (2005) concludes "therapists know little more about the therapeutic experiences of poor people today than they did decades ago" (p. 687). Sue and Lam (2002) conducted an analysis of psychotherapy interventions outcomes, and their observations of clients with lower SES revealed that "despite the important influence of socioeconomic status on an individual's life, this variable has been widely ignored" (p. 414).

Because of their limited opportunity to access to mental health service, poor clients have limited chances of receiving evidence-based treatments compared to the mainstream population (Le, Zmuda, Perry, & Munoz, 2010; Miranda et al., 2005). Both academic researchers and clinicians have failed to explicitly acknowledge such invisible apparatuses of oppression and the systemic dehumanization of the poor. Therefore, understanding the existential struggles of poor clients and the discrimination that they experience due to the brutality of a class gap must be a paramount element of therapeutic endeavors. Yet, there is no consensus on how to incorporate such a mind-set into clinical practice. Zrenchik and McDowell (2012) call for adopting a "critical class consciousness" and taking action throughout the therapeutic process. Similarly, Kim and Cardemil (2012) claim that therapists must engage in a self-examination of their "unconscious classist bias." Harley, Jolivette, McCormick, and Tice (2002) suggest that therapist must be aware of how their class privilege can unconsciously harm clients.

Nonetheless, regarding classism, it appears that the self-proclaimed conscious therapist's effort to dismantle classism in the therapeutic realm remains ineffective—because the first step is a critical self-examination for therapists to realize that their expertise and knowledge derives its legitimacy from the very existence of the classist system. Such visible or invisible loyalty of the psychotherapist toward the maintenance of a classist structure is most often overlooked.

There is a significant dearth of discourses on classism and socioeconomic status in the field of couple and family therapy (Kosutic & McDowell, 2008). Since MFT as a field has not incorporated the impact of classicism and poverty into academic

training, supervision, and research, it further enables the structural injustice and normalizes the internalized oppression of the clients and families who are dealing with poverty. McDowell (2015) claims that "as long as poverty is explained as the result of individual failing and wealth as the result of individual hard work and human worth, class discrimination and internalized classism will thrive" (p. 14). Similarly, Vodde and Gallant (2002) propose that there will not occur an authentic fundamental change until the root causes of the problem of oppressed clients are addressed and a collective macro-level activism initiated.

The Ontological Birth of Multiculturalism

The discourse on the application of multiculturalism and implication of justice-oriented perspective toward therapy is not new. Yet, there has been an immensely limited conversation about why the field of mental health mandates such perspective. If it is so critical to therapeutic progress, why has it been overlooked for almost a century since the birth of the talking cure? In order to respond to the aforementioned questions, one needs to understand the ontological necessities of the emergence of multiculturalism.

Along with the existing empirical data on how minorities live in an unjust parallel universe, there are other theoretical arguments for the epistemological problem with multiculturalism as an ultimate solution to such disparities. Phillips (2007) suggests the following summation of a multicultural society:

> Multiculturalism exaggerates the internal unity of cultures, solidifies differences that are currently more fluid, and makes people from other cultures seem more exotic and distinct than they really are. Multiculturalism then appears not as a cultural liberator but as a cultural straitjacket, forcing those described as members of a minority cultural group into a regime of authenticity, denying them the chance to cross cultural borders, borrow cultural influences, define and redefine themselves (p. 14).

More radically, Ahmed (2008) argues that "multiculturalism is a fantasy which conceals many forms of racism, violence and inequality as if the organization/nation can now say: how can you experience racism when we are committed to diversity?" She further argues that multiculturalism is a fantasy in the favor of white hegemony. Ahmed (2008) discusses that a multicultural attitude simply endowed us with a politically correct language and shallow sense of coexistence while disguising the profundity of inequalities.

Žižek (2008) makes another controversial proposition. He claims that Western liberal multiculturalism has succeeded in obfuscating and disguising significant struggles of oppressed groups such as "economic exploitation, political inequalities, health disparities, and justify them through cultural differences" (p. 141). Because when we state that people's issues stem from their different cultural background, "it means we cannot change them, because it's their culture, rather than stating that the issues are political such as poverty, high unemployment rate, institutionalized and discrimination, which requires justice-based social interventions" (p. 141). Žižek

(2008) also discusses the danger of the current liberal multiculturalism which can easily turn into an oppressive force. “Political differences - differences conditioned by political inequality or economic exploitation - are naturalized and neutralized into ‘cultural’ differences; that is into different ‘ways of life’ which are something given, something that cannot be overcome” (p. 141).

Furthermore, attending multicultural trainings and workshops has become an interesting new way of buying a product and then achieving the static state of cultural competency. Nevertheless, this apolitical purchasing of multiculturalism as a commodity creates even more hindrances for minorities who are still very much misunderstood and mistreated leading to more “Otherization.” Henry, Totor, Mattis, and Rees (2000) argue that multiculturalism mystifies the historical phenomena such as colonization, genocide, slavery, and diaspora that shaped the current existing life dynamics of many minority groups. Constantine and Ladany (2000) claim that “historical definition has gone virtually unchallenged by multicultural scholars and practitioners in counseling psychology” (p. 162).

Additionally, multicultural trainings emerged as responses to multiple clinical struggles. Multicultural psychotherapy for marginalized groups has been uttered for at least four decades now (Sue, Zane, Hall, & Berger, 2009). It is an empirical fact that despite experiencing higher level of psychological distress, minority clients have been underserved and drop out of therapy at much higher rates compared to the general populations (Kearney, Draper, & Baron, 2005; Sue & Sue, 2008).

For instance, many researchers argue that the majority of mental health professionals are white (Ancis & Szymanski, 2001; Fouad & Arredondo, 2007) and there is a sociohistorical mistrust within African-American communities to seek such professional support from white psychotherapists (Whaley, 2001). Gushue (2004) concludes that after participating in an extensive multicultural training, therapists’ racism is still easily displayed during the course of therapy (D’Andrea, 2005). Additionally, Mindrup, Spray, and Lamberghini-West (2011) argue that fundamental theoretical approaches of psychotherapy emerged from the white male epistemology toward mental health which has significantly obscured the sociopolitical factors that position individuals and families’ life condition within the larger social systems. Carter (1995) opposes the deracialized approaches of mental health professionals by stating that “more often than not, race is thought of by mental health professionals to be an unimportant aspect of personality development and interpersonal relationships. Consequently, how race influences the therapeutic process is not well understood by psychological theorists, clinicians, and clinical scholars. Race as a personality and treatment factor has, at best, been treated as marginal” (pp. 1–2). Advocates such as Sue and Sue (2008) proposed that psychotherapy could be conceptualized as “sociopolitical act,” yet the very neutral language and limitation of its praxis failed in pushing the boundaries of justice discourses in the field of psychotherapy.

In summary, it is plausible to argue that the intervention of multiculturalism merely was conceptualized as a form of ethical obligations for mental health providers. The result is the promotion of another individualistic epistemology of “the Other” that mental health professionals can declare just by attending multiple

trainings. This form of culturalism is indeed a theoretical mystification of the sociopolitical experience of minority clients. Akintunde (1999) argues that not only multiculturalism is pro status quo but also a very subtle enabler of white-supremacist ontological, epistemological, and axiological frameworks, since it permits the white trainees to simply become the master of "the Other's" culture. Such an "Otherization" mechanism is yet another form of privilege and entitlement for whites to continue to be the center of knowledge construction and understanding of "the Other" from their colonial gaze.

The Subject of Multicultural Gaze

Historically speaking, white male theoreticians and researchers consciously and unconsciously (strictly Freudian) overlooked the magnificent force of sociopolitical order on the mental health status of marginalized groups. Their positionality of white privilege shaped such ontology, epistemology, and axiology which is inherently ahistorical, depoliticized, and deracialized. Since he has profited from the domination of white hegemony, and is not existentially aware of the sufferings of the oppressed, he continues to ignore how social systems transmit their inherent pathologies to underprivileged families and individuals. The existential philosopher, Sartre (1956), portrays white men's position in society as: "the White man enjoyed, the privilege of seeing without being seen; he was only a look…The white man - white because he was man, white like daylight, white like truth, white like virtue-lighted up creation like a torch and unveiled the secret white essence of beings" (p. 13). More specifically, the very position of the white theoretician and therapist created a context of negligence and distortion of his/her understanding of psychosocial etiology of mental health symptoms. McGoldrick (1998) openly acknowledges that conventional approaches of psychotherapy are significantly in favor of white men, are heterosexist, and predominantly privilege the challenges of middle and upper middle class individuals and families.

The current psychotherapeutic lens is a historical continuation of the enlightenment project, where the philosopher Descartes asserted "I think, therefore I am." Such a centrality of the knower as the primary architecture of truth has been the core assumption of psychotherapist trainings in the Western paradigm. In the so-called Cartesian dualism, there is an epistemological stance which is the separateness of the knower from known, the thinker from thought, and the observer from observed. Descartes' proposition became the rationale for objectifying the non-Western world and colonization of recourses of Others (indigenous population) whose world philosophy was not shaped by the pure instrumental reasoning (Altman, 2003). Therefore, if there will ever be a change in treating "the Other" more humanely, the Western gaze of psychotherapy must recognize its problematic way of understanding the racial Others. Accordingly, Taylor (2011) refers to the challenge of comprehending the mystery of the Other as "the great challenge of this century both for politics and social science" (p. 24). Yet, the arrogance and

dogmatism of instrumental reasoning have not permitted the alternative view of "the Other." Furthermore, Gantt (2000) complains that contemporary psychotherapy has been so overwhelmingly fixated with diagnosis, techniques, and outcomes that it has failed to meaningfully develop a moral and ethical understandings of the Other's sufferings. Thus, the racial Other, as a subject of a multicultural lens, continues to be de-subjectified, in a sense that he/she does not have full range of human experiences equal to the observer, since he/she has been historically an object of the colonial gaze, reduced to a nonliving entity which is governable; does not experience pain, suffering, sadness, anger, etc.; and is subject to the colonizer/colonized relationship.

The colonized are the ones who Foucault (1980) argues are perceived as not being able to experience the full range of humanhood, "thus subjectified and are denied subjectivity." It is indeed plausible to argue that the multicultural lens is a postmodern tool for the colonizer to understand the troublesome existence of the Other, who suffers the castration and has metamorphosed into an abstract concept for experts of the Western/colonial paradigms to be analyzed, studied, or cured. The multicultural lens is an invention of the subject of knowledge who does not tolerate to bear any ambiguity about the Other, since the very unknown is an uncomfortable state of the mind for one who must know to dominate over others. No wonder, despite its theoretical incongruences, the very notion of cultural competency has received so much receptivity among mainstream psychotherapists.

Family Therapist Cross-Cultural Responsiveness Dilemma

Family therapy field has a serious dilemma with respect to cultural responsiveness and must rehabilitate itself from the irrelevancy of the majority of implied theoretical approaches and clinical interventions to help the racial Other and must inquire a paradigm shift in understanding and providing mental health services to the Other. Some philosophers like Levinas (1969) suggest that no matter how hard the subject tries, there are always aspects of the Others that escape and resist any form of symbolization, categorization, and objectification. Therefore, instead of replacing the vexing feeling caused by the cognitive dissonance of the Other's ambiguity, a systemic thinker and therapist must expand his/her conceptualizations to understand complexity of the Other's life circumstances. Perhaps, the psychotherapist must abandon the colonial attitude of multiculturalism and emancipate himself/herself from the obsession of knowing the Other and rather focus on empowering the oppressed Other. The white therapists or those who are indoctrinated with the white ideology should engage in a form of soul-searching experience where he/she develops emotional and intellectual capacity to embrace a new form of reality, which is "there is limitation to my knowledge." Only then, a family therapist can pay attention to the other significant social realities that impact the oppressed Others through recognition of interconnectivity between race, class, politics, etc., and the therapist can utilize multiculturalism as an intervention for understanding the Other. In this way,

multiculturalism will be approached as an introspective tool, where family therapists begin to view themselves from the lens of the Other. Instead of occupying the predominant position of being the omnipotent expert, psychotherapists can resign from such positions and begin to view themselves objectively, as if the Other is observing them. Such introspection is immensely lacking within the professional realm since it demands significant vulnerability on the psychotherapist's side. Therefore, neither narrowed Western paradigms nor a plethora of therapeutic models but rather family therapists' personal journey of "being the Other" can determine how the Other is viewed, understood, and conceptualized.

Family Therapist Utilization of the Social Justice Paradigm

A social justice paradigm consciously magnifies the historical evolvements of the present social order where certain segments of society enjoy an unearned privilege at the expense of historical oppression of other disadvantaged groups (McIntosh, 1998). Seedall, Holtrop, and Parra-Cardona (2014) propose that "A social justice perspective identifies group differences in the context of social inequalities and then analyzes the source of those differences, including the interplay between disadvantage and privilege" (p. 140). Additionally, a social justice lens aims to address the institutionalization of social inequalities in maintaining such order via multiple structural methods and ideological tools such as classism, racism, and sexism (Chizhik & Chizhik, 2002). This framework intends to dismantle the systemic oppressions through empowering members of the marginalized groups by increasing their social awareness about the oppressive conditions and to create networks of support within their communities. Therefore, de-ideologization (Martín-Baró, 1985) of the social machine of oppression should be a critical pillar of social justice in MFTs' clinical work. In this way, the very internalized belief system of oppressed groups is deconstructed and an emancipatory knowledge is given back to the marginalized people in order to realize the falsehood of their problem-saturated stories. Therefore, the liberation occurs when the oppressed recognizes the false consciousness they use to justify their own life conditions. Such anti-oppressive interventions against the "oppressive condition" assist oppressed members to revise their understandings of different aspects of their lives from basic survival needs such as housing and employment to leisure, emotional well-being, and their sense of justice.

Even though the importance of discourses around social justice initiated in the 1980s by many feminist scholars (Ault-Riche, 1986; Avis, 1988; Goldner, 1985; Hare-Mustin, 1987), the family therapy field has been hesitant to make a strong sociopolitical stance against oppression in their academic and clinical training. Consequently, we have witnessed a huge gap in marriage and family therapists' awareness and advocacy for social justice and feminist issues (McGeorge, Carlson, Erickson, & Guttormson, 2006).

During early twenty-first-century conversations, there are signatures of epistemological confusion about understanding the mental health issues of the Other. For instance, Guaniapa (2003) proposes that the lack of enough multicultural course designs in family therapy programs has caused the primary issues of not having multiculturally competent trainees and therapists. There are few studies that have addressed the current struggles of the family therapy field in response to clinical application of social justice into therapeutic interventions. After reviewing 127 published articles by Journal of Marital and Family Therapy from 1999 to 2001, McDowell and Jeris (2004) found only 6.3% of published articles addressed issues related to race and racism even though the authors declare that "There is an emerging trend in MFT literature toward advocating for social justice and resisting socially unjust relationships" (McDowell & Jeris, 2004, p. 90). In a different study conducted by Kosutic and McDowell (2008) called *Diversity and Social Justice Issues in Family Therapy Literature: A Decade Review*, authors examined 1735 articles that were published between 1995 and 2008 in five major family therapy journals. The result reveals that only 0.9% of the article exclusively attempted to address social justice issues. Such findings indicate that the discourses of social justice in the MFT field are still in its infancy. Seedall, Holtrop, and Parra-Cardona (2014) conducted a content analysis of three family therapy journals (Journal of Marital and Family, Family Process, and The American Journal of Family Therapy) on addressing issues related to social justice and diversity examining a total of 769 articles between 2004 and 2011. The result indicates that only 13.5% (n = 104) of all articles implied a social justice perspective. Such a significant dearth of social justice theorization of mental health issues clearly symbolizes the prevalent indifferences of the family therapy field to conceptualize mental health above and beyond the conventional therapeutic models. From a clinical perspective, however, there are some articles suggesting that we should engage in more critical discourses within MFT programs and increase our awareness of the interplay of unconscious assumptions of racism, sexism, and classism on clinical interventions (Ariel & McPherson, 2000; Laird, 2000; McDowell et al., 2003).

There are similar suggestions about the problem with limited emphasis on issues of diversity and social justice in the MFT field to train students to become socially conscious clinicians. Yet, there is a limited contextualization of how those praxes can occur in our current depoliticized academia. It is very apparent that like other social science curriculums, the MFT academic programs are embedded in a Eurocentric paradigm and in favor of a white-hegemony doctrine (Aronowitz & Giroux, 1993). Other scholars have advocated for the inclusion of more critical frameworks such as critical race theory and feminism in order to counterbalance the inherent bias of the MFT trainings and interventions which are significantly shaped by patriarchy, racism, classism, and heterosexism (Carlson et al., 2006; Inman, Meza, Brown, & Hargrove, 2004; McDowell & Shelton, 2002; McGoldrick et al., 1999).

The lack of theoretical and clinical relevancy of the MFT approaches to the daily challenges of minority clients and families remains a deadlock. Hardy and Laszloffy (2002) argue that family therapy has been immensely unsuccessful in addressing the

reality of oppressed groups' needs and challenges. From an ecosystemic epistemological perspective, Killian and Hardy (1998) argue that, ironically, the American Association for Marriage and Family Therapists (AAMFT) as an organization which is the epitome of systemic thinking has failed to address the existing inherent structural inequality. The AAMFT as a system has maintained a deviation-countering (static) approach not allowing a structural reconfiguration matching the change in the social demographics of our society. The unjustifiable fact that members of the marginalized groups are significantly underrepresented in AAMFT compared to the mainstream population conveys a critical message; AAMFT is "closed off from the larger system of society" (p. 216). An AAMFT statistical report indicates that in 1994, there were only 609 members out of 20,269 individuals who declared to be members of ethnic minority groups, which come to approximately 3% (Killian, & Hardy, 1998). In a more recent report, the percentage of minority membership has increased to 17% but only 9% of them are Clinical Fellows. Perhaps, the post-racial identity for members of AAMFT remains a fantasy when 82.78% of its members are white (Todd, & Holden, 2012). Killian and Hardy (1998) claim that unless a critical change such as inclusion of minorities as members of board of directors, keynote speakers, and Clinical Fellow memberships does not occur, the slogan "seeking strength and wisdom through diversity" is merely "an en vogue banner in the era of political correctness" (p. 208). Indeed, the lack of inclusion of minorities' realities of daily injustices imposes significant limitation onto the field of MFT understanding of mental health in a broader social context. Keeney (1982) eloquently proposes that "health in human ecosystems refers to a 'vital balance' of diverse forms of experience and behavior. To engage in an effort of maximization or minimization, rather than diversity, leads to an escalating sameness we have defined as pathology" (p. 126). Close to two decades ago, Killian and Hardy (1998) asked a theoretical question "Is AAMFT subject to epistemological tunnel vision? and still today one might distraughtly reply "yes"." Hardy (1989) does not see any constructive effort from the AAMFT in order to embrace the shortcomings of the field related to the experiences of oppressed groups. He claims, "family therapy has successfully deemphasized the issues of oppression both with women and minorities" (Hardy, 1989, p. 8). Fishman (2008) believes that the seduction for being recognized as an empirically driven orientation has misguided the MFT field to unreasonably compete with more accepted, individualistic, and so-called evidence-based models such as CBT, abandoning its own powerful contextual and systemic understandings of human nature which does not simply fall into the positivist or post-positivist paradigms. Cushman (1995) laments the sociopolitical apathy of the psychotherapy as a field and states that this indifference to the direct relationship between the sociopolitical atmosphere and ordinary people's painful life experiences justifies the status quo even further.

To engage in a more radically unsettling discourse, Sue and Sue (2013) discuss that there is no rigorous research to indicate if psychotherapy is effective for ethnic minorities at all. For a systemic family therapist, there is an epistemological dilemma to accept the inappropriateness of depoliticized, oppressive, atomistic Western paradigms while encountering the perplexity of minority clients' life stories.

Gregory Bateson (1972) called such an error "epistemological fallacies" (p. 492), which is a systemic error leading to faulty conclusions about a phenomenon. In this case, family therapists' approaches in working with minority clients using individualistic perspectives mystify the significant interconnectivity of multiple social context, producing dysfunctional emotional symptoms in the first place. In such cases, what precisely a systemic family therapist fails to recognize is how they "join the forces that perpetuate social injustice" (Albee, 2000, p. 248).

Sociopolitical Differentiation of Self

Derived from Bowenian family therapy, a significant focus of family therapy academic programs has been dedicated on students' increased awareness of "Self-of-the-Therapist." The core idea behind such an endeavor is to assist novice therapists to process emotional reactions to their family of origin and become emotionally mature. This is an important process in preventing obtrusive emotional reactivity while experiencing countertransference or other forms of emotions aroused by clients and families in the therapy room. Yet, limited emphasis has been directed toward a critical self-examination of therapists' positionality (i.e., social web in relation to race, class, gender, sexual orientation, etc.) on how the larger social system (economic, political, ideological) plays a role in the mental health of individuals and families (McGeorge & Carlson, 2010). Lack of a broad implication of a sociopolitical lens toward an understanding of human behavior is inherently against the core assumptions of systemic epistemology that argues human experiences are influenced by the large context of a given society. In *his masterpiece*, *The Sane Society* (1956), Fromm stated: "…many psychiatrists and psychologists refuse to entertain the idea that society as a whole may be lacking in sanity. They hold that the problem of mental health in a society is only that of the number of 'unadjusted' individuals, and not of a possible unadjustment of the culture itself" (p. 6). Fromm challenged psychotherapists' reductionist view of mental health and proposed awareness toward social advocacy and justice in the therapy room. Green (1998) raised an important question, "will we continue to only huddle in our offices waiting for individual families to request treatment, or will we move beyond family therapy to include prevention, community intervention, and family social policy within our scope of practice?" (p. 107).

Why Address Social Oppression?

The therapist positionality and epistemology of change have been core values in the family therapy tradition. Hoffman (2002) argues that opposing the psychiatrization and institutionalization of mental health influenced the birth of the marriage and family therapy because of "pioneering psychotherapists who insisted on working

against our most persistent illusion, the stand-alone self" (p. 1). However, the neutral language of systemic theory and cybernetic perspective obscures the existing power dynamic within the system which somehow normalizes the relationship between abuser and abused and oppressor and oppressed. Therefore, the notion of social justice as a central domain of therapeutic intervention remained predominantly at the margin of therapeutic work. Historically, feminist theorists disparaged the core assumptions of general systems theory for failing to address issues of power (e.g., Goldner, 1985; Hare-Mustin, 1994). It is important to note that in order to imply a counter-hegemonic approach toward oppression and racism, one cannot overlook the power imbalances that exist within social systems such as family and society (Imber-Black, 1990). After the anti-theoretical position of feminist family therapists, other scholars expanded the conversation to other forms of social oppression such as classism, racism, sexual orientation, and immigrants' maladjustment (e.g., Saba, Karrer, & Hardy, 1989). However, it must be remembered that just recently, conceptualization of the significance of environmental factors caused by the sociopolitical atmosphere has become an important discourse (e.g., Knudson-Martin & Huenergardt, 2010).

Michel Foucault's (1980) main discourses are about resisting power and dismantling any form of ruling class hegemonic structures within a society that labels human experiences through a dogmatic dichotomy of healthy/unhealthy and normal/abnormal. Foucault approaches language not simply as collaborative communication but as an effective instrument of power used by the system in order to give meaning to people's daily life experiences (Freedman & Combs, 1996). Since psychotherapy occurs through the medium of language and communication, the very characteristics of such conversations related to the issues of power and oppression can highlight or obscure the problem of the psychotherapy subject. In the same light, a social constructionist perspective proposes that reality has been shaped by power structures at the sociopolitical level and is being internalized by individuals and families.

Foucault (1980) states that those with expert knowledge in society use linguistic jargonism to subjugate and pathologize the experience of ordinary people. Such pathology-saturated stories become internalized truth, such that people judge their bodies, achievements, and personal choices based on standards set by society's judges (psychotherapist, clergy, politicians, doctors, educators, celebrities, etc.) (Nichols & Schwartz, 2008). Therefore, therapists who have anti-oppressive orientations can occupy multiple advocacy roles and should ally with the family. In this perspective, the therapist is not just a mental health professional with a set of theories and techniques to help individuals, couples, and families to improve their relationship or feel better about themselves. Rather, their aim is to support people to recognize the pathology that resides within power discourses and social inequalities.

Almeida, Dolan-Del Vecchio, and Parker (2008) dispute psychotherapists' position of neutrality and embrace the axiom that all forms of social context, either cultural or political, shape and impact client lives at multiple level including physiological, emotional, and cognitive. Waldegrave and Tamasese (1994) argue that such awareness will create a paradigm shift for therapists in their epistemology

of change by making conscious efforts to empower clients and help them understand how different social contexts impact their lives.

Scholars from critical race theory and critical feminism demand professional mental health providers to dismantle structure of systemic oppression by empowering disenfranchised populations (Ortiz & Jani, 2010). Such advocacy for social justice in the realm of family therapy initiates new conversations. McDowell (2005) proposes that the therapist needs to occupy a "position of action" and assist their clients to fight against social injustice and inequalities that are negatively intervening with their life experiences as a human being. Almeida et al. (2008) challenge therapists to apply a sociopolitical perspective by "contextualizing the family's presenting crisis within larger crucibles of historical and contemporary public abuse toward marginalized groups" (p. 5). It is crucial to realize that the lack of a therapist's conscious opposition toward conditions of oppression is an act of morphostasis, perpetuating tyrannical status quo. For instance, a core idea of a critical multicultural approach is "aimed at dismantling structures and discourses that reify dominant cultural knowledge and further privilege the social positioning of those closest to the center" (McDowell, 2005, p. 1).

Furthermore, other critical approaches such as Just Therapy emphasize the importance of the therapist's epistemology of sociopolitical malaises by proposing social mobilization via conscious activism: "When therapists know that certain social and economic conditions prolong ill health, they should be active in creating public awareness concerning these issues…" (Waldegrave, 2009, p. 272). Therefore, family therapists can authentically claim to be a systemic thinker when they view human conditions above and beyond notorious pathology-oriented conceptualization or functionality of intrapsychic and interpersonal conflicts in family systems.

Akin to the aforementioned approaches, Beitin and Allen (2005) argue that "therapists must be equal in participation with those they seek to empower" (p. 13). They encourage therapists' active involvement in the community with their clients not only to grasp a better understanding of their experiences but also "join together to fight for social justice" (Beitin & Allen, 2005, p. 13). Prilleltensky (1994) opposes the conventional psychotherapeutic methods that intervene on theoretical separateness of subjects and environments. He argues that such epistemological positions are pro-oppression and reductionist, when "the individual is studied as an asocial and ahistorical being whose life vicissitudes are artificially disconnected from the wider sociopolitical context. Following this ideological reasoning, solutions for human predicaments are to be found almost exclusively with the self, leaving the social order conveniently unaffected" (p. 34).

Preparing the Next Generation of Conscious Therapist

Many social activists and researchers contend that we need to prepare the next generation of therapists to be involved in social justice and advocacy work so they become more conscious of their sociopolitical positions inside the power structures

(McDowell et al., 2003; McGeorge et al., 2006). Specifically, we need to aid the next generation of family therapists to become aware of how systemic coercion and subjugation of clients impacts their everyday experiences, how they engage in the therapeutic process, and how they understand their own lived experiences. However, if future therapists do not understand their own societal positions and unearned privileges and only explore clients' marginalized experiences, we will not be able to move forward. We need self-reflection to dismantle our own privileges before we can embark on understanding the pain experienced by our clients (Hardy & McGoldrick, 2008; Johnson, 2006).

If we conceptualize society as a larger family and each family as an individual member, then symptom-bearer individuals and families are merely scapegoats of purposefully disguised structural dysfunctionality of the society (larger family). Therapeutic conceptualizations targeting the symptom bearers are simply epistemological fallacies which neutral therapists transform into apparatus or enabler maintaining the architecture of such inherent injustice, inequality, domination, and oppression. Thus, the socially conscious therapist is not merely an individual with a set of theories and techniques that aims to help individuals, couples, and families to improve their relationship or feel better about themselves. Rather, their aim is to support people to recognize the pathology that resides within power discourses and social injustices. In this view, therapists transform into agents of social justice which the liberation psychologist Martin-Baro describes as "…the concern of the social scientist should not be so much to explain the world as to transform it" (1994, p. 19).

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