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Counsellors' Beliefs on Social Justice and the Medicalization of Counselling

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A thesis submitted in partial fulfillment of the requirements for the Master of Arts degree in Education

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Abstract

Counselling is becoming more standardized under a medicalized discourse of diagnosis and manualized treatment partly due to changing standards and administrative needs (Strong, 2017). Through semi-structured interviews and thematic analysis, this study explored how social justice-oriented counsellors are impacted by the medicalization of counselling. Counsellors stated medicalization was pathologizing individuals, marginalizing groups, and homogenizing therapeutic work. Driven by systems and industries gatekeeping resources, maintaining the social status quo, and the profession's pursuit of prestige and profit through the medical model, the medicalization of counselling has been steadily growing. Counsellors centered the profession's emerging identity as primarily relational in the nature of the work, with client-centered and feminist approaches reducing the power differential between client and counsellor. Counsellors believed that decolonizing counselling and adopting a multicultural, trauma-informed, and de-pathologizing approach to assist clients through holistic and individualized treatments would be beneficial to clients and the counselling profession.

Keywords: medicalization, counselling, social justice, relational, pathologizing

Lay Audience Summary

The treatment of mental health problems through counselling is becoming more similar to the treatment of physical health problems through medicine. A focus on individual biology and characteristics, standardized therapeutic practises, and the expansion of which issues can be considered health issues or disorders (such as grief, trauma, and substance use) contribute to a medicalized approach to mental health and its treatment. A medicalized approach to counselling has a number of problems from a social justice perspective, including locating mental health problems within the individual, not accounting for social and environmental impacts on mental health, and diagnoses being used as a method of social control. To understand how the medicalization of counselling is impacting counsellors who use a social justice perspective, this study conducted semi-structured interviews and analyzed their statements to create five themes.

Counsellors stated medicalization was pathologizing people due to its perspective of issues emanating from within individuals, which particularly impacts marginalized peoples due to systemic discrimination and inequality, environmental impacts that are not accounted for in the individualized model. The medicalization of counselling is seen in the narrowing of therapeutic modalities supported by insurance, such as standardized treatments like cognitive behaviour therapy. Counsellors reflected these changes are driven by governments and companies' desire for low-cost therapy, maintaining the social status quo, and counsellors pursuing prestige and profit through the medical model. Counsellors stated counselling should be relational, holistic, and focused on the client's individual characteristics, treatment preferences, and power within therapy to reflect multicultural, trauma-informed, and decolonial practises.

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Counsellors' Beliefs on Social Justice and the Medicalization of Counselling

In the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V), the American Psychiatric Association (APA) updated the Major Depressive Disorder diagnosis by removing an exclusion for grief and bereavement, indicating that those mourning the loss of a loved one could have a clinical mental disorder (APA, 2013). According to the DSM-V, if a person is still experiencing significant depression two weeks after the loss it could mean that they have an illness, rather than continuing to process a devastating life event (APA, 2013; Dalal, 2018). This is a recent example of how aspects of the human condition are being redefined as medical issues in Western society, but this has been occurring for decades. If a child cannot be silent and still in a classroom, then they may have Attention Deficit Hyperactivity Disorder (ADHD). If they disobey adults, then they may have Oppositional Defiant Disorder. Common aspects of the human condition and behaviour that deviates from the norm are being turned into psychologically-disordered behaviour, complete with its own patented treatments. The number of psychiatric diagnoses has risen in concert with the sale of pharmaceutical medications, with ADHD and antidepressant drugs increasing 500% and 400% between 1990 and 2001, respectively (Dalsgaard et al., 2013; Mojtabai, 2008). The collective discourse in society regarding mental health is becoming more medicalized and the reasons behind this continuing process are many and large in scale.

In the field of psychology there has been a growing trend of using the theoretical orientation and structural framework of the treatment of physical health to the treatment of mental health (Strong, 2017). In regard to counselling for mental health concerns, this trend is known as the "medicalization of counselling" (Strong, 2017, p. 3). Nerves,

personality differences, and interpersonal problems have been the subject of many different kinds of examination and healing over the years, from priests, shamans, elders, and doctors. Throughout this continuing process of advancement mental health has not garnered the same respect or funding that physical health has, as the issues are more difficult to conceptualize and less visible (Dalal, 2018). The opinions of professionals vary in agreement more often in regard to mental health issues than they do for physical health issues (Huda, 2020). In the pursuit of pedigree and consistency, the mental health field has adopted the medical model to explain the complicated mental processes and the maladies of the human condition (Strong, 2017). By using the tools of exact scientific measurement to determine whether a person has a psychological disorder like depression or ADHD, just as they would to diagnose cancer or assess a broken leg, health professionals may be trying to squeeze a square peg into a round hole. As the previous president of the American Psychological Association, George Albee, wrote, “Mental health is not ‘an illness like any other’” (Albee & Joffe, 2004, p. 1).

While the increased use of positivist conceptions and empirical measurements from the medical model has allowed for great strides in the ways that some mental health issues are managed, it focuses heavily on individuals and their chemicals, while failing to account for socioenvironmental influences on mental health (Engel, 1977). This view of health and wellbeing is reductionistic and decontextualized, encouraging physicians to ascribe the source of the misery to within the individual, regardless of society-level stressors like poverty or structural racism that may be affecting the individual (Huda, 2020; Winter & Hanley, 2015). In this way the medical model presents an approach that discriminates against marginalized people. This is exacerbated by the dichotomous

perspective on health that is used in the medical model, as an individual is either labelled as normal and healthy or abnormal and sick (Engel, 1977). By classifying some people as “sick”, “abnormal”, or “disordered”, the medical model creates a layer of stigma around mental health that discourages people from discussing their issues and contributes to the alienation that can substantially worsen their problems (Strong, 2017).

While the field of counselling has become more medicalized in recent years, there have also been advances in the social justice movement within counselling. Many counsellors (for brevity the term “counsellor” will encompass both counsellors and psychotherapists) consider social justice as an integral part of counselling, as the populations that have the highest rates of mental health concerns are often disadvantaged by societal problems such as wealth imbalance, oppressive practices, and structural racism (Brown, 2019; Vera & Speight, 2016). Therapists that work to identify and alleviate these large scale issues are indirectly reducing the amount of people that require therapy, a practice known as primary prevention (Albee, 1986). The effects of this work can be seen in addiction programs that changed from an abstinence-only perspective that the medical model recommends to an anti-oppressive harm reduction model, acknowledging that substances can be a method of coping with the problems of an unjust society (Kellogg & Tatarsky, 2012). However, more research is needed to elucidate the challenges that social justice-oriented counsellors face in their professional work.

While the medical model impacts those seeking mental health help, it also has a significant impact on the counsellors that provide therapeutic services, as well as the infrastructure of counselling. There is an emphasis on therapeutic techniques that have been shown to be effective in experimental studies, as well as those which fit an ideology

such as abstinence-only programs for addiction issues. This can constrict therapists by only allowing a narrow range of specific treatments for client problems when working in larger organizations (Kellogg & Tatarsky, 2012). This can be seen most explicitly with the rising popularity of cognitive behavioural therapy (CBT), which has been researched more extensively than any other therapeutic approach (David & Cristea, 2018). The ability to produce effective results in experimental conditions conforms with the empirical perspective used in the medical model, while some other therapies utilize active listening and the development of a relationship to address psychological concerns, which can be difficult to quantify. As Dalal (2018, p. 4) states, “in order for something to count, it has to be countable.”

CBT is a manualized problem-focused approach that involves clients challenging the maladaptive thoughts that contribute to their psychological wellbeing (Hofmann et al., 2012). Its use of psychoeducation and homework assignments enables it to be delivered briefly and over the internet, reducing the time spent with a therapist (Dalal, 2018). This makes it cost-effective for health insurance companies and governments to implement, while the “individual control” approach to thoughts and behaviour is aligned with the neoliberal ideologies of most Western governments and companies, which emphasize self-sufficiency (Dalal, 2018). The focus on immediate symptom reduction, rather than exploring the sources of the problem, gets people off of their benefits and back to work sooner, similar to how ibuprofen allows people to work with pain (Dalal, 2018). Some people can only get coverage from their insurance companies if the therapist uses CBT (Syed, 2017) and 68% of the therapy provided by the United Kingdom’s

National Health Service in 2014 was CBT-based (Clark, 2018). The rise of short-term CBT is a prime example of how counselling is becoming medicalized.

The purpose of the present study is to explore counsellors' beliefs about the medicalization of counselling and the role that social justice can play in humanizing this process. An assessment of the medical model and social justice is vitally important in the current sociopolitical climate, as there has recently been significant upheaval for both medicine, in terms of the novel coronavirus (Khurshid et al., 2020), and social justice, in terms of the Black Lives Matter movement against systemic racism (Egede & Walker, 2020). There is an increased need for psychotherapeutic services to help people manage the realities of a global pandemic and a structurally unjust society (Vostanis & Bell, 2020). As such, it is important to give a voice to front-line counsellors and listen to their beliefs and experiences regarding the challenges of working within the medical model and the importance of integrating social justice practises into counselling.

The following section will expand on the rationale for and against the use of the medical model in mental health, as well as discuss how social justice is connected to counselling, and whether a social justice approach can be used to detract from the medicalization of counselling. This study utilizes a qualitative design to explore how medicalization has impacted the therapeutic and social justice practises of counsellors.

Literature Review

Medical Model

The medical model, otherwise known as the biomedical, organic, or disease model, uses molecular biology as its basic scientific discipline and assumes that mental disorders arise from abnormalities in the biology of the brain (Strong, 2017). The medical

model refers to any system that medical professionals use in their clinical work or research (Huda, 2020). This system is comprised of two mutually influencing aspects: *practice*, the way physicians interact with their patients and identify, classify, and intervene in the client's presenting problems, and *explanation,* a description of the nature of these problems and how they came about (Huda, 2020). With its base in the natural science of biology, the medical model emphasizes a combination of pharmaceutical drugs and empirical evidence-based therapeutic techniques to treat the symptoms of mental disorders (Albee & Joffe, 2004). This is a relatively straightforward and scientific approach to mental health that uses the value-neutral framework of the hard sciences like medicine to diagnose and treat people in a standardized, efficient manner (Strong, 2017).

The medical model allows for the orderly classification of diseases, disorders, and abnormalities within a framework based on evidence, cause and effect, and current scientific knowledge (Huda, 2020). This has significantly reduced the amount of human suffering in the world due to healthcare workers' increased ability to effectively treat physical and mental health problems (Huda, 2020). The ability to group similar symptoms together and discover how they manifest through examining the biological mechanisms of cells is vitally important in understanding the human body and keeping people in a state of wellness for longer.

In the 1970s George Engel challenged the biomedical model by proposing a model of health and illness that took into account the psychological and social aspects of health and wellbeing, which he named the biopsychosocial model (Engel, 1977). In this model the psychological and social were incorporated at a comparable level of importance to the biological, and this advanced a more holistic and comprehensive model

of health, especially for mental health (Engel, 1977). In practise, however, the psychological and social are second and third tier compared to the biological in the current healthcare system (Huda, 2020). They are not equal partners as Engel proposed. Furthermore, in this dynamic the psychological and social still play a role in health through biological means, for example spending time socially with friends increases dopamine or other chemicals (Engel, 1977; Huda, 2020). While it is certainly advantageous to consider psychological and social phenomena, the adherence to molecular biology and chemistry may be limiting when contemplating the complexities of mental health concerns.

One of the most prevalent limits of the medical model is that it views people that are abnormal as qualitatively different rather than existing on one end of a continuum. This perspective of viewing abnormality as "sick" or "diseased" has created significant stigmatization around disability (Frances, 2013) and addiction (Kellogg & Tatarsky, 2012). Aspects of identity have also been used to classify "disorders" such as homosexuality (Kawa & Giordano, 2012). Proponents of the medical model of mental health include some psychiatrists, insurance companies, and most Western governments (Albee, 1998), though it is not without its critics.

There are some figures in psychology who question whether the natural sciences are even appropriate to measure psychological phenomena. The objectivity that natural science requires when examining cells or molecules cannot be attained to the same degree when studying human behaviour and thought processes, as humans are both the researcher and the subject (O'Doherty, 2015). The theories and observations that emerge from empirical psychological science are still couched in the sociocultural perspective of

the researchers, regardless of their attempt to remove their own values (O'Doherty, 2015). Psychologists' discussion of anxiety, depression, or other psychological phenomena becomes integrated into mainstream discussions of human nature, which affects how people think about themselves. In contrast, the carbon and hydrogen molecules inside the bloodstream "remain immune to our discussions of them" (Sham, 2015, p. 118).

Another aspect of the natural science-based medical model that has been criticized in the past is the empirical categorization of psychological phenomena. While the categorical distinction between healthy and sick makes empirical research easier to conduct, it does not accurately represent the dynamic spectrum of psychological phenomena like anxiety or depression, which are present to some degree in every person (Albee & Joffe, 2004). The dichotomy of healthy and sick may be useful for examining physical health issues like a broken leg or a punctured lung, but it may not be appropriate for examining mental health issues. While most physicians adopt the medical model, there are several professionals in the fields of psychology and psychotherapy that do not adopt the medical model due to its orientation to psychopathology (Strong, 2017).

Medicalization of Counselling

Counselling, at its base, is a form of one-on-one social conversation between a client and a professional aimed at helping the client with human concerns and aspirations (Strong, 2017). Within these discourses people try to make sense of the world around them and within them through communication and reflection. Depending on the approach that counsellors use, these conversations can be very individualized and laden with the values of the counsellor and the client (Frances, 2013). Past research has shown that it is

the quality of the counselling relationship or conversational work that is the most important factor to successful counselling, rather than a specific treatment orientation or technique (Duncan et al., 2010; Gelso & Carter, 1994). These relational and value-laden factors may be beneficial for the treatment of the clients, but they are not exactly empirical science, which has led many people to doubt the epistemological foundations of counselling (Albee & Joffe, 2004).

In a push to improve the legitimacy of psychology, reduce harmful psychiatric practises, and secure more funding, the American Psychiatric Association (APA) began developing evidence-based practices similar to those of evidence-based medicine in 1980 (Strong, 2017). One change they implemented was the addition of diagnostic criteria for mental disorders to the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 1980). While this improved consistency between psychiatrists, it also introduced a manualized version of psychotherapy. This large manual contained potential responses and follow-up questions regarding clients' concerns, which created a physical and symbolic barrier between the client and the counsellor, which could stifle the therapeutic relationship (Havik & VandenBos, 1996). The therapeutic research that the manual was based on was also criticized for having low ecological validity, working better in research settings rather than therapy offices (Havik & VandenBos, 1996). It seemed that the initial action in the medicalization of counselling constricted counsellors in the pursuit of prestige and profit. However, the bright side was that if a client's concerns were in the DSM as a "mental disorder" their insurance would be more likely to cover it (Albee & Joffe, 2004).

Third-party payers like medical insurance companies are more likely to be willing to fund therapy for a disabling disorder than they are to fund long-term talk therapy for existential concerns or problems of living (Strong, 2017). In order to retain the largest amount of profit, health insurers adopted the medical model of mental health and only pay for treatments that are “medically necessary”, with no regard for improving someone’s self-esteem or pursuing self-actualization (Albee, 1988). This influenced the APA’s future decisions to create more mental disorders and medicalize more common issues of the human condition to such an extent that the editor of the DSM-IV raised concerns over these expansionist tendencies (APA, 1994; Frances, 2013).

One of the largest forces medicalizing the discourse in society today is the pharmaceutical industry. In the past 50 years, there have been great strides in the discovery and creation of pharmaceutical medications, from the lithium used to treat bipolar and Thorazine to treat schizophrenia (Abraham, 2010). The ability to reduce or manage the symptoms associated with many mental disorders is a feat of technological advancement that should not be taken lightly. The concern for counsellors and the public, however, is in how the science and marketing branches of the pharmaceutical industry combine to expand the industry’s influence and further push the medicalization of mental health (Abraham, 2010).

In the 1980’s, antidepressant and anti-anxiolytic medications became a popular method of reducing depressive and anxious symptoms in clinical populations, but they also extended to “sub-clinical” populations (Strong, 2017). With phrases like “ask your doctor if Xanax is right for you” the pharmaceutical industry encouraged people that did not have diagnosed conditions to seek out medications to treat the highs and lows of their

life, what Szasz termed the "problems of living" (Szasz, 1961). Psychiatrist Peter Kramer (1997) opined that we as a society are too accepting of the bottom or low-point of people's emotions and views medications that enhance our emotional or cognitive experiences, like Prozac, as a means to minimize misery. While some see this expansion of the pharmaceutical industry as disease-mongering (Moynihan et al., 2002), others see it as a new form of biopower that offers clients more agency within a strengths-based approach (Fraser, 2001; Griffith & Griffith, 1994). With consumers seeking out prescriptions rather than therapeutic conversations for their milder depression, the pharmaceutical industry significantly expanded the medicalized discourse into society with their "journey into the economy of melancholy" (Greenberg, 2007, p. 1).

The editor of the DSM-IV, Allen Frances (2013) stated that "the business model of the pharmaceutical industry depends on extending the realm of illness" (p. 28). The more people that can be considered "disordered" or "ill" in the medical model dichotomy, the higher the profits will be for those that make the cures or reliefs from those illnesses. This industry had the motivation and finances to advertise their products to the family doctors and psychiatrists through paid clinical trials and luxurious medical conferences, as well as directly to the people themselves through soothing advertisements on television and the radio (Frances, 2013).

To exemplify this notion, one must only look at one of the emergent disorders of the last thirty years: ADHD. The sale of prescription medication for attention-deficit hyperactivity disorder rose 500% between 1990 and 2001 (Dalsgaard et al., 2013). Similarly, antidepressant prescriptions in the U.S. have increased 400% between the early 1990s and the early 2000s (Mojtabai, 2008). While there is an increase in the number of

people seeking pharmaceuticals, there are concerns that prescriptions are not a long-term solution to mental health problems. The current consensus in the research literature is that medication combined with psychotherapy yields the best results in terms of effective mental health treatment (Cuijpers et al., 2014). From this review of the literature it is clear that the pharmaceutical industry has a vested interest in medicalizing the discourse around mental health.

While pharmaceutical companies have been able to successfully market their products and the medical model of mental health to the public, there are systems that are even larger that continue to advance the medicalizing discourse. Governments have also had a hand in advancing the medical model through the bills that they pass and the statements that they make. In 1990, U.S. President George Bush announced that the 90s would be “the decade of the brain”, corresponding with the advances in neuroscience at the time (Jones & Mendell, 1999). Additionally, in an address regarding the provision of more resources for mental health treatment, U.S. President Bill Clinton stated that “mental illness is no different from physical illness” (Joffee, 2004). Both of these presidents were making these statements in order to reduce the stigmatization around mental health, which is commendable in and of itself, however, these statements support a deficit narrative that further medicalizes the discourse around mental health.

The process of medicalization can most readily be seen in the growing popularity of short-term cognitive-behavioural therapy (CBT). Cognitive-behavioural therapy is a problem-focused therapeutic modality that emphasizes challenging maladaptive cognitions and behaviours to promote emotional regulation and a reduction of negative symptoms (Hofmann et al., 2012). The problem-focused nature and categorical method of

judging cognitions to be distorted or not reflects the dichotomous mentality of the medical model (Strong, 2017). CBT uses psychoeducation and homework assignments to teach skills and, as such, the time spent with the therapist can be condensed or reduced into short-term or brief CBT (Hofmann et al., 2012), and therapist time can be further reduced with online CBT (Dalal, 2018). In terms of evidence-based treatments it is often touted as “the gold standard”, as it has more experimental studies than any other psychotherapy to date (David & Cristea, 2018). It performs well in experimental studies due to its standardized nature and use of manuals for therapy (David & Cristea, 2018). The emphasis on immediate symptom reduction, rather than determining the cause of the symptoms, may also contribute to efficacy in the short-term (Dalal, 2018). Cognitive-behavioural therapy may be one of the most medical model-friendly psychotherapies that have been developed to date.

The growth in popularity for CBT is not only based on its experimental efficacy, as it has also been fostered by the neoliberal ideologies that dominate discourse in political and economic spheres. Neoliberalism, associated with free-market capitalism and the privatization of public services, highlights the importance of independent determination, understood as one’s ability to command and control one’s affairs without being concerned with outside forces (Dalal, 2018). This corresponds to the therapeutic outlook of CBT, which presents thoughts and emotions as things to be controlled by the individual using specific skills and techniques (Dalal, 2018). In CBT clients are shown the mechanisms of behaviour change and if their mental health does not improve then it is a distortion within themselves, not the therapy or the structures of society. Regardless

of whether the client is experiencing poverty, structural racism, or the loss of a relationship, it is on the client to improve and pull their brain up by their boot-synapses.

There are also other reasons why CBT is attractive to governments and health insurance companies. The standardized, condensed nature makes it cheaper than interpersonal psychotherapy for health insurance companies and governments, with some companies only covering the cost of therapy if the therapist uses CBT (Strong, 2017). If a person only has to follow a manual and participate in some training to learn how to implement CBT strategies in therapy, then it can be conducted by those without graduate degrees, making the therapy cheaper and easier to implement (Dalal, 2018; NHS England, 2015). The adaptability of CBT to online environments makes it additionally cheaper, as modules can be created for wide-spread use in a one-size-fits-all system and therapist time can be further reduced (Dalal, 2018). The focus on symptom reduction, rather than discussing the root of the symptoms, is also appealing to many economy-focused governments, as it gets citizens off of insurance benefits or welfare and back to work more quickly (Strong, 2017). CBT has been called the quick-fix approach or "get to work therapy" because of its focus on immediate symptom reduction and relative cost effectiveness (Dalal, 2018; Strong, 2017).

The rise and flaws of CBT can be seen most readily in the U.K., where its National Health Service (NHS) provides psychotherapeutic treatment to its population predominantly in the form of CBT (Clark., 2018). While the widespread availability of therapeutic services is certainly a positive thing, the rationale and rollout of these services leaves much to be desired. The increased availability of CBT is largely due to the work of British economist and politician Lord Richard Layard, who proposed the Increasing

Access to Psychological Therapies (IAPT) program for U.K. citizens in order to reduce the economic impact of mental health problems through the population's use of sick days, benefits, and the welfare system (Layard, 2017). On the advice of David Clark, a clinical psychologist, the IAPT uses CBT as the main treatment with the majority of health centres offering it over other therapeutic modalities (Clark, 2018).

In the U.K. between 2014 and 2015, 68% of all mental health therapy provided by the NHS was CBT-based, with 10% being counselling, 1% being interpersonal therapy, and the remaining 21% being "unidentified" treatments (Clark, 2018). In fact, 73% of high-intensity therapists and counsellors in the IAPT identify themselves as coming from CBT backgrounds (Clark, 2018). Further, the future of the therapeutic services of the NHS is over the internet, as suggested by David Clark, which will include online CBT and asynchronous messaging that will have "substantial savings in therapist time" (Clark, 2018, p. 177). CBT is being used as a one-size-fits-all therapy for many different people and mental conditions, though primarily for depression and anxiety disorders, excluding PTSD (Clark, 2018). This narrowing of choices is problematic, not the least for the previously mentioned flaws of CBT, but because some citizens do not respond to CBT and as such are labelled as "CBT resistant", similar to how some bacteria are antibiotic-resistant (Dalal, 2018). If CBT does not work, they may have to be put on a long waiting list or seek costly private therapy.

CBT in and of itself is not negative, it is an effective and widely lauded therapy, but the hype and expectations around it may fuel the way that it is used. Politicians push it as a cheap way to provide mental health treatment for their populations, ignoring other therapeutic approaches for diverse populations. The distribution of governmentally-

provided therapy with the narrow choice of CBT and the privately available multitude of different kinds of therapies may create a two-tier system where the moderately wealthy can afford to have in-depth conversations with a counsellor and the working poor receive a self-help program with little interaction from a counsellor.

The vast evidence base of CBT is one of the main reasons that it is attractive to organizations, as they want to ensure their money is used efficiently. The emphasis on evidence-based treatments in politics and the wider psychiatric field has its merits, however it is important to note that the foundations of psychology and counselling research have been based on the mainstream population of White, privileged people (Roberts et al., 2020). Psychological studies have historically used samples of White, middle-class men to find therapeutic techniques that work effectively for them (Graham, 1992; Guthrie, 1976; Roberts et al., 2020). The result of having a monocultural sample is lower generalizability to people who do not share characteristics of the dominant culture. This discriminant foundation leads to the situation where people who have different beliefs, cultural backgrounds, and values must conform to the dominant mainstream beliefs about psychopathology if they want to have their therapeutic treatment covered by their health insurance company (Syed, 2017).

Social Justice

Social justice can be understood as “the equitable distribution of rights, opportunities, and resources between individuals and between groups within a given society, and the establishment of relations within this society such that all individuals are treated with an equal degree of respect and dignity” (Lewis, 2010, p.146). In other words, social justice is about promoting equity across people, actively attempting to reduce

inequity in society, and recognizing the factors and context that would form a just society (Winter & Hanley, 2015). In recent years, social justice has become a central topic of conversation, with discussions and governmental policies covering gay rights (Price, 2005), transgender rights (Restar & Reisner, 2017), and structural racism (Sawyer & Gampa, 2018). The topic of social justice is especially visible in the field of counselling.

There is a general consensus within the counselling psychology literature that social justice has been a core component of counselling since its inception (Winter & Hanley, 2015). The fourth principle of the Canadian Psychological Association even states that psychologists have "responsibilities to the societies in which they live and work… and to the welfare of all human beings in that society" (Canadian Psychological Association, 2000, p. 27). Even Sigmund Freud, the father of psychoanalysis, engaged in some social justice practises through operating a free clinic for people with low incomes (Danto, 2005). The importance of social justice to counsellors may have originated because counsellors are often ideally situated to consider these kinds of structural issues, as they develop professional relationships with many people from different social locations than themselves (Perlman et al., 2015). Possessing the empathetic and caring nature of a counsellor combined with many opportunities to hear the perspectives of people of different genders, races, socioeconomic backgrounds, and cultures creates an understanding of the imbalances in society and a drive to change those imbalances for the benefit of those clients and their respective populations.

The work of counsellors also benefits from a holistic view of individuals that includes their strength and resiliency, as well as a focus on individuals in the context of the society in which they live (Brown et al., 2019). While it can be difficult for a therapist

to reduce the negative experiences that marginalized people face, it is important for the therapist to emphasize the strengths of their individual client as well as the marginalized groups of which they are a member (Brown et al., 2019). However, some therapists have the opinion that they should stay professionally apolitical to reduce the chance of alienating one of their clients and keeping their personal beliefs separate from their occupation (Perlman et al., 2015).

Counsellors have a responsibility to be active social justice agents, as the populations that are the most disadvantaged often have the highest rates of mental health issues, often compounded by their marginalized social locations (Vera & Speight, 2016). Counsellors that help to alleviate these situations in society will effectively be helping whole populations, which will result in fewer clients requiring therapy overall (Albee, 1986). This is a concept known as primary prevention and it is one example of how social justice and counselling can be combined to affect change on a larger scale in society (Albee, 1986). Advocating for human rights, health education, and helping create supportive networks in communities are some examples of counsellors reducing stress and promoting competence through primary prevention (Albee, 1986). By acknowledging and addressing the social and environmental factors that impact the inequity in mental health between dominant and marginalized social groups, counsellors can help their clients and communities advance to a more just society.

In discussing the relevance of social justice to counselling, it is important to identify the ways that counsellors could improve. Brown et al. (2019) identified six areas of social justice competency that counsellors should employ inside and outside of their practice. Community activism is one such area, which comprises knowing local resources

and advocating for changes in institutions so that disadvantage does not make clients have to choose between a better life and their roots. The political influence on clinical work is another area, comprised of a systemic understanding of justice and injustice, the knowledge that social and global culture shapes people, and that psychotherapy cannot happen in a vacuum. Critical consciousness was emphasized, as it can help therapists understand the relevance of social location to psychological issues, as well as how multigenerational trauma and economic inequality impact client wellbeing. Additionally, social responsibility was emphasized as practising within one's own scope of practise and utilizing an anti-oppressive framework to be accountable. Finally, self-awareness and a personal style of genuine compassion and curiosity can help counsellors avoid assumptions about clients' experiences and recognize perspectives and beliefs that are different from their own (Brown et al., 2019). By developing these areas of social justice competency, counsellors can engage more deeply with their clients and collaboratively navigate the systemic issues that both clients and counsellors face in an unjust society.

Another example of social justice-informed counselling can be seen in the recent pushback from the area of addictions and substance use regarding the medical model. After noticing the flaws in common abstinence-only treatments, such as stigmatizing users and rigid programs, many counsellors and shelters shifted to a harm reduction and recovery approach that was centered on meeting people where they are (Kellogg & Tatarsky, 2012). This approach takes into account the environmental and structural reasons that people may use substances and it does not stigmatize or discriminate against them. In therapeutic settings this approach often makes the relationship between client and counsellor central to treatment, which is critical to the success of psychotherapy

(Duncan et al., 2010; Gelso & Carter, 1994; Kellogg & Tatarsky, 2012). By moving away from the medical model of mental health and incorporating aspects of social justice, therapy such as addiction treatment can evolve further and become more comprehensive and effective to a wider population.

While social justice and counselling have shared a long history, there is still much to be learned about the integration of social justice practises in modern counselling. The growing trend of medicalization in counselling presents new challenges for social justice-informed counsellors in terms of the framework of their profession and the potential approaches that they may use in a therapeutic setting. While it is important to hear from organizations like the Canadian Psychological Association on topics like these, it may be more beneficial to learn about the realities of modern counselling from a bottom-up approach that listens to individual counsellors. The beliefs and lived experiences of individual counsellors present a wealth of information about the profession, the impact of the medicalization of counselling, and the integration of social justice issues. A bottom-up approach would also reflect the importance of social justice tenets like equality between people and the equitable distribution of opportunities. However, there is no research that examines counsellors' beliefs on the medicalization of counselling and its relation to social justice.

Current Study

This exploratory study will help to garner a better understanding of how the medicalization of counselling impacts counsellors and their implementation of social justice practises by interviewing members of the Social Justice Chapter of the Canadian Counselling and Psychotherapy Association and analyzing their feedback for recurring

themes. By utilizing a qualitative research design, this study answers the research question: how is the medicalization of counselling affecting social justice-informed counsellors?

Method

Participants

In this study five participants were recruited using an advertisement email sent to professional members of the Social Justice Chapter of the Canadian Counselling and Psychotherapy Association (CCPA). Participants were not compensated for their time.

Members of the CCPA were chosen because they represent one of the largest professional counselling organizations in the country, providing a large pool of counsellors whose opinions are informed by practical experience in the field. By using this population, this study was better positioned to recruit those who work in community agencies and those who work in private practices. The structure of this organization also benefited the study by providing access to counsellors across different cities and provinces, increasing the potential for diverse opinions from different areas.

Specifically, members of the Social Justice Chapter of the CCPA were recruited, as their membership with the chapter identifies them as having strong beliefs about the topic of social justice in counselling. One advantage of exclusively recruiting participants from this chapter was an increased familiarity with social justice issues in counselling, removing the need to be assessed on their knowledge of social justice topics involved in the interview. In 2014 the Social Justice Chapter had a membership of 175 counsellors (Canadian Counselling and Psychotherapy Association, 2014).

Participant One had practised counselling for five years and had provided services to adults, older adolescents, and queer populations. They worked in private practise and cited trauma, queer, and LGBTQ+ as areas of specialization. Participant Two had practised counselling for two and a half years and worked in private practice. They have worked with queer, trans, racialized, and Caribbean populations and they cited suicidality, death and dying, chronic illness, active psychosis, and immigration as areas of specialization. Participant Three had practised counselling for two years and worked in private practice. They have worked with children, adolescents, adults, families, and couples and cited general counselling as an area of specialization. Participant Four had practised counselling for five years and worked in private practice. They have worked with youth and families and cited trauma recovery and gender affirming therapies as areas of specialization. Participant Five had practised counselling for six years and worked in private practise and non-profit organizations. They have worked with children, adolescents, geriatric populations, and referrals from police and they cited trauma, violence and domestic abuse, and art therapy as areas of specialization.

Demographic information was collected from participants. Participants were from British Columbia, Ontario, and Nova Scotia. Ages ranged from 34-46. Genders included non-binary, gender queer, male (cisgender), and female (cisgender). Ethnicities included Ashkenazi Jewish, Caribbean-Canadian, and White. Race included White and Mixed. Class included middle class and “not quite middle class”. Ability included chronic pain, mobility issues, and able.

Materials

In order to gather information about counselling, the medical model, and social justice, this study utilized a qualitative interview with a series of open-ended questions that served to answer the main question, how is medicalization affecting social justice-informed counsellors? These questions included, “How has medicalization affected your counselling practise?”, “How has medicalization influenced your social justice practises?”, and “What can our professions do about medicalization?”, among others. Participants were provided these questions in advance in order for them to have adequate time to form a response.

Procedure

After volunteering to participate in the study by answering the email advertisement, the researcher met individually with the participants at a mutually agreeable time for a 60 minute conversation via Zoom. The researcher and participant engaged in a conversation about informed consent and after the participant granted their consent the interview commenced. Demographic questions were asked about the number of years the participant had been a counsellor, the organizations that they currently worked at, and the specific populations that the participant provided services to (if applicable). Additionally, information about race, gender identity, age, ability, and ethnicity were collected in order to describe demographic characteristics in this sample.

The interview was recorded so that participants’ responses to the questions may be understood and represented in the participants’ own words. Participants’ names and other identifiers were omitted for privacy and replaced with pseudonyms (e.g., Participant One). The interviews progressed with the researcher asking a question and the participant providing their answer, with the opportunity for discussion and brief follow-up questions,

before continuing to the next prepared question. Constructing the interview in this way allowed for greater flexibility and more discussion than only employing the prepared questions, utilizing the subjective nature of the qualitative research design. Once the interview was over the participants were debriefed and thanked.

Ethical Considerations

There was no perceived harm, immediate or long-term, for participants in this study. All participants were provided with detailed information regarding the purpose of this study and their role in the study as participants prior to giving their informed written consent. All participants had the right to leave the study at any time, for any reason. All participants had the opportunity to withdraw their data from the study at any time until publication. All materials and procedures that were used in this study were assessed by the Western Faculty of Education Research Ethics Board for potential harm or discomfort to participants.

Participants' data, including their demographic information and the content of the interviews, was kept private and confidential. Personal identifiers and names were omitted and did not appear in the final version of this study. This kind of data was not shared with the CCPA, only the final results of the study. Participants that had concerns about confidentiality or potential harm were encouraged to voice those concerns prior to giving informed consent, as well as during the debriefing phase after the interview.

Analysis

The qualitative data collected in this study was analyzed using a conventional content analysis method. Participants' statements were examined and evaluated for their conveyed meaning, then organized based on similar ideas and common themes (Hsieh &

Shannon, 2005). The data was prepared for analysis through verbatim transcription of the audiotapes and organized into readable files. All of the transcripts were reviewed by the researcher to gather a general impression of their content and meaning. The transcripts were closely examined for exact words and phrases that were used frequently. A coding scheme was developed in which statements were evaluated for meaning and labeled with a single qualitative code that indicated the meaning of the statement. If a statement fit with more than one code the statement was evaluated and placed with the code that best represented the overall meaning of the statement. General categories started to develop as more statements were coded. The codes and categories were organized into themes that best addressed the research question, how is the medicalization of counselling affecting social justice-informed counsellors?

Qualitative content analysis is a research method that allows researchers to collect information-rich data directly from participants and analyze that data in a systematic way (Allen, 2017). It is used to examine the manifest and latent content of participants' statements, providing a better portrayal of participants' thoughts and opinions than could be collected using surveys or quantitative measures (Allen, 2017). Knowledge that is generated by this analysis comes from participants' unique perspectives and is grounded in the data (Downe-Wamboldt, 1992). One advantage of conventional qualitative content analysis is collecting direct information from participants without imposing preconceived categories (Allen, 2017). This means that conversations between participant and researcher can flow more naturally, without trying to restrict the participant to an already developed model.

The process of identifying a meaning unit, assigning a code, and then grouping it with other codes to create a theme can be shown through the following example. In the interview transcript from Participant Three the sentences, "our profession isn't psychologists lite, it isn't medical like… we're not people who failed to become doctors and just have to do this or something" were identified as a single conceptual sentiment or meaning unit. It was assigned the code "Identity of Psychotherapy" based on the participant's discussion of the profession. The code was then included in the Therapeutic Relationships: Clients and Professions theme because of its discussion of counsellors' relationship to the psychotherapy profession. After reviewing participants' conversation transcripts 167 meaning units were created. Meaning units were formulated as the smallest piece of the conversation that retained meaning without the overall context. Meaning units were grouped together based on similar concepts and ideas into 62 codes. These codes were organized into five distinct categories to best convey the overarching themes expressed by participants.

Trustworthiness

Nowell and colleagues (2017) outlined the importance of trustworthiness in thematic analysis research in order to establish the value of qualitative research. Trustworthiness has been conceptualized as the combination of credibility, transferability, dependability, and confirmability, which better represent the value of qualitative research than traditional quantitative measures like validity and reliability (Lincoln & Guba, 1985). Credibility addresses the "fit" between participants statements and the researcher's representation of them (Nowell et al., 2017). In order to establish credibility I demonstrated prolonged engagement with the data and immersed myself in

participants' statements through conducting the interviews, listening to participants repeatedly through the manual transcription of the interview, and reading over all transcripts prior to starting the construction of codes (Nowell et al., 2017).

Through collecting participant social location demographics as well as work experience, geographic location, and populations served, this study can be transferred to different sites wishing to replicate these findings (Nowell et al., 2017). In terms of dependability, I recorded notes regarding interesting statements or topics during the interviews, transcription, and reading, as well as used iterative versions of documents in order to show the progression of ideas and ensure decisions with peers were clearly documented (Nowell et al., 2017). I used Zoom software to record the interviews, stored the audio/visual files safely on the same computer, and personally transcribed them to ensure accuracy. Confirmability was established through the use of direct quotes from participants to show how the theoretical conclusions and interpretations were reached from the data (Nowell et al., 2017).

The meaning units were chosen from participants' statements based on the smallest unit of information that expressed an idea or concept. I used an Excel spreadsheet to examine meaning units on their own in order to generate codes that capture the qualitative richness of the phenomenon. I discussed the coding process with a peer researcher familiar with the study to ensure that codes were not redundant or interchangeable, consolidating and reconsidering codes through this iterative process. Each code contained between two and four meaning units, in order to achieve a balance between conceptual similarity and consolidation of information.

Nowell and colleagues (2017) stated that themes are significant concepts that link substantial portions of the data together. The themes presented in this study were generated inductively from examining the raw data and determining the way the codes best fit together to tell a story (Nowell et al., 2017). Peer meetings with a researcher were conducted to review the themes and reflect on the final make-up of themes. Names for themes were created by posing the theme as a one sentence answer to the research question and utilizing participant quotes as a building block for the names. I returned to the data to ensure that themes reflected participants' voices and that my conclusions and interpretations are grounded in the data (Nowell et al., 2017). Subthemes were created based on conceptual similarity and ordered to form a narrative about the overall theme. Each participant is represented within each theme to show the relevance of the theme is spread across various participants. In producing the final report I discussed all relevant results, returned to the original literature, as well as introduced new literature to support these findings. By establishing trustworthiness through credibility and transparency, the thematic analysis conducted here may hopefully be considered robust and thorough.

Results

After the data was transcribed, coded, and organized into themes, conclusions were drawn. The resulting themes answered the research question by describing the impact of the medicalization of counselling on social justice-informed counsellors. Direct quotes from the interviewed counsellors are included to support and clarify the answers to the research question, with pseudonyms like "Participant One" to protect privacy.

Through the initial review and subsequent analysis, five themes were formulated to best represent the ideas expressed by participants. Counsellors' relationships with their

clients and the profession, the industry and societal systems of mental health, social justice work, bias in pathology and treatment, and the lack of a holistic approach to mental health were the themes identified. A general description of each theme is provided, as well as subthemes that best inform the specific perspectives expressed by the counsellors. Each theme is framed with a heading and a description that details how the medicalization of counselling has impacted social justice-informed counsellors. For the purposes of this research, medicalization can be defined as the increasing use of the framework and orientation of the medical model in the interpretation and treatment of psychological concerns, where more emphasis is placed on the standardization of conversational therapy, the use of practises that are based on empirical evidence, and a fast reduction of client symptoms (Strong, 2017).

Therapeutic Relationships: Clients and Professions

The medicalization of counselling affects social justice-informed counsellors through the relationships that counsellors have with their clients, as well as the relationships between counsellors and their profession, and the relationships between clients and their mental health. This section details counsellors' beliefs on the therapeutic alliance, the standardization of counselling practises, the profession of psychotherapy, and how mental health is discussed.

Therapeutic Alliance

Counsellors expressed that medicalization posed a barrier to developing a strong therapeutic relationship with the client. They highlighted that research showed the therapeutic alliance is the largest factor in determining the efficacy of therapy. Participant Three illustrated this point, "there's this one way that I'm really against medicalization,

usually, because I think it's bad for therapeutic relationships and therapeutic relationships are, as far as I'm concerned, what does the heavy lifting of counselling." Participant Two discussed the importance of "standing with" clients to emphasize the point that the client is not alone in their experience in order to build the therapeutic alliance. They said, "I think elements of self-disclosure can help to kind of help people not absorb the harm of medicalization, being against it in a way." For clients that experienced dismissal, neglect, or medical trauma in healthcare, this can be a helpful way of letting them know they found a counsellor that can empathize with their experience,

> oftentimes your own life experience is going to be more powerful in the room than some therapy intervention that you learned in a workshop… It's okay… but do you actually care about the person sitting in front of you? And can you actually put yourself in their shoes to some extent? (Participant Two).

Standardization

Counsellors discussed how standardization in counselling practises impacted their therapeutic relationships and autonomy. When counselling is standardized the loss of interpersonal connection is disruptive to a relational approach in counselling. Participant Three referred to a Japanese carpentry technique that used the natural bends in tree branches to improve construction strength, rather than breaking down the tree into uniform planks, "in trying to standardize it you lose so much of the innate strength of the thing." He also highlighted the paradoxical nature of manuals, "there will be times when you have to go off manual to follow the client's need and is that allowed… if it is then it's not much of a manual. If it isn't then it's not much of therapy." He outlined a possible trajectory for the profession, "there's some *Black Mirror* episode in this, where we

pursue forever prestige and money and then we get replaced by robots because we are totally just doing manuals and delivering evidence-based interventions."

The critical nature of personal and professional values to the psychotherapy profession was also discussed by counsellors. Participant One mentioned they felt they could not, "fit in to the mainstream model and be happy with myself or happy with the service I was providing." Participant Three said, "I have avoided working in more medicalized environments because I don't think I could live my politics there." He continued, "in that way I have avoided the worst, the feeling of like my social justice work can't show up because of medicalization."

Psychotherapy Profession

Counsellors discussed developing the profession of psychotherapy, as well as working with other mental health professionals. An important part of improving the profession is creating an identity that is distinct from psychology, psychiatry, and social work. Participant Three said, "our profession isn't psychologists lite, it isn't medical like… we're not people who failed to become doctors and just have to do this or something." He defined the identity of psychotherapy as, "we're more about being with people, we're about the interpersonal, we're about the relational" and, "we are about what happens in that room between people and so that is a specialization I think that can move away from this idea of being medical."

Participant Three discussed how improvement had been pursued in the past and said, "I would imagine in the earliest possible days you would go 'oh this is so promising that we can just ride the coattails of the medical system.'" He compared that to how others discuss moving the profession forwards, "almost always talking about how can we

get more government money, get covered by more insurance companies, how can we look more legitimate in the eyes of the structures that are out there that have dollars to spend." He recognized his beliefs about medicalization are not shared by all, "and so anything that might threaten that… I can hear people say that that is deprofessionalizing what is a profession." He pointed out that it may aid the identity of the profession, "that would be really helpful in clients' understanding of what we actually are offering… And also in the therapist's understanding of what is actually… driving what's helpful." He also cited the credentials required to begin working as a psychotherapist as a barrier to getting more people, particularly people from diverse backgrounds, in the profession.

Counsellors frequently work in concert with other mental health professionals. However, some counsellors shared they did not receive the same level of respect from other health professionals. Participant One discussed the hierarchical structure of healthcare professions, "the psychiatrist was kind of handing [the client] down like 'No. This is what you have. You have this disorder.' Which was really hierarchical… Why is she overruling me after sitting with her for half an hour?" Participant Five described working around the healthcare programs designed by others, "I will see clients with like a hit list of medications that sometimes really impact the work we're doing." While problems exist between health professionals, Participant Two expressed hope for the future through using "elements of building bridges across professions" and, "as they advocate within their professions and we do the same in ours maybe there is a shift that happens by collaborating and understanding the potential harm that is coming about medicalization."

Discussing Mental Health

Counsellors reflected on the mental health vocabulary that medicalization has provided, from which both validation and stigmatization may stem. Participant One said, "medicalization has been helpful because it can give people language." Some counsellors reported that a medical diagnosis can be relieving for some clients, "oh this language now gives me some understanding that I've been struggling with something that is actually real. And prior to diagnosis I would have thought it was just me being an idiot" (Participant Three). Participant Two added that a diagnosis can, "help them connect with the community of other folks that have similar experiences and it can help find the things that might work for them." Participant Four noted, "people have more of the language around the types or modalities that they're looking for."

An increasingly medicalized language of mental health can also contribute to stigmatization. Participant Five stated, "I think it adds stigma a lot of the times to behaviours or responses, to things that have helped some of my clients survive and cope." The public recognition of some words or actions as related to a disorder may impact those with mental health problems, "which often times further causes them to be ostracized or isolated." Participant Four reflected on the value of working to normalize various feelings as part of the spectrum of human experience, "I have to do a lot more education… around like really making sure when people say like 'I'm depressed'… how they are defining it." She also noted an increase in clients self-diagnosing, "I work with youth who say 'I have this'… it's like you're actually responding to your situation right now and that's a totally normal response."

Industry and Systems in Mental Health

The industry and systems in mental healthcare are some of the largest factors that impact both counsellors and clients. The systems I refer to are the regional, provincial, and national government, the private and public organizations that provide health related goods and services, and the less tangible socioeconomic and cultural systems that pervade our everyday lives. This section explores how medicalization impacts social justice-informed counsellors through the business of medicalization, treatment navigation, and medical institutions.

The Business of Medicalization

When considering the impact of medicalization on the business side of counselling, Participant Three noted, “the legitimization that comes with the medicalization of the profession has gotten me access to insurance, which also means that clients have access to a lot more therapy, if they have coverage.” He continued that, “it’s hard for me to imagine structures paying for it if they don’t think of it as medical care.” Insurance companies often have a strict view of what they are liable to cover. Participant One stated when working with military veterans,

> their problem had to be specifically connected to this very clinically diagnosed thing that originated in an event at the military. Otherwise they wouldn’t be covered. So that would impact my practice… people would say to me ‘please don’t tell them about the sexual abuse when I was five when you write the report because they won’t cover it.’

Participant Two reflected on the practical aspects of medicalization, “there are pragmatic elements to the diagnostic protocols that the medical system has created… it’s helpful to organize resources and treatment plans.” However, this pragmatism and cost

efficiency can have drawbacks as well, “this focus on diagnosis is really about streamlining the treatment approach and curtailing resources and kind of gatekeeping access to therapy and to treatment.” Sometimes clients are only covered for the minimum treatment, if that, “you wouldn’t want to give someone a half a dose of something when you know a full dose works because of some sort of administrative structural thing. And we definitely do that for cost saving” (Participant Three).

Participant Three noted the financial benefits on insurance and medical coverage for counselling, though recognized there is still conflict between counsellors and companies, “I think business-wise I benefit a little bit… I’m not sure if I were to describe counselling in the way that I believe it works, that like Blue Cross is going to cover it.” He also indicated that counselling that is more medicalized can be more profitable for counsellors,

> there are at least two jobs that have popped up… if I worked full time there I’d make triple what I will make this year and I didn’t even apply and I won’t apply. One because I know the people that manage there are super big on short-term CBT sort of stuff… so I don’t want to work through that. Because it doesn’t match with what I think helps people and I don’t want to be a tool perpetrating… less than good help.

Treatment Navigation

Counsellors discussed clients’ experiences navigating mental health treatment. Participant One highlighted the fragmented structure of mental health care and how medical staff can oversimplify navigating treatment, “it’s not seamless… I think it leaves people shuffling around trying to piece things together.” They shared that some clients

were relieved at her collaborative and relational approach to therapy, “that’s so discouraging… it’s not rocket science what I’m doing, like this should be an average counseling experience.” They said, “sometimes that system is overwhelmed and they’re like ‘oh just do DBT (Dialectical Behavioural Therapy) with your counselor.’ But if you’re truly doing DBT it’s a whole group thing, but I know the waitlist for that is a year and a half.”

Participant Four noticed the use of clinical terms in a more casual way among the general populace, “people will be like ‘oh I am so OCD’ like those types of comments just says how medicalized the mental health field is.” However, treatments are not as widely known as the disorders. They stated, “in some circumstances people aren’t sure what they need and they’re just going with what they’re told and those are the more common things like CBT, DBT, or EMDR (Eye Movement Desensitization and Reprocessing).”

Treatment navigation also looks quite different depending on where a client falls on the wealth spectrum. Participant Three disclosed, “there is almost a part of me that wants to argue in the language of medicalization that like if you believe this is medical care for someone, doesn’t everyone deserve it?” He was hesitant to use that argument though, “it’s the same as the economic cost of poverty argument, there are way better reasons that people should have care. I think it hurts more than it helps to argue that direction, but it’s tempting.” He referred to his work in the United Kingdom where government-subsidized counselling is more accessible. While increasing access to therapy, it also creates a two-tier system, “where people that have access in the public

system get like five or six sessions of CBT… And people who have money to pay… they can do whatever therapy feels good. And potentially therapy that works better."

Medical Institutions

Medical institutions such as hospitals and long-term care facilities are central healthcare structures, however negative or traumatic experiences in these institutions can seriously impact a person's trust in healthcare. Participant Four said that medicalization, "has created a lot of potential for harm, maybe more than the potential for growth." Participant One disclosed the impact on her practise, "if they've had a lot of therapy beforehand sometimes there's a fair chunk of the beginning of our work together that's basically getting over the trauma of their previous therapy or experiences in medicalized settings or institutions."

The potential for traumatizing a patient in a medical facility is coupled with a poor understanding of trauma by institution staff. Participant Five shared, "I worked in long-term care facilities… the medical industry was my place of work. Succinctly it was just the lack of trauma-informed care." She provided examples, "nursing staff and care aids often talked about my clients when they were around, kind of infantilizing them and speaking of them as people often speak of very small children, which I think is really insulting and somewhat dehumanizing."

If mental health is a medical problem then hospitals should be the ultimate place for care, however clients' experiences have varied. Participant One disclosed a client who, "had a panic attack and went to the hospital and they left her alone in a room for five hours and she just kept thinking 'if I was suicidal... .'" Participant Three highlighted that not all hospitals are equipped for properly caring for those suffering psychological

distress, “so many people end up, especially suicidal kids with scared parents, in emergency rooms which… it’s awful, it’s going to make things worse almost for sure, especially in rural hospitals. They’re just trying to get rid of you.”

Social Justice Work

Counsellors discussed the ways in which social justice and counselling intersect, as well as the ways the medicalization of counselling is impacting their social justice practises. This section will explore how social justice and mental health are discussed in concert, counsellors’ beliefs on challenging medicalization, accountability of both counsellors and those of the dominant culture, and the individual deficit perspective of the medical model.

Discussion of Social Justice and Mental Health

Participant Five acknowledged that simply having a vocabulary to discuss social justice topics is, “a direct result of the work that People of Color have already done, both inside and outside of our profession.” Work is needed to expand the definition of therapy, as the medical model is often viewed as the only plausible model. Participant One said, “it’s one thing that’s available, but it’s not the only way… it doesn’t mean any other way is invalid” and suggested counsellors “be clear on broadening the description of what therapy can look like. Exploring ways to decolonize it.” Decolonizing therapy was a message that counsellors shared.

Counsellors also discussed the need to reframe mental health in a less pathologizing way. Participant Four referred to this when discussing the cultural factors that impact mental health, “clients say they’re suffering through burnout and even that’s a medicalized, individualized term. It’s created by a grind culture of capitalism where you

don't take breaks and you have to make this much money. That's not a medical issue!" Participant Five cited the benefit of clients viewing particular issues without a medical lens, "that invitation to reframe and de-medicalize their experience, say 'you are not an alcoholic, you are someone who is coping with trauma' helped them see themselves as more worthy of healing." Pathology is so ingrained in our ideas of health that it can be difficult to parse out. Participant Four shared how medicalization influences their social justice practises, "I think it just makes me more aware, it's kind of like with White supremacy, like 'look out, it's just lurking,' I feel like they are linked."

Challenging Medicalization

Counsellors remarked that thinking critically and challenging medicalization was an important aspect of their development as counsellors. Participant Two highlighted, "I think actually just being a therapist who approaches that model critically or refuses to use… pathologizing language. That's pretty meaningful." Evaluating the utility and accuracy of a particular model and discerning how beneficial it is to clients and society is important. "I think any system that refuses to be critically evaluated is a very dangerous system" (Participant Five).

We must re-examine the ways we "diagnose and demonize" certain disorders and how that relates to our own colonialism and internalized racism. Participant Five said, "no shade to the founding fathers of psychotherapy, but they were all men, a lot of them White, that's problematic." She suggested the central mental health document needed edits, "I think we need to rewrite the DSM completely. A lot of those diagnoses are not made taking into account cultural and historical trauma… or even gender. A lot of studies… were just done on dudes."

Some counsellors opposed medicalization outright and advised other counsellors to "push back." Participant Two put it plainly after discussing their experience as a consumer of mental health services, "my practice and my studies are in open revolt and reaction to the psychiatric model or to medicalization in mental health." They specified their provocative rationale, "dare I say, all of the psychiatric diagnoses lack any kind of causal understanding." Participant Four described the work they have done during the pandemic, "I put messages out there… to resist that mainstream messaging of pathology and individual and remind us about collective grief… especially with Covid, but before Covid too."

Accountability

Counsellors have an accountability to both our clients and the larger society. This does not stop at the profession however, those who are part of the dominant culture must keep themselves accountable to foster a more equitable society. Participant Four highlighted that, "because we're hearing people's stories all the time, that actually gives us so much power to make change. So if we don't do anything with that information, to me, that's like a failure of our profession." They noted that Western medicine, psychotherapy included, is primarily staffed by White people and historically has mostly been concerned with other White people, to the detriment of marginalized communities. She stated, "our profession has done so much harm in the past and like we do not want to perpetuate… the dominant culture." She spoke of cultural humility and holding oneself to account when one commits cultural transgressions, as well as,

> holding people in our profession to an extremely high standard of knowledge… especially the White therapists… to make sure that we are not causing harm… I

don't see a ton of accountability for that. So I have to find ways to hold myself accountable.

In referring to actions for newly trained counsellors she said, "my advice is watch out for Whiteness, it's always showing up."

Counsellors also talked about the Social Justice Chapter of the CCPA. Participant Four said, "I would love the Social Justice Chapter to meet every six months to talk about it [what our profession can do about medicalization]." They stated their desire to work towards, "bringing all of the different community voices together to create some sort of action in how we can contribute to like reconciliation."

It's Not Me, It's You

Counsellors discussed how the medical model focuses on individual deficits, creating shame and stigmatization when applied to mental health. Participant Two expanded, "it places the locus or cause within the self. Even though we don't really have a biological basis to kind of point to." The messaging that anxiety, depression, and other mental health issues stem from within can cause people to think there is something inherently problematic with themselves, sometimes internalizing, "ok well what's wrong with me. I've heard people joke 'I've failed at therapy'" (Participant Three). Participant Three reported that, "people will diagnose themselves with these things, it perpetuates that feeling that they are the problem." Participant Four also voiced concerns about an overly individualized healthcare model,

> it's like 'oh you're burnt out? There's something wrong with you. You need to do self care…' There's always branches of medicalization that reamed into other health and wellness things that are capitalist and moneymaking and individual-

based. I haven't seen any collective self-care suggested because it doesn't work in this structure that we have.

The individualized approach can also create tension and marginalization in institutional settings when a patient's identity differs from the norm. Participant Three discussed helping clients navigate resources in the medical system,

> I have some knowledge… for which places to go to try and navigate, depending on your identity or social location. Some places can be trusted and some places less so… It's more about your identity and being accepted by the medical system or at least tolerated.

Pathologizing Difference: Bias and Oppression in Mental Health

Counsellors discussed how the medicalization of counselling impacted their work through the biased ways the medical model has been used to systemically oppress marginalized and vulnerable populations. People who differ from the dominant cultural identity or behave in ways that do not conform to our ideas of normalcy are pathologized. This section explores how a medical mentality in mental health, power dynamics in doctor-patient relations, and the psychological impact of injustice contributes to overpathologizing marginalized communities.

Medical Mentality

If the cause of a mental health problem is rooted within the individual, then it is no surprise that the solution is also individual-based. Participant Four stated, "I think that that has really created counselling that is not culturally safe for a lot of different folks." An individual's mental health is not considered in a vacuum though, it is one part of their intersecting identities. Participant Five noted, "if someone is Indigenous or a Person of

Color they may receive a diagnosis of ADHD or ODD, as opposed to a child from an upper class neighborhood and is White. They may receive an autism spectrum diagnosis." Participant Two said, "I think that the medicalization of mental health does serve as a way to call people 'crazy' if they're activists or they're passionate or they're advocates."

The perspective of the medical model simplifies the processes of mental health and contributes to increased stigma. "Because we medicalized it people think in the same way that I have a broken leg, I have a broken brain. That story is pretty damaging" (Participant Three). Many people only seek medical attention when a health problem becomes serious. Participant Three expressed concern at adopting this mentality for therapy, "if you think you have an illness, then you come to therapy, otherwise never. Don't waste the resource if it's a medical resource… That makes preventative work really hard. There's whole types of work you can't do."

Participant One expressed their frustration at how aspects of the human condition have been pathologized. In describing a client who was struggling with familial separation and death they said, "it was just grief, everything was in chaos. So she was having a very hard time, but there wasn't something medically wrong with her." They also discussed a client that lost their long-time partner, "she lost him four or five months before, like of course she's 'dysregulated,' she's grieving. This isn't like 'better get in there and do EMDR and clear this up.'"

The process of assessment, diagnosis, and treatment can impact people both during the process and long afterwards. Participant Four mentioned how labels like ADHD or PTSD "really impacts how they see themselves… their ability to succeed in the future." Participant Five shared their experiences working with children and adolescents

that the process “affects their sense of value of themselves” and even their “sense of purpose and ability.” This diagnostic process can be particularly fraught when assessing trauma, as it can “keep them at a distance from the experience… it’s like a label for their life, it doesn’t set them up so that they could heal and grow and live a fruitful, beautiful life even after trauma or with trauma” (Participant Five).

Power and Pathology

Respected professionals like doctors or therapists have more cultural clout and authority which can impact how professionals conduct their work and how patients interact with them. Participant Three described the power imbalance in the medical professional-client relationship, “you have the knowledge and they are coming to be treated with the knowledge, and they just have to do what you say and they’ll be better.” Participant One said the focus on medicalization has, “a lot to do with power and hierarchy, systemic issues that end up also doing a lot of harm.” They referred to situations in which a diagnosis or treatment plan was framed as a person’s “only option” and “presented in a way that it was coming from an authority” which led people to feel coerced. Participant Two described a client from an Indigenous background whose auditory hallucinations became more disruptive after a doctor referred to them as “sick” and “bad”. Participant Two examined the “auditory phenomenon” with the client and found it was actually a soothing song their grandmother had sung and it became “no longer disruptive.” “That power dynamic… produced more of the effects of sickness in a sense, constructed the sickness almost.”

Counsellors recounted stories of clients’ experiences or mental health concerns being invalidated, to the point where they felt “gaslit by the medical system” (Participant

One). Participant One summed up the difference in power as, "there's a million ways for a practitioner to continually blame the person and not question whether they are not doing their job well or not doing it well for this particular person." Participant Five discussed empowering clients to challenge diagnoses, "letting clients know they can challenge their doctors, ask for referrals, reframe their medical experience. That invitation can be really powerful" or "even start to deconstruct the roots of a lot of diagnosis and notice that there are oftentimes bias."

Impact of Injustice

The emotional and psychological impact of experiencing injustice is enough to strain anyone's mind and affect their wellbeing. Counsellors emphasized the role that medicalization plays in pathologizing the impact of injustice. Participant Four spoke about how it has affected her work, "you may have to do a lot of work to unpack that with them so that they can recognize the social context and come back to their own power." The notion that the problem lies within an individual perpetuates the status quo of societal injustice. "Sometimes that depression is like your body resisting that injustice to you, it's not a diagnosis, it's not that there is something wrong with you" (Participant Four). She continued to describe the impact it had on her clients,

> like the ongoing emotional labor of living in a racist community and then you're diagnosed with depression, to me that's really unjust… Because how can you not be depressed, you live in a world that was designed to kill you. So you should be sad about that, you should be mad about it, and all of those natural human responses.

Participant Four criticized the medical model's conceptualization of what acceptable mental health presents as, since it "needlessly pathologies certain types of mental states." They shared that in their work for not-for-profit organizations they noticed a focus on "trying to get people to be more normal, to have less reactions to something."

With the context of pathologizing the impact of injustice, it is no surprise that some of the counsellors viewed medicalization as oppressive. For historical context Participant Four said, "we need to talk about the time when hysteria was a thing that women could be diagnosed with. That is such a good example of how messed up our diagnostic system is… It's not that long ago." Participant Two succinctly stated, "the medical model of mental health is still being wielded like a blunt instrument to suppress people, suppress their voices, or slow down change."

Counsellors suggested the inclusion of a trauma-informed perspective to improve the diagnostic process. The piece-meal fashion of looking at different aspects of mental health and ability for different disorders can miss critical information. Participant Five expanded,

> I think about the kids that I work with… a lot come with complex histories of trauma… and the diagnosis of ADHD and ODD, and how those diagnoses are not trauma-informed and those kids are not often tested in a way that looks at them as a whole person.

This lack of trauma-informed assessment does not impact all communities equally, however. Impoverished communities generally have more frequent and severe traumatic experiences than wealthier communities. "The medical system is not a trauma-informed

practice, doctors are not versed in this, even pediatricians are not… I see that to be really problematic for a lot of people who are already marginalized" (Participant Five).

Cells and CBT: Lack of a Holistic Approach

The medicalization of counselling impacts social-justice informed counsellors by centering mental health treatments around pharmaceutical medication and standardized treatments such as cognitive behaviour therapy. By focusing narrowly on those two methods, other therapeutic methods that could be more tailored to an individual are not explored. This section explores how this approach simplifies mental health treatment, standardizes treatment application, and the importance of a holistic approach to mental health.

Simplifying Mental Health

The effort to simplify and standardize the assessment and treatment of mental health issues has contributed to a reductionistic and directive approach that leaves little room for individual difference or preference. Participant One described a client's experience, "she was having these realizations of 'this feeling, I know when it started' and it got immediately diverted to 'oh, well this is what you have and for that we do DBT.'" They discussed the prescriptive way that some doctors work, "the hospital is just like 'no, this is what you've got, so this is what we do." Participant Three discussed the ubiquity of CBT, "if CBT is not going to work for you, you are still going to get it if you use the public system, for the most part." Rather than utilizing many different therapeutic modalities to better suit different people, institutions often use CBT as a catch-all for mental health support. Participant Four added how it has impacted their clients, "somebody has told them 'you should try CBT' and then you meet them and you think

‘oh CBT is not at all going to resonate with this person’ but they’ve been told it’s something they need.”

Participant Three noted our concept of “what is and isn’t healing” has deep roots in the medical model. Alternatives for mental health support that are community-based (e.g., Indigenous practises like sweat lodges) or experiential (e.g., art therapy) are often not regarded as acceptable treatment. “If it’s not medical, it’s not healing” (Participant Three). Participant One acknowledged the utility of medicalized therapy, but also suggested “seeing that as one way of treatment… but not blindly using it as the be-all and end-all in decisions about how to support a person.” They shared that a client’s doctor would only write a note to miss work if she took medication, as the counselling with Participant One “was not part of the model.” The lack of a holistic perspective on mental health is seen explicitly in the separation of the mind and body in Western thought. Participant Five shared her thoughts that, “the view of De Cartes even to separate us as a mind-body… really speaks to the way that White ableism is rooted in the theory of our practice. Art therapy and a lot of experiential therapies challenge that notion.” Participant Two shared their ideas of how to improve,

> so how could we think less about naming and labeling and instead focus more on like what’s this person’s experience of the world, where are they running into trouble, and how do we work back. We must not be concerned with what category they fit into. So try to be less reductive and being more messy and complex and being open to that.

A Prescription for Health

Counsellors noted that medication was being used more frequently and with more populations. Participant Four shared her experience that, "when I first started I wouldn't see GPs touching medication with thirteen-year-olds, now it seems like a lot are more up for it." It is important to highlight that pharmaceutical medications have a demonstrated utility in treating mental health and supporting those who may be struggling. Counsellors stated, "I'm not anti-prescription medication, like there's obviously a need and a utility to it" (Participant Five), and "for some people absolutely, medication has saved their lives, hands down" (Participant One).

In tandem with the increase in pharmaceuticals comes a stronger reliance on prescription medication in the medical system. Participant Five shared her experience in hospice care when the antipsychotic medication Seroquel was frequently prescribed to "just help calm people with dementia down" in long-term care facilities. She expressed frustration at the overuse of the drug,

> not having the time or the space to adequately socially and emotionally support people at the end of their life, struggling with really complex health issues, and the best 'answer' to that is to just give them an antipsychotic… Just thinking about the ways in which those people were limited and essentially trapped in their own bodies because of bureaucracy… That drug in particular is a medicalization, that is a medical approach to treating a symptom of a disease that we don't particularly understand.

A Holistic Approach

Counsellors expressed a desire to learn more diverse methods of counselling and have those methods be respected by the wider healthcare professions. "Ideally to me

people have access to information and choice and respect for whatever route they choose to take and that many different things be considered therapy” (Participant One). Participant Two noted a positive trend in therapeutic approaches, “we’re increasingly seeing art, cultural production, and art therapy entering into therapy practices and being allied with advocacy and activist practises.” Participant Five said it was fulfilling to see new research from neuroscience affirming the work that therapists do, including art therapy and “Indigenous and more ancient practises of healing.” They also suggested using an Indigenous Medicine Wheel as a model of reinterpreting wellness, “if something is broken in us physically, that means that our emotional, our spiritual, the way that we connect to other people, all of those things are going to be affected.”

In terms of a holistic approach, counsellors discussed collaborating with clients to discover where their mental health issues are impacting them and tailoring a treatment plan to the individual. In light of the rote way that mental health is sometimes practised by physicians, Participant Two suggested, “focus more on the components, the symptom sets, that an individual is experiencing and treat that, because those are pretty tangible.” Participant Five recounted their experience working with women recovering from addiction, “it was even just refreshing to them to feel seen as a person instead of a diagnosis.” Participant Four brought up the need for, “more work around educating people around… why you would need a diagnosis.”

The message of de-pathologizing therapeutic services was one that was important to each participant and how they operated their therapeutic practice. As the medicalization of counselling continues, more counsellors may find themselves reflecting on their practises and searching for a more holistic approach to supporting clients and

providing therapeutic services. Participant Two remarked, “I think increasingly I’m noticing that there’s an immense demand for psychotherapy in this way, in a de-pathologist way, in a meet you where you’re at kind of way.”

Discussion

The themes resulting from the interviews with counsellors included therapeutic relationships with clients and professionals, the industry and systems of mental health, social justice work, medicalization as oppression through pathologizing difference, and the lack of a holistic approach to mental health. In this chapter these themes are explored in relation to previous research and literature in order to add context and garner a better understanding of how counsellors’ beliefs relate to the wider field. Finally the practical implications of this study are discussed, as well as the limitations present in this research.

Main Themes

Therapeutic Relationships: Clients and Professionals

The interaction between medicalization and the therapeutic relationship is one of the most important points, as it hits at the core of therapeutic work. Counsellors framed medicalization as a barrier, not only to the client-counsellor therapeutic relationship, but also to the relationship counsellors have with their profession. The adherence to evidence-based treatments and manuals effectively standardizes therapy and reduces the quality of interpersonal connections (Havik & VandenBos, 1996). Counsellors highlighted the need for autonomy in their social justice-oriented work in order to serve the client’s needs and also feel a sense of professional satisfaction with the service they are providing, and research similarly suggests this can be negatively affected when working with managed care companies (Cohen et al., 2006). Counsellors discussed the

need for therapy that is delivered in a non-pathologizing approach to reduce the potential harm to clients and also improve the therapeutic relationship, which has been found to be particularly helpful for clients with trauma (Gómez et al., 2016).

Multiple counsellors emphasized that the therapeutic relationship is the most important factor in successful therapy, as was discussed in Chapter 2. The therapeutic relationship can be conceptualized as the combination of the therapeutic alliance, real relationship, collaboration, and empathy. A meta-analysis of 295 studies has shown that the alliance was one of the most important and robust factors in therapy outcomes (r = .28, d = .58; Flückiger et al., 2018). Another meta-analysis of 82 studies showed that therapist empathy is moderately associated with patient success (Elliot et al., 2018). The real relationship (Gelso et al., 2018), collaboration, (Tryon et al., 2018), and self disclosure (Barrett & Berman, 2001) have also shown to impact the therapeutic relationship and therapy outcomes.

In terms of establishing an identity for the field of counselling, counsellors highlighted the need for the profession of counselling to wholly adopt a relational approach to therapy. One of the most pressing issues for counsellors in terms of identity is the use of evidence-based treatments (Norcross et al., 2017). One counsellor brought up the possibility of being replaced by robots in the future due to evidence-based treatments (EBT) and this not as far away as one may think. In fact, initial research has tested a social robot to conduct iCBT as a "viable alternative to traditional human-delivered therapy" (Dino et al., 2019, p. 1) and other research on the ethics of AI therapists has cited the potential for misuse of this technology to replace established services, exacerbating health inequities (Fiske et al., 2019).

Counsellors also discussed potential changes to the credentialism that exists in the field, which poses a barrier to people from diverse backgrounds who may experience barriers to postgraduate education and college registration. One difference between the literature and what counsellors said was that evidence-based treatments and manualized therapies may actually be one path toward changing the high bar to practise counselling. The IAPT program in the UK is one example, where individuals can become PWPs (Psychological Wellbeing Practitioners) through a 45 day curriculum at the undergraduate level (NHS England, 2015). PWPs can provide low-intensity services utilizing CBT practises to support people with low levels of depression and anxiety (NHS England, 2015). The ease of implementation and cost-effectiveness of this role would contribute to cheaper therapy which is attractive to health structures, as mentioned in Chapter 2 (Dalal, 2018). This path may not have been brought up by counsellors in this study because it may perpetuate the hierarchical nature of healthcare professions and keep those without credentials in a less autonomous role than changing the requirements to become a registered psychotherapist.

Counsellors reflected on the double-edged sword of the ways in which mental health is discussed in society. While it contributes to greater awareness and mental health literacy in the general populace, the increasingly diagnostic discussion of psychological health contributes to increased stigmatization (Corrigan, 2007), as discussed in Chapter 2. Patients in more medicalized contexts described feeling torn between the stigma of being labeled with a DSM diagnosis and receiving services that would only be provided with a diagnosis (Strong, 2017, p. 191). The need to be labeled in order to receive more beneficial care will punish those who do not wish to be pathologized.

Industry and Systems in Mental Health

The medicalized mental health industry and the systems incorporated with it come into conflict with the ethical principles of counselling and social justice. Counsellors highlighted the need for therapy that is based in caring for others and genuinely wanting to see others succeed, rather than simply keeping people working. The use of a strengths-based approach that is trauma-informed and steeped in the values of social justice was proposed as a better approach, consistent with reviewed literature (Vera & Speight, 2016).

Counsellors criticized the streamlined way that mental health services are provided as impersonal, cutting to the heart of the work in therapy. The pragmatism that allows for reduced operational costs was viewed as “gatekeeping resources”, creating barriers to those less privileged and contributing to increased health inequality (Steele et al., 2009). Counsellors looked to other countries, such as the UK, and found that this two-tier system of medicalized therapy for the masses and individual preference in therapy type for the economically privileged is not a socially just model to follow, which is consistent with literature by Roderick and Pollock (2022). However, something not mentioned by counsellors was that much of the public is in a one-tier system, as there is a lack of government funded therapy in Canada and most insurance companies do not cover registered psychotherapists, leaving many to pay out of pocket anyways.

Differences were noted between the counsellors’ statements and the research literature regarding the cost effectiveness of CBT and its status as the “gold standard” of therapy. The demand for therapy in Canada is outpaced by the availability of mental health practitioners (Statistics Canada, 2019). Research supports short-term CBT as a

method of increasing access to therapy for many people by increasing the number of people seen by therapists at the cost of number of sessions each client receives (Clark, 2018; David & Cristea, 2018). Furthermore, as the systems and structures have historically had lower opinions of mental health generally, a standardized evidence-based treatment like CBT may be the best bet to have counselling recognized as a scientific endeavour worth increased public funding (David & Cristea, 2018). These differences between counsellors' statements and literature may be because counsellors may negatively view reducing therapist sessions in order to increase the number of clients as watering down the complex process of therapy. Additionally, counsellors that expressed more critical views of the ubiquity of CBT may be hesitant to give it more power in the field in the hopes of more money and privilege, as it may overshadow other therapeutic modalities.

Medicalizing the mental health field has been quite profitable for businesses, particularly pharmaceutical companies who have had higher profit margins than any other sector of industry, including the energy and finance industries (Hawksbee et al., 2022). Medicalization can also be quite profitable for the counsellors themselves if they use the preferred modality. Counsellors stated that counsellors offering primarily short-term CBT sessions make higher wages than those offering other types of therapy. However, no literature sources corroborated the relationship between CBT and higher salary for the practitioner.

Counsellors described one of the largest barriers to their therapeutic work is the shadow of insurance companies. Counsellors highlighted the disconnection between insurance companies' understanding of therapy and therapists' understanding of how

therapy works. Friedson (1994) argued that third-party funding in counselling highlighted the tension between providing a quality service and the economic interests of the service providers. Counsellors described needing to hide information from the client's insurance company in order for the client to continue having the services covered. Literature states many counsellors do not accept insurance coverage because of the ethical issues of autonomy, restricting the content of discussions, issues of privacy, and requirements that disrupt the process (Cohen et al., 2010).

An issue that was brought up by several counsellors was the lack of trauma-informed approaches to mental health in medical institutions. Research shows that nurses in hospitals have little knowledge of trauma-informed care and those in acute settings or those employed for more than five years reported less favourable attitudes to trauma-informed care (Vincenti et al., 2022). Long-term care homes were also criticized for medicalized treatment of residents through the use of pharmaceuticals, including the use of psychoactive medication to sedate residents and reduce problematic behaviour associated with dementia (Lucas & Bowblis, 2017). In order for counselling to continue to improve there must be a reckoning with the industry and systems involved with mental health and wellbeing.

Social Justice Work

The work that still needs to be done to move therapy to a more social justice-oriented position was noted by counsellors. Decolonizing mental health, the potential harms of using a medical lens on certain social problems, and counsellors' responsibility to fight for a more socially just society were some of the main pieces of work that counsellors mentioned.

Literature on decolonizing mental health states that an understanding of the historical context of colonization is a necessary first step, combined with an approach based on consultation and collaboration with Indigenous and colonized peoples (Stewart, 2009). Stewart (2009) suggested a social constructivist approach may pair well with Indigenous ways of knowing, as it focuses on culture and context in understanding human interactions and relationships. Other suggestions include minimizing the power differential in the client-counsellor relationship, recognizing Western counselling as individualized and perpetuating Western pathologies, and expanding what can be considered therapy to include ceremonies, community events, and healing processes outside of Western culture (Lewis et al., 2018). Reassessing our approach to mental health using perspectives outside of the medical model, such as an Indigenous Medicine Wheel, can help to address some of the immediate concerns while also beginning to address the underlying causes of health inequities.

Counsellors highlighted the need for those who work in the mental health field to reflect on concepts of internalized colonialism, hierarchical power systems, and systemic barriers to health that impact their work. The notion of objective truth through science, while staying silent on systemic oppression, have fueled the pathologizing narrative of the medical model and the DSM is steeped in this narrative. Gayle and Raskin (2017) surveyed 121 counsellors and found that counsellors viewed the DSM-IV-TR as putting more emphasis on diagnosis than treatment, applied medical labels to psychosocial problems, and obscured individual differences. However, alternatives that adopt a "social-interpersonal diagnosis" have received support from counsellors (Gayle & Raskin, 2017). The Power Threat Meaning Framework is one such alternative that takes a

nondiagnostic approach to conceptualizing psychological wellness and incorporates the potential of past trauma as well as environmental and social influences (Johnstone & Boyle, 2018). In this way counsellors can challenge one of the central documents of medicalization.

Counsellors also suggested taking responsibility for the harms that have been committed by therapists historically and the harms that continue to occur. Counsellors expressed concern regarding perpetuating White privilege and holding themselves and others accountable for cultural transgressions. Social responsibility and the use of an anti-oppressive framework to keep oneself accountable was emphasized by Brown et al. (2019) for social justice-oriented counsellors. It is important for White counsellors to engage each other in conversations about privilege and the development of a critical consciousness (McDowell & Hernández, 2010). Counsellors noted that they had power to change society based on their unique view into people's lives, which was mentioned in the literature in Chapter 2 (Perlman et al., 2015). Through these different changes counsellors can advocate for social justice within the mental health field.

Pathologizing Difference: Bias and Oppression in Mental Health

One of the largest criticisms of the medical model of mental health is that it overpathologizes psychosocial issues and this has had a particularly disparaging effect on those whose social location does not align with the dominant social locations (e.g., White, heterosexual, economically stable, male, cisgender). The use of psychological science to denigrate marginalized communities is as old as the field itself, as the individualistic biological approach to mental health fails to account for the context in which symptoms emerge.

Counsellors discussed how the medical model has historically been in conflict with social justice values due to pathologizing people who were seen as different, imposing intrinsic faults based on race, gender, or sexual orientation. Counsellors called for more discussion and recognition of past prejudicial pathologies such as hysteria in women (Lazaroff, 2006), drapetomania in African American people (Majors, 2020), gender identity disorder in trans people (Riggs et al., 2019), and homosexuality being a DSM disorder (Drescher, 2015). A disparity in diagnoses was another contentious subject brought up by counsellors, as social location may influence the diagnosis one receives. A growing body of research shows that ethnic and racial minority youth are more likely to receive a diagnosis of disruptive behaviour disorder and less likely to receive an ADHD diagnosis than non-Hispanic White youth, even when controlling for adverse childhood experiences and sociodemographics (Fadus et al., 2020). Woolfolk (2015, p. 165) summed up that, “medicalization is not an objective, value-free process, regardless of how felicitous its ultimate outcome may be. In some cases it is a straightforward value judgment or an act of social control.”

Counsellors expressed concern about the expansion of pathology into other areas of life such as addiction, grief, and trauma and the impact that medicalized labels can have on people. A diagnostic label is a recognition that an individual differs from the norm and should be categorized in order for smoother treatment in the healthcare system (Son, 2019). Labels can be stigmatizing, reductionistic, and marginalizing to those that bear them (Son, 2019), though they can also be quite meaningful to individuals. Consistent with counsellors’ reports, a systematic review found 44% of individuals with a label experienced a disruption in self-perception, including viewing themselves as unwell

or less competent (Sims et al., 2021). In terms of specific diagnoses, classifying those with experiences of trauma as having an illness within them is a form of victim-blaming that is only too common in the medical model (Son, 2019). Additionally, reframing substance abuse treatment with a harm reduction approach was viewed as de-stigmatizing in the previous literature (Kellogg & Tatarsky, 2012). This may be one of the reasons that some counsellors and clients are pushing back against medicalization and challenging the diagnoses they receive.

Counsellors discussed how they conceptualized power from a social justice perspective in which client empowerment is a central goal. The power dynamic that exists in therapist-client relationships is inherently unequal due to the expertise of the therapist and the cultural authority that therapists and doctors are given (Morrill, 2021). Counsellors articulated the use of a feminist-informed, client-centered approach to navigating power relationships in therapy, where therapists refer to client's expertise on their own lives. Literature suggests that medicalized therapy creates a disempowered position for the client as the one who is sick and should follow the plans of authority figure (Morrill, 2021). Counsellors described reframing previous diagnoses and medical experiences in a less deterministic and more humanistic way to empower clients.

Counsellors particularly criticized the continued pathologizing of the impact of injustice and citing the loci of the problem within the individual. Counsellors highlighted the need for mental health symptoms to be contextualized with the client's experiences, rather than considered in a vacuum. Literature shows that experiences of racism and sexual objectification are associated with increased depressive symptoms, particularly when individuals internalize the oppression as a way of coping (Carr et al., 2014).

Literature corroborates the notion that locating mental disorders in individual's biology and not accounting for social factors perpetuates injustice in the mental health field (Woolfolk, 2015; Strong, 2017; Corrigan, 2007). The oppressive force of medicalization and its increased impact on marginalized people is possibly one of the most nefarious outcomes from the medical model.

Cells and CBT: Lack of a Holistic Perspective

When discussing the concept of mental health and the ways to improve it, the approach can become narrow when confined to the medical model. Counsellors agreed that much of the attention in the field of mental health is toward pharmaceutical solutions and CBT. Experiential therapies, community-based methods, and other alternatives are less acknowledged by the healthcare structures, even though they may benefit people.

The criticism that the medical model reduces people's nuanced and complex lives down to categories based on biology is one of the oldest and most repeated criticisms in the literature (Albee, 1998; Dalal, 2018; Engel, 1977; Frances, 2013; Strong, 2017; Szasz, 1961; Woolfolk, 2015). Counsellors regarded not only the medical model's conceptualization of mental health as simplified, but the treatment as well. For disorder X conduct treatment Y. Counsellors identified treatments tailored to an individual's experience of their symptoms would create a less rigid support system, which is corroborated by research (Duncan et al., 2010). Deconstructing complex mental processes into simpler ones facilitates easier understanding, though it is time to reconstruct the parts into a whole in order to further develop our understanding.

Cognitive behaviour therapy is one of the most eminent examples of simplifying and streamlining treatment to treat a wide variety of disorders. Counsellors criticized the

hyper-rational model that many researchers used to validate evidence-based practises. While CBT certainly has utility as an important therapeutic modality, counsellors called for more space for other modalities to be practised alongside CBT as well and for those modalities to be covered. Research shows that humanistic therapies have comparable outcomes to CBT (Elliot, 2002), and experiential therapies have been shown to be more effective for emotional processing than CBT (Watson & Bedard, 2006). Others in the literature have also criticized CBT as being the right ideology for the neoliberal capitalist social system, as it focuses mainly on internal maladaptive thoughts and can be conducted with less therapist interaction (Dalal, 2018).

Counsellors highlighted the increased use of psychopharmaceutical medications to treat mental health issues either in combination with therapy or on their own. Prescriptions for young children and an increased reliance on medication to solve social problems, such as disruptive behaviour in a long term care home, shows the prevalence of medication. In 2014 the Centre for Disease Control and Prevention estimated that 10,000 US children aged 2-3 were prescribed stimulant medication for ADHD such as methylphenidate and other amphetamines (Schwarz, 2014). While non-medicalized solutions such as teaching parents to create more structured environments were the first line of support, these were often ignored (Schwarz, 2014). This finding is a good example of the crossroads between medicalization and social justice, as those toddlers whose parents' insurance was Medicaid were more likely to be put on medication (Schwarz, 2014). Some psychiatrists have even called for changes to the standard practise so that emphasis is given to highly individualized psychosocial treatments to determine which patients can be treated with minimal medication or none at all (McGorry et al., 2013).

Counsellors' statements differed from some literature reviewed in Chapter 2 on pharmaceutical medication. Pharmaceutical medication can be part of increasing an individual's agency within a strengths-based approach, as companies subvert the doctor-patient power dynamic by advertising directly to individuals and providing more options (Griffith & Griffith, 1994). Additionally, having alternatives or accessory components to therapy may be beneficial for those who cannot access therapeutic services due issues of scheduling, supply, or stigmatization, as taking a pill may be less stigmatizing than therapy (Fraser, 2001). These differences between counsellors and the literature may be because of the social perception as pharmaceutical companies as greedy and not motivated by goals of social justice. Counsellors also criticized elements of the UK's reliance on EBTs for their public mental health therapy support, however it can be viewed as a step away from reliance on medication and toward a more counselling-focused approach to treatment (Woolfolk, 2015).

If counselling does diverge from the medical model, it will need a different approach to therapy. Counsellors advocated for a more holistic approach to mental wellbeing that incorporates physical, psychological, cultural, social, and spiritual factors impacting people. Counsellors also expressed interest in learning more diverse methods of therapy and having those methods covered by insurance and respected by the field. Research has shown promise for art therapy in reducing psychological distress related to trauma (Abbing et al., 2018). Treatments that involve the body such as yoga therapy have also been found to be effective in reducing symptoms in a range of psychiatric disorders (Cabral et al., 2011), as well as the wealth of research on meditation's impact on psychopathology (Wielgosz et al., 2019). A more holistic approach to counselling that

would take into account social justice values would comprise a humanistic, non-pathologizing, and collaborative approach grounded in feminist and multicultural theory while utilizing trauma-informed practises to provide a variety of different therapeutic techniques that can be tailored to the individual.

Implications

This study has many theoretical and practical implications within research, policy, and counselling practise. Within the research literature on counselling it emphasizes the importance of qualitative research and having conversations with counsellors that use a social justice approach. Considering that much of the work in counselling is based in conversation, it follows that research would reflect and amplify this aspect. These counsellors have been on the front line of the increased demand for mental health services during the Covid-19 pandemic and social upheaval with the Black Lives Matter movement. This study used direct quotes as it is critical to listen to their voices and determine what challenges they face in order to better facilitate the mental health of society. The content analysis method allowed for the construction of themes across participants leading to a broader and more holistic perspective on counsellors' beliefs.

This research contributes to a growing literature on medicalization, social justice, counselling, and the intersecting relationships between all three. It is hoped that this research will spur more interest on the effects of pathology on wellbeing and the differences between medicalized and non-medicalized therapies. The use of positivist, predominantly biological science to justify and validate therapeutic techniques is one method of scientific examination, though it is not the only method. Centering the experiences of participants, an openness to mixed methods and qualitative methods of

research, and increasing ecological validity to ensure techniques work outside of the lab will help facilitate development and discovery in the counselling field.

Examining the intersection between social justice and medicalization in the context of counselling has introduced some of the largest structures and most ingrained habits of Western society. Through examining these large scale factors it is apparent that policy changes at the professional, industrial, and governmental levels are required. Governmental policies that reflect and embody social justice practises should be enacted in the form of greater funding for therapeutic modalities of many different kinds. While CBT is good start and helps divest from the pharmaceutical industry, the field of counselling is wider than CBT and the therapies available to the public should reflect this. Similarly, governments should enact policies to examine the rate of coverage that major insurance companies cover mental health treatments in comparison to physical health treatments and suggest improving access to counselling. Furthermore, the professional bodies of psychology, the APA, CPA, and CCPA, should recognize and acknowledge the profession's history of pathologizing marginalized groups as a method of social control. More education on the effects of institutional racism, sexism, and colonialism would assist in therapists' awareness of cultural issues. Additionally, a professional body of cultural accountability could be instituted to ensure that therapists are not perpetuating dominant ideologies related to race, gender, sexual orientation, and indigeneity.

Many counsellors criticized medicalization, however some noted that it has benefitted them financially through increased funding for service through insurance and governmental systems. This double-edged sword of both being against many aspects of

medicalization and benefiting from increased coverage is like counsellors biting the hand that feeds them. The greater coverage for clients from third-party payers is arguably the best aspect of medicalization, as it allows more clients to access therapy and more counsellors to receive remuneration for their services. This speaks to what one counsellor stated about the common approach of improving the profession through getting more money from structures. However, this may not be in line with social justice-oriented counsellors' opinions, as putting profits over their values in light of medicalization may be a Faustian bargain. Medicalization may also increase access to therapy for wide swaths of the Canadian population, as it is more status-quo friendly than other approaches to mental health. However, this access comes at the cost of greater pathologizing, reductionistic and narrow views of mental health, and less appreciation of the marginalized communities' mental health. It is up for individual counsellors, as well as the profession as whole, to determine whether the medicalization of counselling is worth the downsides. Further research into counsellors' beliefs about medicalization could illuminate this contentious discussion.

The practical implications of this study for counselling practises center on the pathologizing impact of medicalization, its conflictual relationship with social justice, and social justice-oriented approaches to counselling. Counsellors emphasized the value of adopting a relational approach to mental health for both the clients and the profession's identity as a whole. Counsellors pushed back against medicalization through supporting clients to reframe their own diagnoses and medical experiences, as well as working to change power dynamics in the practitioner-client relationship to be more equal and tailoring treatment plans to an individual's preferences. This research has offered ways of

improving the field of counselling from a bottom-up approach through the use of trauma-informed, strengths-based discourse in therapy to address the medicalization that is growing in the field.

A surprising crossroads between the medicalization of counselling and social justice comes up against resistance from a broader cultural force, individualism. Group counselling is cost effective as many clients can receive therapeutic services while requiring less therapist time, similar to one of the main advantages of short-term CBT for industries and systems. It is also a form of community-based treatment that better accounts for social elements of wellness, which can also contribute to less stigmatization (Tong et al., 2020) and increased social action (Vera & Speight, 2003). However, it can be difficult to fill a group therapy session as many people prefer individual therapy sessions. This is unsurprising, considering that the medical model locates problems within the individual, so it would take an individually based treatment to solve. If mental health is considered in a more social and environmental way, group therapy sessions may be more attractive to people. The individualism that is so present in Western culture and particularly evident in the medical model must be addressed by both service users and providers in order to continue developing the profession of counselling.

Limitations

Although this study illuminates the connections between social justice and the medicalization of counselling, there are some limitations that require discussion. With a limited sample size of five and the participants predominantly identifying as White, the generalizability of this study is one such limitation. Future research on counsellors' beliefs would benefit from a larger sample that included more BIPOC voices.

Additionally, all participants were recruited from the Canadian Counselling and Psychotherapy Association, and as such counsellors outside of that organization may have different beliefs.

Conclusion

After reviewing the literature and participants' statements, there is a high degree of congruence between counsellors' beliefs and the counselling research literature. Counsellors discussed at length the pathologizing impact of medicalization and this was one of the most frequent criticisms in the literature. The impact of diagnostic labels, the cultural differences in receiving certain diagnoses, and the expansion of pathology into psychosocial issues are some the main criticisms. Counselling that adopts a de-pathologizing approach, particularly for issues of grief, substance abuse, and trauma, has been touted by both counsellors and the literature.

Research corroborated counsellors' statements that the therapeutic relationship is the most important factor in successful counselling and medicalization affects that relationship through reducing therapist autonomy and manualized evidence-based treatments. Counsellors differed from research in that EBTs facilitate a greater number of people to receive services and also may serve to reduce the credentialism in counselling and increase practitioner diversity. Expanding what is considered therapy to include holistic approaches and tailoring mental health treatments to individuals can increase the efficacy of counselling. Counsellors suggested reducing the unequal power dynamics that exist in the practitioner-client relationship and empower clients by working in collaboration with them, which is consistent with the literature.

Counsellors and literature cited their unique position within society and their responsibility to advocate for social change. Recognizing their position of power, both in terms of their profession and their individual social locations, is important for the development of the field and to avoid perpetuating the ideologies of those with dominant status. Decolonizing mental health and elevating multicultural and feminist-informed approaches to counselling were endorsed by both counsellors and literature. Additionally, the use of trauma-informed practises in counselling and medical institutions would facilitate better mental health care and support.

Counsellors tended towards criticism of the medicalization of counselling and as such they cited substantially more drawbacks than benefits in their discussions. Counsellors said some of the main benefits of medicalization have been the legitimization of counselling and mental health issues in the public and industry spheres. By using physical health as an entrenched comparison for mental health the issues of mental health were taken more seriously and the treatments for those issues were granted more validity and respect. The impact of that legitimacy is that insurance companies paying for their clients to receive counselling and counsellors getting access to more avenues of remuneration. A secondary impact can be seen in the reduction of social stigma for individuals seeing a counsellor, as it has become more normalized.

Counsellors also cited diagnostic labels as helpful and beneficial in legitimizing someone's struggles and providing them with concrete reasons for their symptoms. Medicalization can also give people language to discuss their mental health and help with finding communities of people with similar experiences. Counsellors also noted that there were pragmatic benefits in the way the medical system organizes resources and treatment

plans. The utility of pharmaceutical medication and its place in an individual's treatment was also cited as a benefit of medicalization.

Counsellors cited many downsides to the medicalization of counselling that impacted both clients and counsellors. The foundations of the medical model emphasizes the biological aspects of a person and does not account for the social or environmental qualities. Focusing heavily on biology is a simplistic perspective on complex mental processes and puts the locus of problematic symptoms within the individual, framing the problem as potentially unchangeable and creating a perspective of shame and guilt that inhibits people from reaching out for support. The expansion of medicalization to new aspects of human experience such as grief, trauma, and substance use was another downside that counsellors expressed regarding medicalization.

Counsellors considered locating mental health issues within the individual as one of the main downsides of medicalization. This is reflective of the individualism that is prevalent in Western culture and seeks to maintain the status quo by attributing maladies to the individual, rather than socioeconomic policies and systematic oppression that contributes particularly heavily to the mental health of marginalized communities. The solution is also viewed at an individual level with one-on-one counselling, which can be a form of pushing Western individualism onto cultures that are more collective and heal in a more collective manner. Counsellors also cited another downside in the historical use of pathologies as a method of social control and ostracization of those who do not conform to social standards, as well as the disparity in psychological diagnoses based on ethnicity, culture, gender, or poverty.

Counsellors expressed negative beliefs about how the medicalization of counselling impacted their counselling practises and the field overall. The narrowing focus on short-term and manualized therapies is one of the main trends that counsellors cited as downsides, as the standardized practises restrict counsellor autonomy and use a one-size-fits-all approach. Many medicalized therapies focus on quick symptom reduction at the cost of addressing the root causes of the symptoms, leading counsellors to reflect on it as providing half of a treatment for administrative or economic reasons. The gatekeeping of resources by systems and companies also makes preventative therapeutic work difficult and contributes to mental health inequities. Counsellors also cited the power dynamics in medicalized relationship as a downside, considering the authoritative position of the therapist, which is not in line with feminist and person-centered approaches. Another downside mentioned by counsellors was the lack of trauma-informed care within medical institutions as well as the hierarchical power structures of the mental health professions.

Succinctly, social justice-informed counsellors believed the medicalization of counselling to be pathologizing individuals, marginalizing groups, and homogenizing therapeutic work. The process is driven by systems and companies gatekeeping resources, a desire to maintain the social status quo, and the profession's pursuit of prestige and profit on the heels of medicine. Counselling can continue to evolve through a relational approach that values holistic practises and individually tailored treatments. Through more conversations with counsellors we can garner a better understanding of the intersection between social justice and the medicalization of counselling.

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Appendix A – Recruitment Letter

Survey on Social Justice and Medicalization in Counselling Practice
Jason Brown, Ph.D.
Principal Investigator
1137 Western Road, London, ON, N5P0C3

The Social Justice Committee Executive are interested in learning about the issues you consider important. We are seeking the views of all CCPA members to inform our Chapter's planning and priority setting.

We are writing now to request your participation in a study. We continue to recruit participants for a single telephone interview focusing on Social Justice and medicalization in Counselling/Psychotherapy.

Your views will assist the Chapter Executive with planning and priority setting. Our new RA, Christopher Mullin will assist with the collection of interview data, and will use the views on medicalization for his Master's Thesis on the Medicalization of Counselling.

Results of this thesis will be shared with the CCPA membership and appear in scholarly publications.

If you are interested and agree, you would be asked to participate in a telephone interview at a mutually agreeable time to discuss the topics of social justice and medicalization. Questions will be provided in advance of the interview. The interview would last approximately 30-60 minutes.

For more information about this study, or to volunteer for this study, please contact: Christopher Mullin

Appendix B – Letter of Information

Letter of Information and Consent

Project Title: Social Justice and Medicalization in Counselling Practice

Dr. Jason Brown, Principal Investigator
1110 Althouse, Faculty of Education,
1137 Western Road, London, Ontario
N6G 1G7

Because you are a member of the Canadian Counselling and Psychotherapy Association you are invited to participate in this research study about social justice and the medicalization of counselling/psychotherapy.

The purpose of this study is to describe counselling/psychotherapy students' and professionals' perceptions of social justice and effects of medicalization on their practice.

Participation will take approximately 30-60 minutes.

The interviewer will take notes throughout the interview. We are asking for your consent to tape record the interview.

Participant quotes will be used in reports and publications. Quotes will be identified only by pseudonym.

If you agree to participate you will be asked to engage in a telephone interview at a mutually agreeable time.

There are no known or anticipated risks or discomforts associated with participating in this study.

The possible benefit to you may be to have your experience reflected in research about social justice and medicalization. The possible benefit to society may be increased wellbeing for individuals receiving or delivering counselling/psychotherapy services.

You may withdraw from the study and have your data withdrawn at any point.

Representatives of Western University's Non-Medical Research Ethics Board may require access to your study-related records to monitor the conduct of the research.

The researcher will keep any personal information about you in a secure and confidential location for 7 years. A list linking your study number with your name will be kept by the

researcher in a secure place, separate from your study file. If the results of the study are published, your name will not be used

You will not be compensated for your participation in this research.

Your participation in this study is voluntary. You may decide not to be in this study. Even if you consent to participate you have the right to not answer individual questions or to withdraw from the study at any time. If you choose not to participate or to leave the study at any time it will have no effect on your professional or employment status. You do not waive any legal right by consenting to this study.

If you have questions about this research study please contact Jason Brown, Principal Investigator.

If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Human Research Ethics. The Research Ethics Board is a group of people who oversee the ethical conduct of research studies. The Non-Medical Research Ethics Board is not part of the study team. Everything that you discuss will be kept confidential.

A copy of this letter can be emailed to you if you provide an email address for this purpose.

Project Title: Social Justice and Medicalization in Counselling Practice

Dr. Jason Brown, Principal Investigator
1110 Althouse, Faculty of Education,
1137 Western Road, London, Ontario
N6G 1G7

Have you read the Letter of Information and had the nature of the research explained to you?

______ ______
Yes No

Have all of your questions been answered? _____ _____
Yes No

Do you agree to participate? _____ _____
Yes No

Do you agree to allow the interview to be tape recorded? _____ _____
Yes No

Name:

Date:

Appendix C – Interview Guide

Project Title: Social Justice and Medicalization in Counselling Practice

Interview Guide
Demographic Questions

City/community where you practice:
Populations with whom you practice:
Areas of specialty:

Years practising counselling or psychotherapy:
Years as member of SJ chapter:
Years as member of CCPA:
Regulating body or bodies:

Social Location

Age:
Gender: I identify as male
I identify as female
I identify as (please specify)
Ethnicity:
Race:
Class:
(dis)Ability:

Questions about Social Justice

1. What does social justice mean to you?

2. What social justice issues do you feel are particularly important?

3. In what ways could the chapter help you in your social justice work?

4. How can therapists address social disadvantage with clients from socially advantaged groups?

5. How can therapists address social disadvantage with clients from socially disadvantaged groups?

Questions about Medicalization

1. How is medicalization affecting social justice-informed counsellors and psychotherapists?

  a. How has medicalization affected your counselling and psychotherapy practice?

  b. How has medicalization impacted your clients?

  c. How has medicalization impacted your business/organization?

  d. How has medicalization influenced your social justice practices?

  e. What can our professions do about medicalization?

  f. What advice do you have for counselling and psychotherapy students about medicalization?

Appendix D – Debriefing Form

DEBRIEFING FORM

Project Title: Social Justice and Medicalization in Counselling Practice

Principal Investigator: Jason Brown, University of Western Ontario

Thank you for your participation in this study.

We really appreciate the time you have taken to share your insights about the intersections between social justice, medicalization and counselling/psychotherapy.

The purpose of the study is to describe of counsellors' understanding of social justice and how medicalization affects their practice.

Once interviews are complete, the data will be analyzed and summarized.

A summary of the results will be available to all interested participants by the spring of 2022. If you are interested in receiving a copy of results, please send an email to Christopher Mullin.

Appendix E – Ethics Approval

Date: 29 March 2021

To: Dr. Jason Brown

Project ID: 115437

Study Title: Social Justice Practice

Application Type: NMREB Amendment Form

Review Type: Delegated

Full Board Reporting Date: April 9 2021

Date Approval Issued: 29/Mar/2021 14:07

REB Approval Expiry Date: 11/Mar/2022

Dear Dr. Jason Brown,

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the WREM application form for the amendment, as of the date noted above.

Documents Approved:

Document Name	Document Type	Document Date	Document Version
LOI_ACCEPTED	Verbal Consent/Assent		
Interview Guide_ACCEPTED	Interview Guide		
Email advertisement_ACCEPTED	Recruitment Materials	28/Feb/2021	2
Debriefing Form_ACCEPTED	Recruitment Materials		

REB members involved in the research project do not participate in the review, discussion or decision.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario. Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Kelly Patterson , Research Ethics Officer on behalf of Dr. Randal Graham, NMREB Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

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Curriculum Vitae

Christopher Mullin

Education

Master of Arts – Counselling Psychology 2020 – 2023

University of Western Ontario

Honours Bachelor of Arts – Psychology 2014 – 2019

Wilfrid Laurier University

Concentration: Research Specialist

Minor: Sociology

Academic Honours and Awards

In-Course Scholarship – Level 2 2018 – 2019

Wilfrid Laurier University

Dean's Honour Roll 2017 – 2018

Wilfrid Laurier University

Presentations

Enhancing Accessibility: Confronting Barriers Within Practice 2022

Ward, R., Mullin, C., Smith, D., Rubin, A., Lengyell, M., Johns, C., Jay, M., MacKenzie, L., Brown, J., & Siddique, R.

Talk presented at the CCPA 2022 Virtual Conference

Resilience Workshop: Police Foundation Students 2022

Mullin, C., & Axenova, K.

Workshop presented at Fanshawe College

Canadian Counselling and Psychotherapy Association Student Representative Presentation 2022

Mullin, C.

Presented at University of Western Ontario

Understanding Self-Talk: Coding Self-Talk Style and Situation Across Time 2019

Mullin, C., Sadler, P., & Woody, E.

Talk presented at the 49th Annual Ontario Psychology Undergraduate Thesis Conference, Waterloo, Ontario.

<u>Clinical Experience</u>

Personal Counselling Intern 2021 – 2022

King's University College

Direct Support Worker 2019 – 2022

KW Habilitation

Research Assistant 2018 – 2019

Wilfrid Laurier University

<u>Volunteer Experience</u>

Socializer 2019 – 2020

House of Friendship (Charles Street Men's Shelter)