CLIENT-CENTEREDNESS, POWER AND POSTCOLONIAL FEMINISM: How occupational therapists can become leaders in mental health

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Occupational therapists consider client-centred practice as a central value of occupational therapy (OT). The belief in egalitarian power-sharing relationships between therapists and clients is widely taught in Canadian university programs in OT and is part of many practice settings. In the field of mental health, attention to power structures is vital, as there are many vulnerable clients. Within this field, occupational therapists are well positioned to step into leadership roles. However, in order to act according to OT principles of client-centredness, to advocate on behalf of clients, and to advance and improve OT practice, occupational therapists must be willing to critique and examine the theories and foundations on which their practices are based. Postcolonial feminist theory not only provides a framework for such critique, but also provides a multitude of ways occupational therapists can act to make OT a profession of leaders in mental health and health care at large. Occupational therapists can draw upon the principles of postcolonial feminism to understand the connections between client-centredness, power, and the role of OT in mental health.

Before discussing the specific ways in which postcolonial feminist principles can impact the practice of occupational therapy, it is important to have a good grasp of the meaning of these concepts. First of all, various ideologies will be discussed in this paper. An ideology is “a system of ideas, beliefs and assumptions that operates below one’s level of conscious awareness and, by being taken for granted, appears to constitute normal common sense” (Hammell, 2006, p 205). Feminism has been defined in many ways, but simply it can be seen as a response to the systemic oppression of women in society, and the questioning of the right of one group to have power over another (Proctor & Napier, 2004). Feminism can be practiced at a variety of levels: daily life and everyday activities; relationships and community; collective action in groups, networks, and movements; and theory and writing in academia or the production of knowledge (Mohanty, 2003). Feminist theory can influence OT practice at any of these levels. Postcolonialism is another set of theories that can intersect closely with feminism. According to Hammell (2011), postcolonial theories critique and expose how dominant groups in society give power to their own values by defining and
marginalizing other groups who do not have access to societal power. Postcolonial perspectives are inherently political, as they are focused on eliminating injustice and inequalities within social hierarchies, particularly for people who are marginalized (Hammell, 2006). Postcolonial feminism is the interweaving of the struggle to uncover and change the systems in society that oppress women with the recognition that there are many layers of oppression in society at many levels of identity.

It is important to ask why therapists should use this theoretical perspective in OT practice. Occupational therapists believe there is a relationship between occupation, well-being, and health (Hammell, 2008). Postcolonial theory contends that people’s well-being and occupations are influenced by the environments in which they live, including the physical, social, political, economic, and cultural environments (Hammell, 2011). However, much of the literature within OT focuses on individual issues and places emphasis on personal impairment (Hammell, 2011). This is problematic, since ignoring or even de-emphasizing the impact of environmental factors means ignoring the oppressive constraints economic, political, and policy could be having on people’s lives (Hammell, 2011). Oppression refers to experience of disadvantage and injustice, and includes marginalization, cultural imperialism, powerlessness, and exploitation. (Hammell, 2008).

Postcolonial theory is useful for taking a close look at the judgments that we make about what is considered normal, the oppressive effects these judgments have on people who are deemed “abnormal”, and the use of these judgments to justify inequities in our society (Hammell, 2006). Furthermore, since occupational therapists value client-centredness, they should strive to be client-centred in their actions (Hammell, 2006). This would require challenging the structures of power encountered within the profession, academia, and workplaces (Hammell, 2006). Finally, applying feminist theory can make a therapist more sensitive to people’s lived experiences, which would help occupational therapists to promote themselves as leaders in client care (Hammell, 2011).

Occupational therapists can use postcolonial feminist principles within each therapeutic relationship. In mental health there are existing models of practice that have been built upon or
incorporated feminist principles, and may be helpful to see how feminist principles can be incorporated into practice. One of these is the person-centred approach (PCA). PCA rests on the central tenet that individuals have the ability to guide their own lives in a way that is satisfying and constructive (Proctor, 2004a). Both feminist theory and PCA respond to the structural aspects of society that place one group in power over another group or individual, both are reactions against hierarchies of power, and both strive to liberate people from the damaging methods of control society imposes (Proctor & Napier, 2004).

However, whereas PCA is an approach that focuses on individual relationships, feminism focuses on understanding the relationships between individuals and wider societal structures of power and the criticism of patriarchal institutions (Proctor & Napier, 2004). Occupational therapists can take note of this distinction and improve upon PCA to work with individuals using aspects of PCA to recognize individuals’ interpretations of their lives, and aspects of feminist theory to recognize the larger forces in society that impact individuals’ lives. For example, feminism considers gender and the effects of sexism when attempting to understand an individual’s experiences (Proctor & Napier, 2004). In particular, occupational therapists can benefit from PCA and feminist theory’s shared stance on power: it is important to consider, with each client, the damaging effects of power, authority, and coercion, and to advocate for each client’s internal sense of agency (Proctor & Napier, 2004).

A feminist perspective can also help occupational therapists critique dominant constructions of mental illness in medicine. Through the consistent emphasis on environment as a factor in a person’s mental illness, feminist theory provides an alternative to the medical models’ understanding of diagnosis, and does not assume that mental illness is always the result of internal pathology (Napier, 2004). The redefinition of pathology is also an important way feminist principles interact with mental health. Feminism can reveal how women’s reactions to various forms of violence or abuse have been traditionally seen as pathological, but could instead be seen as an
adaptive way of dealing with the abuse (Proctor & Napier, 2004). Furthermore, therapists who incorporate feminism into their practices seek to understand clients and offer assistance without labeling clients’ feelings and thoughts as abnormal (Proctor & Napier, 2004). This way of relating to clients could help to lessen the power imbalance in a therapeutic relationship.

Critique of the labeling of clients and the use of gendered diagnostic categories has grown over time, and continues recently in the challenge to the diagnostic category of borderline personality disorder (BPD) (Napier, 2004). BPD is predominantly diagnosed for women, most of whom are survivors of abuse (Proctor, 2004b). This is problematic because the diagnosis does not appear to take into account the effects of trauma, but instead focuses on the personal and internal characteristics of the individual. Additionally, as the medical community has a history of denying the extent and impact of abuse, BPD diagnosis can be seen as an extension of this denial (Proctor, 2004b). The defining symptoms of BPD could alternatively be understood as memories, thoughts, and feelings associated with the trauma that survivors of abuse have used in order to cope with the trauma (Proctor, 2004b). Feminist theorists argue that the label of BPD locates all distress within an individual, thereby decontextualizing it from any social causes (Proctor, 2004b). A feminist analysis of a client’s situation can help an occupational therapist understand the potential impact of violence as well as improve the therapist’s understanding of power in therapeutic relationships (Proctor, 2004b). The way in which a therapist interacts with clients with BPD will differ based on the therapist’s ideological perspective (Proctor, 2004b).

Research from the field of disability studies has demonstrated that therapist-client interactions are often predicated on an ideological perspective that can be seen as colonizing attitudes (Hammell, 2006). Services and professionals in the rehabilitation field have been described as oppressive, irrelevant, decontextualized, dehumanizing, and reinforcing of power differences (Hammell, 2006). Moreover, clients see professionals as pessimistic, indifferent, and controlling (Hammell, 2006). These descriptions reiterate the dominant culture of health care that
places professionals in the position of experts who have power over clients. For occupational therapists to work within a postcolonial feminist paradigm, the first steps they would have to take would be to relinquish power (Hammell, 2006). Power can be emphasized in education, assessment, intervention, and other professional activities (Hammell, 2006). Therefore, it is of utmost importance that an occupational therapist who strives to be client centred challenges and questions the beliefs and systems in each of these areas. This is something that can be done by individual therapists in their own practices. It is also imperative to note that clients have said that what they value most is professional expertise, but therapists who value clients as human beings (Hammell, 2006). The role of occupational therapists includes the acts of questioning, challenging, and critiquing ideas that are put forth as “common sense” (Hammell, 2006).

Clients’ personal stories help to demonstrate where occupational therapist leadership is lacking. An openly gay client who was on an inpatient psychiatric ward in a hospital recounts an experience of being made invisible by clinicians. The client said that staff had “a tremendous amount of tolerance for other people hurling slurs... I think its lack of information and lack of training... I think that a lot of people don’t like conflict on that type of level. In a clinical setting, someone might be afraid to stick up for the queer girl because they are afraid of how they will be perceived” (Barbara, Chaim, & Doctor, 2007, p 41). In this situation, had an occupational therapist acted on the feminist principle that everyone is of value, then staff would not have been perceived maintaining the peace to be more important than combating the oppressive attitudes toward this client.

There are some programs that do incorporate aspects of postcolonial feminism. One of these is the Canadian Association for Mental Health’s suggestions for celebrating, communicating, and connecting with young women with mental illness (Validity Team, 2005). This program seeks to promote diversity and empower young women with mental illness. Its suggestions are compiled from young women clients, and include: combating sexism through role modeling, changing waiting room environments by having realistic posters and magazines catered to diverse interests, and creating
partnerships with organizations that support realistic and empowering images and roles for women (Validity Team, 2005). This program is a good start, but does not reflect an awareness of intersecting axes of oppression, and is geared toward a specific clientele. Other programs can build upon these suggestions to create inclusive practice environments and that strive to reduce oppression within therapeutic relationships.

Occupational therapists can use the principles of postcolonial feminism to affect society in a broader way than individual relationships. On a societal level, occupational therapists can work to ensure the occupational rights of clients living with mental illness by being activists for political and policy changes. According to Hammell (2006), professional ideologies justify and place privilege upon expert knowledge and authority which reinforces professional power and dominance. For autonomy and self-determination to occur for all clients, a form of decolonization must occur (Mohanty, 2003). This can be achieved through self-reflexive collective practice (Mohanty, 2003), meaning therapists must maintain vigilance in reflecting upon their choices and actions within their practice.

Language choices are one way in which occupational therapists can apply postcolonial feminist theory to practice. Theorists in disability studies use the term “disabled people” instead of “people with disabilities” to refer to people who have been disabled by society’s impact on their impairments (Hammell, 2007). In the field of mental health, some clients prefer the term “consumer” while others find that term does not encompass the ways in which clients interact with the health care system (Hammell, 2006). Others may use the term survivor to describe themselves. With this multitude of terms used, occupational therapists must be aware of how each individual client wants to be seen, and how each person refers to him or herself. By giving the power of self-definition to clients, occupational therapists help shift the balance of power. Furthermore, by advocating within institutions for policy to reflect clients’ self definitions, occupational therapists can achieve change in power structures on a broader level.
Occupational therapists can view their place in the power structure of our health care system as colonizers, and with clients as the colonized (Hammell, 2006). While OT does purport to be collaborative, in reality occupational therapists hold the power to determine acceptable goals for clients, and to determine how intervention will occur (Hammell, 2006). This system of oppression serves to constrain clients to an inferior, dependent role (Hammell, 2006). OT faces the challenges of systemic oppression beyond individual institutions as well. The economic systems in our society reinforce the power of the dominant groups over the marginalized. An economically and socially just postcolonial feminist politics needs to have a clear understanding of how marginalized groups face unfair consequences of being a part of those groups depending on the level of economic and social marginality (Mohanty, 2003). As well, postcolonial feminist politics needs to have a recognition of the ways sexism, misogyny, racism, ableism, and heterosexism support and uphold ruling institutions, and often lead to hatred and stigma of marginalized groups (Mohanty, 2003). Clients with mental illness have historically faced, and continue to face, this type of stigma, which is upheld by the way society’s political and economic forces maintain traditional, patriarchal power structures that assert they know what is best for the less powerful. Therefore, in order for occupational therapists to truly work towards empowering clients living with mental illness, they must advocate in the political arena for change in how we, as a society, support people within marginalized groups, and give voice to people who have been silenced.

Having discussed the links between postcolonial feminism, power, and client-centredness, this paper will now address the question: where does occupation fit in? OT’s core assumptions include: people can influence their health; occupations contribute to life’s meaning, humans can participate in occupations as autonomous agents, and occupation can and should be divided into categories of self-care, leisure, and productivity (Hammell, 2009). This highlights the neglect of occupations concerned with human interdependence and connectedness. Upon reflection back to definitions of the person-centred approach and feminist theory within mental health, it is notable
that both PCA and feminist theory focus on relationships and their meaning at individual and societal levels (Proctor & Napier, 2004). This is clearly minimized in OT perspectives on occupation, as there is little mention of relationships or connectedness within the major models of the PEO or the CMOP-E. Instead, these models are individual-focused with the minor inclusion of “social environment” to hint at relationships. While promoters of current categorization within OT suggest that any occupation can be made to fit in one of the categories, it can be very difficult to force certain occupations into these spaces. For example, prayer or meditation, caring for others, or sitting by a person’s bedside while they are ill are difficult to sort (Hammell, 2009).

Hammell (2009) relates the story of a man who is the primary caregiver for his wife, who has a severe neurological impairment. He dedicates most of his time and energy to his wife’s care, doing almost everything for her. He strives to enhance his wife’s quality of life through his caregiving, at the expense of his own physical health. While this may appear to be a productive occupation, as he is contributing to the economic fabric of society by removing the need for a paid caregiver, the labeling of it as just a productive occupation ignores that the ways he provides care may contribute to the quality and meaning of his life. In reality, he may see many of his caregiving activities as leisure, or even as self care if his own wellbeing is improved. With this discrepancy in definition, how can occupational therapists classify occupations that are based on relationships and connectedness into only one category?

According to critical disability theorists, the emphasis on occupations that contribute to the economic fabric of communities (such as productive occupations) places people who are seen as unproductive lower in the hierarchy of power and reinforces their marginalized economic social status (Hammell, 2009). Recent critiques of occupational theories have argued that these theories are often based on assumptions that are culturally specific, classist, and ableist (Hammell, 2011). Postcolonial feminism can benefit an understanding of occupation by providing a rationale for valuing occupations that do not contribute economically, but may contribute to society in other ways.
Furthermore, occupational therapists must be aware that theories of occupation may achieve widespread use not because they are the best theories, but because they have been created by people in an environment that has the best access to power and marketing (Hammell, 2011). Because theories of occupation inform the practice of OT, it is important that these theories change so that they are not grounded in assumptions that prevent the empowerment of clients (Hammell, 2011).

A new direction for OT is to advocate for people’s right to occupational engagement and participation (Hammell, 2008). Occupational rights could be defined as “the right of all people to engage in meaningful occupations that contribute positively to their own well-being and the well-being of their communities” (Hammell, 2008, p 62). Since well-being cannot be attained under oppressive conditions that prevent meaningful occupation, and since there is a link between well-being and participation in meaningful occupation, there is a relationship between oppression and occupation (Hammell, 2008). For occupational rights to become valued in our society, occupational therapists must engage politically with issues that prevent people from attaining or exercising their occupational rights. This can be done through engaging with issues of marginalization, exploitation, and the limitations on opportunities and resources for disabled people (Hammell, 2008).

Occupational therapists must also reconceptualize how we regard clients: instead of seeing clients as “good” (submissive, cooperative, obedient, compliant), or “bad” (assertive, self-directed, critical), we must collaborate with clients to build on those behaviours that will enable them to successfully live with a mental illness (Hammell, 2006). Instead of therapy focused on making our clients “normal”, OT should involve a process of enabling our clients to have pride and dignity, not denying difference but instead make it not matter, and provide the resources and environment to make it possible for clients to see themselves as equal and deserving of their right to occupation (Hammell, 2006). This means focusing on people’s strengths, tearing down social and political barriers to opportunities, and resisting classifications that divide people (Hammell, 2006).
Occupational therapists must engage in reducing the oppressive conditions and circumstances of their clients, both in a societal and political arena, and in personal practice. To avoid this critical thinking and action is to be in collusion with the oppressive forces that disable our clients and limit their ability to exercise their right to occupation. Occupational therapists must therefore always be doing their utmost to change conditions of oppression; otherwise, we are not enabling our clients or acting in a client centred manner, but instead participating in a system that oppresses our clients and exercises power over them. To be silent is to be complicit.

In summary, the values of OT and postcolonial feminist values are and should be closely linked in order to provide mental health intervention in a way that truly impacts occupational engagement and participation. By virtue of postcolonial feminism’s principles, this combination of theoretical approaches is valid not just in “western” culture, but in other environments and contexts as well, and can be regarded as culturally respectful. It is only through recognizing, critiquing, and challenging the multiple axes of oppression faced by our clients that occupational therapists can truly become client centred.
Locating yourself as a therapist: A self-reflection tool

Occupational therapists and OT students are socialized to think of themselves as lacking power in comparison to other health care professionals (Hammell, 2006). Due to this, they are unaccustomed to thinking about where they fall within axes of power, or their own values and assumptions in terms of ideologies (Hammell, 2006). OTs do participate in a dominant ideology of health care, as the idea that their theories, beliefs, and interventions are beneficial is seen as natural (Hammell, 2006). A dominant ideology operates by legitimizing inequalities and entrenching power relations (Hammell, 2006). Therefore, occupational therapists have an obligation to reflect on their power, values, and assumptions.

Here are some questions to guide therapists in this type of self-reflection:

1. In what ways am I oppressed by societal structures? (On the basis of gender, race, sexual orientation, impairment, disability, class, and so on)
2. In what ways do I have privilege and power due to societal structure?
3. How do these impact how clients see me?
4. How do I mitigate the privilege I have in my relationships with my clients?
5. Am I being client-centred? In what ways?
6. Is my practice environment contributing to or challenging accepted power structures and oppressive barriers to occupational rights?
7. Am I contributing to or challenging accepted power structures and oppressive barriers to occupational rights within my therapeutic relationships?
8. Reflect on your personal mission versus the realities of practice – compare your vision of occupational therapy with the realities of what you do every day. Are there things you want to change? Are there things you don’t have power to change? (Duggan, 2005)
9. Reflect on your clinical experience: what are positive experiences you’ve had with clients or practice settings, and what are negative experiences? Why? (Duggan, 2005)

Here are some ideas for becoming more self-reflective:

- Start a reflective practice group with colleagues to discuss these issues (Duggan, 2005)
- Include discussion of client-centred practice in team meetings (Duggan, 2005)
Take 5 minutes each day to reflect on your day and what went well, and how you could use principles from postcolonial feminist theory to make your practice more egalitarian and client centred.

Observe colleagues and ask questions about their approaches (Duggan, 2005)
References

Ballon, D. & Gamble, N. (2005). *Beyond the label: An educational kit to promote awareness and understanding of the impact of stigma on people living with concurrent mental health and substance use problems*. Toronto: Centre for Addiction and Mental Health.


Validity Team, CAMH. (2005). *Hear me, understand me, support me: What young women want you to know about depression*. Toronto: Centre for Addiction and Mental Health.
Appendix A

From *Hear me, understand me, support me* - A guide to applying the “my health, my life” framework (Validity Team, 2005, p 64-65).

We asked a group of young women to review the VRHB framework and see if it made sense to them when looking at issues related to depression and young women. They made adaptations and created a tool that reflects their lives and identities. It’s called “My Health, My Life” (see below).
Suggestions for using the My Health, My Life framework in work with young women

- Copy it and post it in your office or examination rooms.
- As a way to initiate talk with young women, give them a copy and ask what they think about it.
- Ask them to draw an “x” or an arrow in any area they think may be affecting their health and well-being.
- Use it as the basis for an activity in your classroom. For example, ask young women to write an essay response to the question, “Which area of health do you think affects young women the most?” and/or “Does this area of health affect young men as well, equally? Why or why not?”
- Ask young women to create posters, poetry or art based on the ideas in the My Health, My Life framework.
Appendix B

From Beyond the label toolkit: activity to do with a group (Ballon & Gamble, 2005, p 22-24)

Beyond the Label has been designed to:

1. Help service providers ensure that their services are accessible and supportive to people with concurrent mental health and substance use problems by examining stigma and the barrier it presents
2. Provide mental health and addiction workers with concrete tools to use in their agencies and in the community, to raise awareness about the stigma associated with concurrent disorders.

(From Ballon & Gamble, 2005, p 1)
2. Hand out one activity card to each participant (or small group).

3. Have each participant (or small group representative) read the label out loud and list some of the negative stereotypes attributed to this label.

4. Ask the entire group what limits or barriers this might present for someone.

**NOTE TO FACILITATOR**
To further illustrate the impact of labels, you could write down the label on a flipchart, list the responses and then tape the flipchart paper onto the wall to give a visual representation.

5. Pose the following question: “Imagine if you were someone who had to wear several of these labels at once.” (Discuss.)

**NOTE TO FACILITATOR**
To illustrate the multi-layers of stigma, you could collect the cards and then select one “addiction label,” one “mental illness” label and a third (or even fourth) label, and ask participants to discuss the additional challenges and barriers someone with all of these labels might experience in his or her daily life.

6. Ask participants to suggest words or phrases to replace some of the labels.

7. In closing, note to participants that other “limits of language” can include low literacy levels, English as a second language and the use of jargon.

**KEY MESSAGES**

- Stigmatizing labels create barriers and lead to prejudice and discrimination.
- Language can hurt emotionally and psychologically.
- The stigma associated with concurrent mental health and substance use problems can prevent people from seeking help.
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“The limits of my language . . . mean the limits of my world.”

—Ludwig Wittgenstein (1963)