Governing by Expert Therapuetic Discourse
Expert Therapeutic Discourses, Practices and Counter-Practices Across Six Service Contexts

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Abstract

Evidence of aspects of a "therapeutic state" can be seen as operative in different contexts, though such a state would not be possible without a diagnostic discourse to enable its administration. In this article, we examine how the diagnostic discourse of the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5, American Psychiatric Association, 2013) has been taken up as a singular language for understanding and "governing" human concerns from the view of each author in six different contexts. Through Foucault's lens of governmentality we examine the following practices associated with the use of DSM-5: i) as a means for self-identification by college students, ii) as it is used to train the next generation of graduate trained counsellors, iii) as a discourse that organizes family understandings and interactions, iv) as it is used to medicalize "excessive behaviors," v) as an official institutional language that coordinates practice in an addictions treatment centre, and vi) as it governs the thinking and practices of corrections officials and incarcerated or post-incarceration women. Within these six different contexts, each author will share diverse counter-practices used by practitioners and service-users that challenge expected or dominant use of the DSM-5.

Key Words: *diagnosis, dialogue, collaborative practice, helping professions*

The death of a culture begins when its normative institutions fail to communicate ideals in ways that remain inwardly compelling. (Rieff, 1968, p. 18)

Standardizing a discourse of mental health has been seen as a way of legitimizing human suffering and what can be done about that suffering. If we live in a biopolitical era, as Thomas Lemke (2011) suggested, it is because contemporary society has placed its faith in biomedical knowledge as our means of overcoming that which threatens, vexes, and hurts us, or stands in the way of our changing ambitions. Mental health discourse not only articulates human concerns, it does so in actionable meanings of a particular medicalized kind. This discourse fails to communicate compelling cultural ideals as Rieff pointed out above. Such a discourse, for Foucault (2008a), instead offers a pathological basis from which to *govern* ourselves and each other.

Frank Furedi (2004) warned of an emerging "therapy culture" in which people increasingly understood and lived by expert therapeutic discourse. The terms of such a discourse promote a preoccupation with vulnerability and deficiency that Ken Gergen (1990) suggested invites enfeeblement and infirmity. Western expert therapeutic discourse has succeeded on a global scale, replacing cultural traditions of understanding and responding to human concerns with the DSM and its corresponding evidence-based treatments (de Vos, 2012; Watters, 2010). Psychiatric discourse, as Ian Hacking (1999, 2006) has shown, requires a historico-cultural niche

in which to grow, and as critics like Furedi and Illouz (2008) highlight, people currently and eagerly take up this discourse to address varied concerns and aspirations.

A particular logic is at work with this discourse: "governmentality" (in Foucault's sense) for managing life using expert therapeutic discourse. This knowledge doesn't stop with mental health professionals; it is available to a public often seeking to apply such logic and expert therapeutic discourse to their own circumstances (e.g., Giles & Newbold, 2011). This logic is also well-suited to computer algorithms used for governing mental health services (Steiner, 2012). It is a logic that suggests human concerns can be correctly named and addressed (or treated), and it is a logic that hasn't stopped with mental health professionals and the institutions for which they work. For example, individuals now assertively self-identify and live by psychiatric understandings of themselves (Charland, 2004), and family members increasingly diagnose one another (Lewis-Morton, Dallos, McClelland, & Clempson, 2014), and then interact accordingly. People seem to increasingly govern themselves and each other according to this expert therapeutic discourse.

There is no escaping discourse; what matters is what any discourse enables or constrains in terms of human possibilities (Martin & Sugarman, 1999). We originally presented our ideas on expert therapeutic discourse as a workshop for the 2014 TAOS Institute conference "Beyond the Therapeutic State" in Drammen, Norway. In this manuscript, we would like to share the main aspects of our presentation. Our aim in this related paper is to examine how: i) people self-identify in ways associated with mental health diagnoses, ii) "excessive" behaviors are medicalized, iii) family members interact on the bases of diagnostic understandings of each other, iv) mental health institutions govern practice in prescriptive ways, v) individuals in the correctional system are frequently organized by their diagnoses, and vi) new generations of counsellors are trained in practices shaped by psychiatric understandings. We review these contexts while also highlighting counter-practices within them, in what others have termed a growing therapeutic state (cf. Epstein, Duda, & Weisner, 2013).

Governing Oneself and Others

"The state is nothing else but the mobile effect of a regime of multiple governmentalities." (Foucault, 2008b, p. 77)

Late in his life, Foucault (2008, from his 1982-1983 lectures) turned his attention to how the fears and aspirations of society become *described* in discourses that *prescribe* how one should live and expect others to live. Accordingly, expert therapeutic discourse can be seen to prescribe how schools, correctional systems, treatment centres, and the media should be *governed*. Within these contexts, one also finds examples of what Foucault (1997) referred to as "technologies of the self": ways of governing oneself in accordance with expert knowledge. Governing, for Foucault (2008b), occurs through numerous "governmentalities" which can be seen as particular (and usually unquestioned) normal understandings, logics, and practices for doing "what is best."

Mitchell Dean (2013) suggested that governmentality operates at the intersection of pastoral and regulatory power. Pastoral power is a carry-over from pre-modern religion; it operates via the faith people invest in what they believe will make their lives better. Such a faith is carried out in

ritualized social practices meant to ward off feared consequences or ensure valued or virtuous ways of living (Sloterdijk, 2013). Modern regulatory power is that power which people disavow as having any connection to the virtuous or the valued (La tour, 2010). It is power enacted in mechanical and bureaucratized ways accountable to centres and processes of calculation and governance. Across the contexts we are examining, governmentalities translate into expected ways in which particular contexts are understood and enacted by the people within them. Sometimes, as Foucault (2008a) stated, it is where people's virtues become vices – where a cultural pursuit of thinness might translate to eating disorders. However, coinciding with most governmentalities, one can find counter-understandings and counter-practices to them – intended or unintended.

The therapeutic state has adopted what Rose has referred to as a "psy-complex", a way of understanding and responding to human concerns using psychiatric terms, logics and practices. As Foucault's earlier quote suggests, such a state requires a regime of different governmentalities - that are "mobile". Thus, we study how expert therapeutic discourse and its related practices have been shifting and can become interwoven with people's interactions, understandings and expectations in different contexts, while furnishing logics consistent with a therapeutic state in these contexts. For each context we propose a term to epitomize a governmentality for that context, given how it implies a kind of organizing logic. We also consider how people already act within these contexts in ways inconsistent with a therapeutic state. Thus, we want to highlight understandings, practices, and counter-practices involved in enacting (or countering) a therapeutic state across six different contexts. We begin by considering how post-secondary students come to self-identify using expert therapeutic discourses.

Context I. A "Mental Health" Crisis On Campus

A story is credibly a contribution to a person's identity if it possesses the right amount of heft. The criterion of heft underscores the idea that identity-constituting narratives are woven around the features of peoples' lives that they, or some of the rest of us, care about most. (Lindemann Nelson, 2001, p. 96)

In North America, alarm has been raised over an apparent "mental health crisis" (Lunau, 2012) among college and university students. Following several student suicides, the President of Cornell University described these deaths as "the tip of the iceberg, indicative of a much larger spectrum of mental health challenges faced by many on our campus and on campuses everywhere" (Skorton, 2010, para. 4). A recent Canadian Mental Health Association campaign, "Healthy Minds/Healthy Campuses" (2015), promoted mental health and "reducing risky substance use," while another Canadian province recently allocated $9 million to three universities to address mental health and addictions concerns (Monforton, 2013). Postsecondary students are increasingly scrutinized through a lens of expert therapeutic discourse and invited to self-identify in psychiatric or "mental health" terms.

Within psychiatric discourse, emotional concerns become diagnosable individual deficits or impairment conditions requiring psychiatric or psychological treatment. More broadly, these so-diagnosed concerns compellingly inform neoliberal projects focused on individual self-improvement (Illouz, 2008). Accordingly, psychiatric discourse furnishes linguistic resources for

identity work – examples of Battaglia's (1995) "rhetorics of self-making." New kinds of persons – new ways of understanding, experiencing, and being a person – come from taking up such "resources" or psychiatric classifications through what Ian Hacking (2006) has referred to as a "looping effect": our ways of considering and then "growing into" a classification. Through complex interactions of classifications, people, institutions, knowledge, and experts, the identity implications of diagnostic categorizations have become reflexive and fleeting "moving targets."

Adolescence and young adulthood have long been posited as particularly relevant times for identity construction (e.g., Erikson, 1963; Habermas & Bluck, 2000). McAdams and Janis (2004) claim that in emerging adulthood "people begin to put their lives together into self-defining stories" (p. 161). Young people's identity stories help them maintain a sense of self-continuity across time, establish their uniqueness and normalcy, and claim personal agency in the world (Bamberg, 2011). The interpretive resources of psychiatric discourse can be recruited to navigate such dilemmas.

For instance, on the website *RightByYou.ca*, a student ("Joshua," 2014) explained that, upon beginning university, his "life went on a downward spiral faster than [he] could have ever imagined" (para. 2). Finding himself "shutting down" around exam time due to excessive worry, he reported: "I … just blew it off as exam stress; although looking back on it now, I know it was a lot more than that" (para. 2). Ultimately, he was diagnosed with panic disorder – a "wake up call," since he was previously unfamiliar with this diagnosis. Joshua's story helps him preserve a continuity of self across time and changes; he constructs himself as someone who had been coping with panic disorder for a long time, but did not yet know the true nature of his confusing experience.

Another identity accomplishment addressed via therapeutic discourses can be that of "[differentiating] ourselves as special and unique (or as everyday and mundane)" (Bamberg, 2011, p. 5). In a blog article, a graduate student (Collins, 2014) relates two identity challenges: one common to graduate students (overcoming "imposter syndrome"), and a similar but more debilitating challenge that she associates with being diagnosed with learning disabilities or Attention Deficit Hyperactivity Disorder (ADHD). Through sophisticated identity work, Collins invites consideration of commonalities across graduate students ("graduate school is tough for the best of us"), and then distinguishes between typical graduate students and those with ADHD or learning disabilities. Throughout, she claims common experiences for students sharing this diagnosis: "we are unique" (from other students), and that is normal. Later in the article, Collins (2014) writes that she needed to disclose her diagnosis in order "to explain to my supervisor that my marginal progress to date was not a lack of effort or motivation" (para. 7). This disclosure addresses Bamberg's (2011) third task of identity work: agency. In this case, Collins positions herself as someone constrained by psychological or biological realities – rather than, for instance, as someone unintelligent or morally deficient (lacking effort and motivation). Similarly, Thompson (2012), in a study of identity narratives in an online journal forum, cites this account:
I am a 22 year old college student who has been bulimic for roughly 7 years. This past year, it has gotten progressively worse to the point where I dropped out of school (Fall 2003) and am actively seeking professional help in order to conquer this disease. It took a long time for me to realize that I need outside help and that my eating disorder is actually [a] disease and not a past time that I just dabble in. So now I'm making a real effort towards recovery. (p. 99)

Here, the student re-evaluates the nature of her eating disorder – from "a past time" (over which she might presumably have some control) to "actually a disease" against which she must mount a "real effort" centred on actively seeking "professional help." The shifting direction of her self-perceived influence – from self-to-world to world-to-self (Bamberg, 2011) – can be seen in the blog comments this student uses to articulate (or negotiate) a particular identity.

University instructors and administrators may encounter tensions in responding to students' identity claims, especially claims drawing from therapeutic discourses. Although many university staff may feel compassion for a struggling or suffering student, questions regarding appropriate learning accommodations may be more dilemmatic. Through diverse media discussions and awareness campaigns, one finds concerns about mental health stigmatization, extending to advocacy for mental health concerns to be taken as seriously as physical diseases. For example, "Joshua" (2014) wrote, "imagine if you got blamed for having cancer . . . how would that make you feel?" However, others contend that we are seeing a "madness for identity" (Charland, 2004) in which, with Internet assistance, groups are embracing labels as central to their identities while demanding recognition and legitimation for these identities (Giles & Newbold, 2011). In this era of diagnostic inflation (Frances, 2013), as advocates argue for the canonization of new "conditions" in formerly unmedicalized aspects of life (e.g., loneliness; see Merkin, 2010), almost any human challenge or shortcoming could be added to this inflationary therapeutic discourse.

In a recent and striking exemplification of this diagnostic inflation, a teenager from a wealthy American family received an unusually lenient sentence for his drunk driving that killed several pedestrians. His lawyers and psychologist argued that he suffered from "affluenza" (i.e., his wealth and social distance from people of lower socio-economic status made him pathologically oblivious to their everyday concerns) and therefore could not understand the link between his actions and their consequences (Hennessy-Fiske & Muskal, 2013). Who (if anyone) should assess the legitimacy of diagnostic or proto-diagnostic claims, and – in the case of postsecondary students – what is the university's responsibility to assist such a student?

Despite the increasing power of mental health discourses on campus, they are not the exclusive language used in constructing students' identities. On today's Canadian university campuses, one finds diverse discursive repertoires – academic, political, cultural, recreational, and so forth – competing for currency and validity in explaining "who I am." Even in the realm of emotional distress, non-medical "languages of suffering" (Brinkmann, 2013) – such as spiritual or existential explanations – can still be credibly leveraged.

In the wake of a tragic event at the University of Calgary in 2014 (the murder of several students at a party), institutional responses invoked a number of organizing discourses. Therapeutic discourses of "self-care" and "post-traumatic stress" were cited in mobilizing around-the-clock counselling services and "outreach" by volunteers tasked with approaching students who appeared "withdrawn" or "in distress." However, alongside these "therapeutic" responses were others oriented to collective remembering and meaning-making, to social and physical connectedness (e.g., a large billboard simply reading "Hug a student"), and to political responses (e.g., discussions around possible sociocultural conditions that could have influenced this

tragedy). Students, in this case, were not invited to exclusively consider their individual mental health. They were invited into multifaceted and often-collective responses, possible counter-practices to a neoliberal therapeutic state**.** Let us now turn to how "excessive" behaviors have increasingly been recast in the language of addiction.

Context II. Medicalizing? Counsellor Education as Contested Object

Once a profession of diverse ideas and practices, counselling is increasingly reimbursed by public and private health insurance while being regulated as a "health profession" across different jurisdictions. Further, many counsellors have appropriated the additional title of "psychotherapist," reflected in the Canadian Counselling Association's recent name change: to the Canadian Counselling and Psychotherapy Association. One rationale for this change was reimbursement through health insurance. A few strings are attached to these health dollars, however – such as required use of the *DSM-5* and evidence-based practices (Strong, Gaete Silva, Sametband, French, & Eeson, 2012).

Currently, I (Tom) am mid-way through a nationally funded study examining medicalizing tensions within graduate counsellor education programs. Increasingly, such programs are expected to ensure students are competent in using *DSM-5* and evidence-based interventions, yet counselling has long been a pluralistic profession and practice. The tensions between these expected competencies and the field's continuing professional pluralism – as they play out in students' learning and instructors' curricular dilemmas – are the focus of the study. Such programs and their students might seem immune to a therapeutic state, until one factors in such stakeholders as regulatory boards, medically administered health settings in which the students do their internships, already-diagnosed clients, and program-accrediting bodies with standards to uphold. Counsellor education programs need to be responsive to such stakeholders without making their graduates into professional subordinates of psychiatry (cf. Elkins, 2009).

A quintessentially modern response is at work in the scientific and administrative thinking supporting the *DSM-5* and its related research underpinning "evidence-based practice." By standardizing and medicalizing human concerns in the *DSM-5* and coupling evidence-based interventions to its diagnosed disorders, the complexities of human life can be abstracted from their complex circumstances to be addressed as administrative verities (Rose, 1997). Certain pedagogical possibilities follow from this standardizing and medicalizing direction, though tensions emerge as students of counselling try to balance adherence to diagnostic and treatment protocols ("treatment fidelity"; Tucker & Blythe, 2008) with quality therapeutic relationships with clients. On one hand, helpful structure is provided by these protocols for students keen to apply their knowledge as *scientist practitioners.* Evidence-based practice is presented as a responsible antidote to counselling from capricious whims; one can instead use scientifically supported practices and understandings. However, the other hand becomes relevant in face-to-face dialogue with clients who are not content with being the kind of "docile bodies" (Foucault, 1975) necessary to allow professionals to apply their evidence-based knowledge. Adding to the students' tension is the frequently-cited evidence that the quality of the therapeutic relationship is paramount (Duncan, Miller, Wampold, & Hubble, 2009).

Standardizing practices and outcomes of education, of any kind, is a recurring pipedream of politicians and politically-minded administrators. Counsellor education, fortunately, has escaped being the kind of political football that elementary school education has been. While its textbooks, curricula and internship sites increasingly reflect a more medicalized practice – consistent with the view of scientifically supported practice described above – than was the case a generation ago, counsellor education may yet retain its pluralism (Cooper & McLeod, 2011). The greater challenges relate to such expectations as program accreditation standards, intern sites requiring medicalized practices and paperwork to meet funders' requirements, or graduates needing to join regulated "health professions." In a recent national survey (Strong et al., 2012), counsellors indicated that they were often expected to use expert therapeutic discourse – but more importantly, that it didn't determine their practices. Medicalizing tensions in counsellor education are certainly present, though students continue to have a mix of educational experiences and a range of experiences when doing their internships.

Context III. Psychiatric Discourses in Families

A concern with how children develop skills in argumentation as they grow older often exists alongside, and in mutual interchange with, concerns with how arguing is an arena of social action in which children manage relationships among peers, with siblings and with adults. (Hutchby, 2007, p. 9)

Before sharing with you my (Monica's) thoughts on how *DSM-5* and other psychiatric/ psychological discourses organize families in particular ways, often to the extent of structuring unintentional interactional patterns, let me tell a brief story that a Mexican mother shared with me.

Maria (pseudonym) has a son, Carlos (pseudonym), who had been in therapy for several years. Therapy was initiated because his teachers at preschool felt he behaved in difficult and problematic ways. His classmates complained, as did the parents of other children. Teachers tried several strategies; however, the behaviors persisted, so they recommended that Maria take her son to therapy. Maria was struggling at the time with a very difficult separation (and later divorce), and Carlos' father moved out of the house without saying goodbye to him. Maria's therapist suggested that: a) Carlos' behaviors were a consequence of Maria's "depression" (she reported feeling disappointed but not sad or angry) and b) Carlos was eroticized because he slept in the same bed as his mother.

After several months, Maria saw no change in Carlos, so she sought another therapist. The second therapist told Maria that Carlos' behaviors resulted from a) personal crisis from his father's departure, and b) conflict and tension within the parents' marital relationship. Despite several months in this therapy, neither the school nor Carlos' parents saw any improvements. Finally, Maria had Carlos assessed at a school for gifted students, where he was identified as having a genius-level IQ – thus explaining his being "different." I invite you not to judge Maria's decisions, the school's management of this situation, or the involved therapists' practices. Let us instead consider how these expert therapeutic understandings influenced the family's organization and interactions.

What kinds of interactions (and resulting family organization) were invited when concerns about Carlos were understood as resulting from "eroticization" or Maria's "depression?" How might Maria, teachers, peers, Carlos' father, and other people who interacted with Carlos have responded when he was thought to be struggling with a stressful parental divorce? Or, suppose Carlos's concerns had been framed in terms of being a spoiled child, or as having ADHD, autism, PTSD, and so on. Professionals cannot predict how families will understand *DSM-5* and therapeutic understandings of a child or another family member, but we invite you to reflect on how psychiatric discourse plays an organizing role within families and other interacting systems (i.e. extended family, peers, teachers, friends).

Mental health and mental illness discourses are ubiquitous (Frances, 2013; Illouz, 2008; Watters, 2010; Whitaker, 2002), influencing not only professionals' understandings but also those of "non-experts" (Furedi, 2004). Families and their members appropriate these discourses as understandings of themselves and each other, and risk becoming captured or governed by them. Family members' responsive interactions, based on such understandings, often become routines, patterns, and habits. Consider how a mother, father, or sibling might relate differently to a child after being expertly informed that they are unintentionally "eroticizing" the child. Would they hug and kiss the child as often as before? What if he/she has nightmares – would they allow him/her to spend some time in the parents' bed while she/he calms down? What if she/he insists? How might the physical contact differ if they were instead interacting with a "gifted child?"

Diagnostic discourses do not stay inside the therapy room; their effects reach beyond the experts' "descriptive" and informative purposes in using them. Haruki Murakami, a Japanese writer, has been quoted as saying that "learning another language is like becoming another person." (Haruki Murakami Stuff, 2012). Discourse is action (Potter & Wetherell, 1987); its meaning is revealed through how it is used in relational and cultural interactions. How might Carlos' family have been transformed by so many languages expertly describing the "same" concern? What Maria and Carlos (and others in relationship with them) understood about their experiences is what they performed, as these discourse differences shaped and organized their interactions. How do families become discursively captured (Bowe, Ball & Gewirtz., 1994; Massumi, 2011) by experts' discourses? How do they escape such capture? Institutions, such as the addictions treatment setting we next examine, offer another context in which people are drawn into discursive capture, yet avoid being fully captured.

Context IV. It's all in the practice: Defining Behavioral Addictions using a Social Practice Discourse

As a society, we have become almost addicted to the discourse of "addiction," and applying this construct to various substances and behaviors. Long gone is the notion that addiction refers to "hard core" substances alone, such as cocaine or heroin. According to the headlines of popular media, we are now addicted to chocolate (Ducharme, 2013), tanning (Rettner, 2010), and perhaps, more seriously: shopping (Black, 2013), Internet (Sang-Hun, 2010), gambling (Moore & Manville, 2013), exercise (Doyle, 2012), and food (Sygo, 2011).

This current and inflationary discourse of addiction has not always dominated. Throughout history, and across cultures, various models and discourses have been used to understand, label,

and ultimately guide treatment for "addictive" behaviors. Scholars (Bailey, 2005; Brodie & Redfield, 2002; Davies, 1992, 1997; Keane, 2002; Valverde, 1998) have examined the multiple, and often competing discourses of addiction and excessive behavior including models focusing on: morality, social learning, neurobiology, medical disease (dual diagnosis, self-medicating), social disease (poverty, social dislocation), family, trauma, and social construction.

Medical discourse is arguably the common discourse or conceptualization of addiction and excessive behavior (Mudry et al., 2011). In the *DSM-5* problem gambling was reclassified from an "impulse-control disorder" to an "addiction and related disorder." Adding "related disorders" enables diagnosing "behavioral addictions," if such behaviors are engaged in "excessively" (e.g., gambling, Internet use, shopping, working, exercising, eating, video game playing, sex; Mudry et al., 2011). This suggests a dominant mental health discourse by requiring the classification of problem gambling as an addiction. This new classification and privileging of the medical, disease model has many (perhaps unseen) potential consequences for what this discourse enables and constrains. Consider the effect of this medical discourse on treatment options, medication, funding for programming, stigma, and agency of those diagnosed.

Social Practice

A recent call for "recovery oriented" *practice* has been developing in addiction and mental health treatment, attending primarily to persons and their contexts, rather than to symptoms or diagnosis (Davidson, Tondora, O'Connell, Lawless, & Rowe, 2009). Graham and colleagues (2008) urged researchers to "consider and describe addiction processes over time, especially when considering how addiction manifests in relationships and daily life" (p. 122). Dreier (1999) advises that addressing "mental health" concerns of any kind occurs "across the contexts of their family, work, school, psychotherapy sessions…[pointing to the] significance of grounding a theory of individuals in structures of social practice" (p. 5). Collectively, these researchers suggest that practitioners understand how "addictions" and recovery are *socially practiced*.

A social practice discourse views many activities in life as composed of social practices, including addiction and recovery practices. Someone engaging in addiction practices also engages in other social practices including work, social, and family - practices in a larger "network" (Latour, 2005) of practices. Each practice is interdependently connected in a network, influencing and being influenced by other practices (Kemmis et al., 2012). These various social practices in the person's life function to enable or constrain the addictive behaviors.

The American Psychiatric Association (APA, 2014) contends that its diagnostic criteria were based on "careful consideration of the scientific advances in research underlying the disorder, as well as the collective clinical knowledge of experts in the field." It is not hard to imagine that the social practices involved in coordinating the collaboration between 160 researchers and clinicians, representing 15 disciplines and professions, were difficult. Similarly, each of those individuals and the research considered undoubtedly drew from divergent and sometimes-competing discourses in their understandings and explanation of addiction and mental health. Researchers, clinicians, and field experts are committed to (if not captured by) the discourses they use to frame their work. The field of addiction currently can be seen as being captured by the medical model, potentially preventing or occluding the opportunity for other, multiple

discourses for addiction. The same might also be said about how family concerns might be medicalized and similarly capture family relations.

Context V. Addiction & Recovery

Two types of discourses often develop in addictions treatment settings. The first type is formal, written, and shared by the managers and administrators. This official, institutional way of knowing "addiction" and "recovery" is often prescribed and perpetuated in texts, counsellor education, forms of language, and within mandates and policies of addictions counselling institutions. The second type of discourse that develops is submerged, unwritten, and shared by people who live and work on the front lines (Diamond, 1992). These unwritten discourses develop through how people do and experience the actual work of addictions treatment and recovery (Campbell & Gregor, 2008).

Depending on where addictions counsellors position themselves within these discourses, rigorous institutional accountabilities can follow, governing counsellors' "appropriate" use of practices and language to ensure the treatment centre's legitimacy. These institutionally objectified and ideological versions of addiction and recovery can be at odds with the addictions counsellor's invaluable experiential accounts of how "recovery" happens in actual, observable practice. Nonetheless, addictions counselling happens in what counsellors do across multiple sites, enabling and constraining institutional possibilities for practice as well as recovery.

Recovery Work Within the Institutional Context

Viewing "recovery work" through the lens of Institutional Ethnography (as described by Dorothy Smith, 1987; 1999; 2005; 2006), my (Emily's) research problematic, related to having practiced as an addictions counsellor, answers questions particular to the "actualities of the experienced world" (Smith, 1987, p.91). A problematic is a conceptual tool for identifying relevant features of social organization, arising from people's everyday experiences as they encounter institutional "ruling relations" (i.e., governmentalities) and identifies disjunctures between these experiences and ruling relations. Thus, the observable world of addictions counselling is an "unfinished arena of discovery in which the lines of social relations are present to be explored beyond it" (Smith, 2005, p. 39). This lens can be used to explore how people's observable practices in everyday work are coordinated and articulated by institutional relations invisible within the particular local setting. Through this exploration, we can gain new understandings of how counsellors translate institutional policy into "recovery" practices, how these practices are controlled and coordinated, which can then enhance professional, societal, and cultural understandings of recovery.

Points of Tension

Significant differences can exist between "knowers" of discourse who are ruling (or governing) at an institutional level, and "knowers" engaged in performing the discourse in day-to-day work practices (Smith, 1987, p. 88). Institutional capture occurs when a counsellor's (or researcher's) experientially based knowledge is disrupted or obscured by institutional or ideological discourses (Smith, 2005). This contributes to a potential disjuncture, disrupting the knowledge of everyday, frontline experience with an institutionally objectified, official version of that same knowledge

(McCoy, 2008). The submerged and unwritten practices of "recovery" are implicitly developed by people doing "recovery" work (and their accounting for it) on a day-to-day basis; yet, the official, objectified version dominates (Campbell & Gregor, 2008).

From the 14th floor of a building, we may observe patterns and consistencies in activities that can be described in language specific and specialized to the discipline informing our observing. However, if we are instead standing on the sidewalk, we are no longer "above" the activities we observe; we stand "among" people who are doing the work (Smith, 2008). Staying with this metaphor, while counsellors are accountable for their ground-level practices to 14th-floor observers, such "accountability" is often not anchored in the actual, observable practices by which addictions counselling work is being done.

Beginning with the everyday, personal experiences of individuals like addictions counsellors one can identify and explicate social relations structuring and governing their experiences. How such people purposefully coordinate activities together can be linked to sites and interests beyond sites of action, like treatment centres (Campbell & Gregor, 2008). Specifically, information about the institutional contexts and conditions that complement (and impede) day-to-day activities of frontline workers for the experience under investigation can be identified and explicated – on their terms. Such information can then extend knowledge they already possess and be hopefully used to inform advocacy for change.

Institutional capture is societally expected for people incarcerated in our prisons, yet overcoming discursive capture (i.e., avoiding being totalized as "criminals") focuses resistance for people in and beyond the correctional system. Barbara next shares details of her work with women post-incarceration, as well as her current work with children of incarcerated parents.

Context VI. Psy-Discourses, Criminalized Women, and Resistance Counter-practices

Any mental or behavioral act through which a person attempts to expose, withstand, repel, stop, prevent, abstain from, strive against, impede, refuse to comply with, or oppose any form of violence or oppression (including any form of disrespect) or the conditions that make such acts possible, may be understood as forms of resistance.
(Wade, 1997, p. 25)

How do diagnostic discourses affect women in conflict with the law? One answer is in the story of how a group of women challenged and resisted dominant discourses that constructed their psychological and public identities as ex-cons. My (Barbara's) story explores how psychiatric and psychological discourses evolved in corrections systems and continue to organize how incarcerated women are constructed and managed. Few groups are subjected to diagnosis more than women who have been involved in the criminal justice system (Fazel & Seewald, 2012). Although prevalence rates vary greatly across contexts, incarcerated women are more likely than other women to meet criteria for a mental disorder (Centre for Addiction and Mental Health [CAMH], 2013; Fazel & Seewald, 2012; Tye & Mullen, 2006). Thus, the social construction of women in conflict with the law is dominated by psy-discourses (Rose, 1997).

Demons, Degeneracy, and Mental Disorders

Theories of criminality have changed over the ages: from medieval possession (Neugebauer, 1979) and modern era degeneracy (Jalava, 2012) to bio-psycho-social explanations of the present (Ellis, 2005). Prior to World War II, criminal behavior was accounted for by modern theories of degeneracy grounded in biological or genetic explanations of the physically substandard human (Jalava, 2012). Such explanations were abandoned after Hitler used them to justify mass genocide. For Jalava, biological explanations of criminality have "simply assumed new forms" (p. 416) in the lexicon of psychopathy, which he describes as "a pattern of socially and morally undesirable behaviors the cause or causes of which may be found within the individual." These theories are largely male-centric and the female criminal experience did not invite comment until relatively recently (Kendall, 2005).

Resistance Counter-practices

The psychological and psychiatric literature or discourses on women and the law is infused with a vocabulary of control (e.g., manage, contain, regulate, high risk). Feminist criminology writers have been deconstructing the rhetoric that punishes marginalization and shackles women to an oppressed identity of compliance and deference (e.g., Chan, Chenn, & Menzies, 2005; Daly & Chesney-Lind, 1988). Pollack and Kendall (2005) contested the discourses surrounding Borderline Personality Disorder (BPD), a pervasive diagnosis for women in the prison system, and its "companion treatment": dialectical behavioral therapy (DBT, Linehan, Schmidt, Dimeff, Craft, Kanter, & Comotois). Nikolas Rose (1997) argues that democratized societies are maintained by self-regulation rather than force - through *responsibilization,* which locates responsibility for meeting societally agreed upon (read: neoliberal) values and morals within the individual. This ideology discounts contextual and structural factors that account for women's offending patterns such as poverty, violence, and systematic racism (Pollack, 2012). Pollack and Kendall (2005) assert that "women's gendered, classed and racialized experiences of exclusion are reconstructed as being a result of individual psychological and cognitive deficits" (p. 73).

Resistance to such individualizing and pathologizing constructions of incarcerated women is articulated in new theories and practices acknowledging the unique contexts of women's experience (Lawston, 2008; Leeder, 2012; Maidment, 2007; Pollack, 2004). Covington and Bloom (2012) suggest therapeutic practice should be based on pathways theory (which acknowledges a gender-specific trajectory into criminal activity), relational theory, and trauma and addictions theories. Allan Wade, developer of response based therapy, (1997) maintains that acts of resistance to violence and/or oppression are omnipresent in ways people want recognized and amplified. Institutional activities such as creative work (e.g., writing, drawing, theatre), forming peer groups on the inside or forging connections with supports outside (Lawston, 2008), or developing a spiritual practice (Fallot, 2001) are ways (subtle and overt) that inmates resist authority (Goffman, 1969). These are but a few counter-practices to discursive capture based on individuated helplessness and pathology.

Resistance After Incarceration

It was my privilege to work with a group of recently released women who challenged the discursive prison shackling them to an identity of mental disorders, criminality, and an outsider cultural status. Through an action research project (Pickering, 2012), these women shared stories

of strength and hope with the broader community, thereby challenging the stigmatizing label of ex-con. The group found solace and support among similarly experienced peers and joined scholars who acknowledged their oppression by a system determined to contain them in a criminalized identity. With the support of the group the women transcended psychiatric and psychological labels such as borderline disorder that locate shame, blame, and mental disorder within the individual (Maidment, 2007). As one participant noted (Pickering, 2014, p. 277):

We're a pretty strong group of five—and whether we like or dislike each other we're there to offer support … and um I've learned that there are women who go through the exact same things or similar experiences that I do, that I am not isolated, that I am not the only one, or you know what I mean? Like I'm not doing it on my own.

Using a photovoice framework we created representative banners of photographs and narrative captions that they presented to members of the community, professional organizations, and educators. They wanted to share their stories of survival, hope, future dreams, and, to use their words, "normalcy." They demonstrated insight, resilience, and courage that went well beyond medicalized borders associated with diagnoses like "borderline" to collaborate on expanded perspectives of themselves and their community. The women found hope in the give and take of being part of the community (Pickering, 2014, p. 278).
\I just took every opportunity to ah, to make myself better. I eventually, I came around. The more I did for myself—a little bit every now and then—society would accept me. Then whenever society accepted a little bit more of me, I wanted to give a little bit more to them.

We finally turn to an institution associated with intellectual freedom, the university, to highlight some medicalizing tensions associated with the graduate education of counsellors.

Discussion

The therapeutic narrative calls on us to improve our lives, but it can do so only by making us attend to our deficiencies, suffering, and dysfunctions. (Illouz, 2008, p. 185)

Our aim, throughout this paper, has been to highlight governmentalities across different contexts relevant to a therapeutic state. Expert therapeutic discourse (i.e., the *DSM-5* in North America) has enabled aspects of what Epstein and colleagues (2013) have referred to as a "therapeutic state." It is clear, across our six contexts (postsecondary students/institutions, addictions researchers, families, addiction treatment centres, correctional systems, and graduate counsellor education), that expert therapeutic discourse is dominant. Enabling this dominance is the undeniable utility of expert therapeutic discourse for governing understandings and practices across such contexts. However, this dominance extends an individualizing, psychologizing direction associated with a neoliberal ideology based on self-determination (deVos, 2012; Illouz, 2008). As our accounts show, this dominance marginalizes, if not prohibits, other possible ways of understanding and addressing human concerns. While counter-discourses and understandings also are evident, enabling other responses to human concerns, these approaches currently seem less likely to be administratively supported than those funded as health services where expert therapeutic discourse is the expected norm. In today's biopolitics (Dean, 2013; Lemke, 2011), our cultural dreams seem to be hitched to governing increasingly medicalized aspects of the

human condition – purportedly *in* ourselves and others. We invite more voices to join us in changing the scope and direction of this important conversation.

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