Position Paper: Assessment in a Feminist Framework

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 Assessment is an important and valuable component of the counselling process. The use of inventories, observation protocols, standardized tests and scales can provide important information about the client that may otherwise go undiscovered (Stewart, 2010). There have, however, been some criticisms of assessment from a feminist standpoint, particularly when referring to diagnosis and labeling. It is important here to mention that diagnosis and labeling are two different concepts, and I will therefore be addressing them separately throughout the paper. The focus of this paper will be on exploring the problematic aspects of assessment within a feminist framework, and creating an approach to assessment that is more in line with feminist principles. I have chosen this particular topic because I work from a feminist framework, and feel strongly about the principles of feminist theory. Therefore, as the theoretical position from which I practice has been critical about assessment, it is important for me to explore my beliefs and pre-conceived notions about it, as well as the distinction between diagnosis and labeling.

**A Feminist Approach to Counselling**

 As a brief overview, feminist theories place the concepts of gender and power at the core of the counselling process (Lalande & Laverty, 2010). A central premise in feminist counselling is that the personal is political, meaning that the client’s experiences are shaped by social and political influences which intersect with personal spheres (Worell & Remer, 2003). Furthermore, egalitarian relationships are central in the counselling process, and power differentials between client and counsellor are acknowledged (Lalande & Laverty, 2010). Feminist therapists help clients to depathologise women’s experiences, and reformulate the approaches towards diagnosis and labelling of women in the counselling process. For example, mental health illnesses such as depression, are seen in a larger social context and related to women’s experiences of oppression, rather than the individual’s own problematic functioning (Worell & Remer, 2003).

**My Professional Challenges with Diagnosis**

 As a counsellor on the Toronto Rape Crisis Line, I frequently speak with women who are stigmatized in our society, because of mental health issues they are experiencing. Women who have survived sexual violence and are dealing with the aftermath symptoms of depression or anxiety are typically labelled as dysfunctional or mentally unstable (Nicki, 2011). In Canada, women are vastly overrepresented in the mental health care system, and are twice as likely as men to be diagnosed with a mood disorder (Lalande & Laverty, 2010). A quarter of women in North America have been prescribed anti-depressants, compared to 12% of men (Bindley, 2011), which leads me to ponder if women’s complaints about sadness are more likely to be pathologised by their doctor than male patients. I believe that the definition of mental health, and the diagnoses based upon this definition is largely determined through a dominate male culture’s lens, which pathologizes women’s understandable reactions, for example, reacting to sexual violence with long term experiences of depression and anxiety.

**Current Thinking on Diagnosis from a Feminist View**

 Prevailing medical models of mental illness, such as those found in the diagnostic and statistical manual (DSM) locate the problem within the client and place emphasis on diagnosis and labeling (Worell, 2001). When assessment and diagnostic tools are created within the dominant culture, those assessed who are from the non-dominant culture can be viewed as “deviant, deficient and changeworthy” (Worell, 2001, p.335). Therefore, any behaviour that deviates from societal norms (as defined by the dominant culture) is seen as disordered. It has been theorized that women are so frequently pathologised through diagnosis that “borderline personality disorder simply took the place of hysteria, capturing contemporary values about the behavior of women” (Ussher, 2013, p.65). I find that diagnoses such as those of borderline personality disorder (BPD) can be problematic, as clients with BDP are typically viewed as “demanding, angry, aggressive women” who are difficult to treat (Ussher, 2013, p.66). Having a diagnosis of a mental illness can lead to experiences of stigmatization, lowered self-esteem and depression (Lalande & Laverty, 2010). BPD has a negative stigma attached to it, and the label of ‘being borderline’ can eclipse the client’s natural strength and resiliency (Mezzich, 1999).

**My Conceptualization of the Role of Assessment, Diagnosis and Labeling in Counselling**

 In terms of my own understanding of assessment and diagnosis, I acknowledge that prior to taking this course, I held a bias towards assessment as a general term. I believed that assessment only meant testing and diagnosis, which automatically led to labeling and stigmatization. Through the feminist-based education I received at the rape crisis centre, I learned that diagnoses through the DSM were damaging, and anti-feminist. I began this course feeling that assessment was a negative, dehumanizing, reductionistic process. I now, however, have a better understanding of what assessment is, and how it can be a critical process in counselling. Assessment is an ongoing process in the counselling relationship, and involves using formal or informal techniques to better understand psychological, social, biological and cultural factors that influence a client’s behaviour (Stewart, 2010). During this process, the counsellor makes a series of decisions and takes a number of actions that help to create treatment goals and guide interventions (Stewart, 2010). It is a more complex and broadly defined term than diagnosis, as it involves personality dispositions and contextual factors (Stewart, 2010). Assessment can also benefit the counselling process by adding depth to the relationship (MacDonald, 2013a). It can allow for deep-rooted issues to emerge, which may not have not otherwise come to light. By effectively using assessment skills, the counsellor can hone in on specific issues that are important for the client to address (MacDonald, 2013a). I feel that this definition of assessment would fit into my feminist approach to counselling.

 In terms of diagnosis and standardized testing, I am still somewhat weary of this process as it relates to feminist counselling. We have come an incredibly long way in terms of how we diagnose clients, but I feel we still have far to go; as recently as the 1960’s, homosexuality was seen as a mental disorder in the DSM. However, I do see the value in obtaining information through these tests in order to gain a deeper understanding of a client’s level of functioning. A major learning for me in this course was differentiating between the terms ‘diagnosis’ and ‘labeling’. At the outset of the course, I assumed (largely from my feminist education) that they were the same concept, and diagnosis is an overly negative concept. However, my learning in this course has led me to discover how a diagnosis can be helpful. As aforementioned, it can provide detailed information about the client and his or her functioning, and offers a more structured discovery process that is based on concrete evidence rather than the counsellor’s own interpretations. Furthermore, it can be helpful in qualifying clients for necessary support, such as financial aid through the government (Mezzich, 1999). It can also be useful in my ability to collaborate with my clients as well as with other people involved in their care. For example, this fall I will be commencing my practicum at York University’s counselling centre. If a client I am working with has been diagnosed with a certain disorder, this is useful information that I can easily communicate this information to my supervisor to help us formulate a treatment plan. Diagnoses can also help me guide my interventions. For example, certain therapeutic techniques have been proven in research to work effectively with certain client groups. If I had a client with borderline personality disorder, I may consider using a dialectical behaviour therapy approach (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004).

 Labelling, on the other hand, can be harmful as well as dangerous (MacDonald, 2013b). Labeling refers to the application of a title on a person without the proper diagnostic process to back it up. In no uncertain terms, this is unethical behaviour. Labeling can also negatively affect a client’s sense of self-esteem (Anderson & Gold, 2008). Referring to a client as “a borderline” is reductionist and depersonalizing as it reduces the client to a label as their identity (Hood & Johnson, 2007). A more humanistic approach would be to refer to your client as “an individual with borderline personality disorder”, in order to clarify that the disorder is just one aspect of, not the whole identity of the client.

**My Course of Action Plan**

 It is important for me to continue developing my understanding of assessment in counselling, as to date, my knowledge is very limited on the topic. In order to better understand the role of assessment within a feminist framework, I will continue to conduct research this topic. In researching for this paper, I have found many articles that offer feminist approaches to assessment. It is important during the assessment process to be aware of how my cultural lens impacts the counselling relationship (Stewart, 2010). For example, I may minimize my client’s fear of police officers, and try to ease his anxiety by explaining that they are not ‘out to get him’. I might assess his weariness of police officers as paranoia. As a White person, who happens to be married to a police officer, I have never felt threatened by police presence. However, this client who happens to be Black, grew up viewing the world through a completely different cultural lens, where police officers were not to be trusted. Before I make assessments on this client, it is imperative that I strive to further understand how his social location has shaped the way he experiences his world. In order to do so, I will explore with the client his experience of being a member of his culture, and his culture’s social expectations. It is also important to explore these factors from that specific client’s viewpoint, instead of making an assumption based only on what I know about his culture (Stewart, 2010). In this way, I can begin to understand what normal behaviour is for him, and I can then more accurately assess his future behaviours.

 I will also approach assessment from a strengths based position. Instead of focusing on only the deficits in clients, I will emphasize my clients’ strengths, particularly when communicating the results of their assessment (MacDonald, 2013b). I will also ensure that all assessment processes I use are collaborative and transparent so the client is fully involved in the process. This approach is vital in order to lessen the power differential between myself and my client (Lalande & Laverty, 2010).

 In conclusion, it is important for me to continue learning about assessment practices, in order to continue to challenge my judgements around it. It is clearly an integral component of the counselling process. In order to move forward with my practice of assessment in a feminist, person centered approach, I will continue to focus on my client’s social and political contexts in relation to their issues, avoid pathologisation and promote a collaborative relationship.

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