Working the System:
Doing Postmodern Therapies
in Aotearoa New Zealand

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ABSTRACT

This thesis documents a qualitative research study of twenty postmodern therapy practitioners in Aotearoa New Zealand, focusing on their experiences in the wider field of therapy. The participants were aligned in their subscribing to postmodern critiques of therapy as a instrument of power, and in their interest in, and use of, therapy techniques and approaches that have grown out of those critiques – including narrative therapy, critical psychology, "Just Therapy", and feminist poststructuralist therapy approaches. I argue that these practitioners represent a social movement within the field of therapy. The thesis examines the nature of the wider therapy field in Aotearoa New Zealand, analysing the perspectives of the participants. I demonstrate how this field has become increasingly dominated by the twin forces of neoliberalism and bio-science, making postmodern therapy work difficult, particularly within public sector services. In the final substantive part of the thesis, I critically examine and appraise the strategies used by participants to negotiate and resist these forces. This discussion is divided into two main chapters, dealing first with the participants who have difficulty in engaging in official politics and who consequently attempt to operate "under the radar" of management surveillance: these participants are characterised as "battlers", "burn-outs" and "blow-outs". Then, I turn my attention to the second group of participants – "infiltrators", "outsiders" and "accepters" – who strategically utilise symbolic capital to pose resistance, or simply leave the public system. I also consider the professed abilities of this second group to cultivate a postmodern sensibility and to tolerate contradiction and compromise. I conclude this investigation of the possibilites for resistance to neoliberal and bio-scientific discourses by recommending greater strengthening of this local postmodern therapy movement.

PART 1

1. Introduction

Starting points

At the start of his book *Acts of Resistance* (1998), Pierre Bourdieu reflects on the contradictions of the social world that are often experienced by public sector "social workers" as personal dramas. He describes a project leader, responsible for coordinating all the work on a "difficult [housing] estate" in a small town in northern France:

> He is faced with contradictions which are the extreme case of those currently experienced by all those who are called "social workers": family counsellors, youth leaders, rank-and-file magistrates, and also, increasingly, secondary and primary teachers. They constitute what I call the left hand of the state, the set of agents of the so-called spending ministries which are the trace, within the state, of the social struggles of the past. They are opposed to the right hand of the state, the technocrats of the Ministry of Finance, the public and private banks and the ministerial *cabinets*". (pp.1-2)

Bourdieu goes on to declare:

> I think that the left hand of the state has the sense that the right hand no longer knows, or, worse, no longer really wants to know what the left hand does. In any case, it does not want to pay for it. (p. 2)

Bourdieu's comments politicise the personal and everyday struggles of various social – in this broad sense – workers. Rather than simply personal dramas, these struggles represent and result from the relationship between these left and right hands of the state: the remains and traces of what might be termed a "welfare state", and the modern ministries and financial bodies and leaders that direct state interests and activities. For Bourdieu, this is a relationship of tension and opposition, where the left hand opposes the right, while the right hand, oblivious, does not actually know what the left hand does, but is opposed to paying for it.

In this book, Bourdieu analyses 1990s European social and economic life, exposing and challenging the ideology of neoliberalism – which has seen the retraction of the state from social life – and defending the public interest. While this thesis is based in Aotearoa New Zealand and has taken its final shape more than a decade after Bourdieu's work, his depiction of the relationship between the left and right hands of the state serves as a useful introduction to my subject. This research began as – and very much remains – an investigation into the working lives of a very specific group of practitioners within the generalised field of therapy (including counselling, social work, psychology, and psychiatry) in Aotearoa New Zealand. These practitioners were chosen because they broadly identified with a postmodern approach to their therapy work.[1] This involved conceptualising clients'/patients' problems as arising out of, and inextricable from, their social and political contexts; assuming that language and discourse are implicated in the construction of experience and perceived reality; and actively reflecting on and responding to the power differential between therapist and client/patient in their work. This postmodern position encompassed a general scepticism towards exclusively bio-medical explanations and treatments for problems.

As I came to analyse my data, I found that Bourdieu's left/right hand metaphor was in many respects an apt descriptor for the ways in which my participants characterised their perceptions of their place within the field in which they operated. Their descriptions of how they endeavoured to practise therapy in ways that they perceived as ethically and professionally appropriate highlighted a schism between their interests as "social workers" and the management outlook and official discourses that directed their workplaces, particularly within the public sector. Therapists in this study described witnessing throughout the 1990s greater and greater cleavage and separation between the left hand – practitioners providing public sector therapy

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[1] I use "postmodern therapy" as a generalised term throughout this thesis to describe the ways of working that I argue – particularly in chapter 4 – characterise my participants' self-descriptions, notwithstanding the great variety of roles that they occupied as a group. It is my term, not my participants', who instead tended to refer to such interests as narrative therapy, "Just Therapy", critical psychology, feminist theories, social constructionism, and specifically to the ideas of Johnella Bird, Michael White and others.

As for the term "postmodern" itself, again this is used in a relatively general sense to refer to a critical mode of thought that subscribes broadly to poststructuralist and deconstructionist understandings of knowledge; social constructionism; the roles of language, discourse and power in shaping society; and scepticism towards "grand narratives," including entrenched belief in the scientific method as a universal tool in the search for understanding.

services – and the right – state ministries (especially as influenced by the New Zealand Treasury), policy-makers, bureaucrats and public sector managers. The language and practices of the right hand became dominant and far-reaching over this period, playing an increasingly influential role in both the organisation and conceptualisation of therapy services. This influence was largely one-way, directed by right hand representatives with little interest in conversing or collaborating with the left hand: the right hand seemed not to know – nor want to know – what the left hand was actually doing, but was increasingly reluctant to pay for it. While my original intention in undertaking this research was to learn about the possibilities for doing postmodern therapy *at all*, as I came to analyse my data, the focus became increasingly on the possibilities for doing it *in this environment*. The neoliberal context became an unavoidable, and major, player in my analysis.

The thesis, then, using qualitative research methods, critically examines the postmodern therapy movement in Aotearoa New Zealand from this context of tension and alienation. It focuses on the interview texts of a group of postmodern therapy practitioners working during the 2000s, using these texts to analyse the mobilisation of postmodern therapy approaches within the wider field of therapy.[2] My analysis highlights particular tensions and obstacles that face postmodern practitioners as they try to practise these therapy approaches: *doing* postmodern-inspired therapies in Aotearoa New Zealand proves a difficult task. In particular, difficulties arise as therapists clash with the dominant forces that currently structure the therapy field, namely neoliberal/managerialist and medical/scientific discourses. The thesis examines both the competition between rival forces and discourses within the therapy field – the postmodern therapy movement's struggles with the official, endorsed "right hand" discourses and forms of capital – and the strategies and practices used by postmodern therapy practitioners to negotiate and, where possible, resist the hegemony of the field.

The thesis highlights significant tensions between different realms of social activity, in particular emphasising disjunctions between the spaces of theory and practice. In

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[2] The thesis focuses on therapists' self-reports and descriptions of their professional practices. My analysis of the postmodern therapy movement in Aotearoa New Zealand is necessarily partial: the thesis does not attempt to consider the efficacy or effects of these practices and does not include the accounts of clients/patients who are the recipients of postmodern therapies.

Aotearoa New Zealand, postmodern approaches to therapy theories and practices are a strong feature of many counselling and social work training programmes. Trainee therapists are taught to consider how the narratives and difficulties of clients/patients are socially constructed in particular ways, to be alert to the operation of power in both these narratives and in the processes of therapy, and to avoid imposing meaning or explanations on clients'/patients' experiences. As is discussed in this thesis, these approaches focus on client/patient knowledge and skills, rather than those of the therapist, and take an anti-pathologising stance. Yet, as is also demonstrated throughout the thesis, applying and practising these therapy approaches within actual therapy work proves to be profoundly difficult. Within the relevant institutions in Aotearoa New Zealand, the directives for therapy practice are often contrary to the expectations and assumptions of therapists themselves: indeed, it appears that there is a fundamental language gap between postmodern therapy practitioners and the systems in which they operate. My research identifies and explores this conflict of meaning, as well as the effects it has on postmodern therapy practitioners and their work, and the actions they take to negotiate it. The thesis lays bare a picture of a social movement that is at once burgeoning and active but also – particularly in the public sector – fraught with disheartenment, compromise, and difficulty.

More broadly, the thesis touches upon a concerning general phenomenon. Critical postmodern ideas, influenced by poststructuralism, feminism, cultural studies, and the "linguistic turn" in epistemic analysis, are largely commonplace in a liberal arts or (to an extent) social science tertiary education today. While these ideas and ways of thinking stem from and relate to progressive social movements, modern neoliberal workplaces offer limited opportunities for their expression or practice. This thesis is confined to the area of therapy in Aotearoa New Zealand, but it points to a wider field of potential research and questioning. It is worth asking whether the relationship between theory and the workplace needs to be given greater critical attention, focusing on the pragmatic skills of negotiation that are required to take classroom theory into the realms of professional practice.

Theoretical approaches

By referring to Bourdieu at the outset, I also wish to foreground his influence on how I have approached my analysis of the research data. This thesis involves investigation

of both the postmodern therapy movement in Aotearoa New Zealand and the wider institutions, workplaces, spaces and relationships of therapy in which the therapists' participate, and analysis of the interactions between these two entities. In undertaking this research, I utilise Bourdieu's concepts of the "field" and "capital". I talk about my subject as a struggle over the meaning and workings of the therapy field in Aotearoa New Zealand, as rival forces seek to shape and define it in particular ways, with varying degrees of success. Bourdieu describes fields as "networks of social relations, structured systems of social positions within which struggles or maneuvers take place over resources, stakes and access" (Everett, 2002, p. 60). Fields are spaces in which particular resources are prized and sought – have "currency" – and are characterised by struggle, as the meanings of a field and the terms of its operations shift and change in response to various forces. Jeffery Everett (2002), drawing on Bourdieu, explains the struggles that take place within fields, illustrating their shifting and dynamic nature: "Fields are occupied by the dominant and the dominated, two sets of actors who attempt to usurp, exclude, and establish monopoly over the mechanisms of the field's reproduction and the type of power effective in it" (p. 60). Fields, then, are born from and structured and reconstructed by specific forms of power relations. This thesis examines the power relations of the field of therapy, exposing the relationships between the dominant and dominated and the struggles over the mechanisms of the field and the types of power effective within it.

The power relations at play within fields and the nature of the struggles that take place on their terrain are concerned with the possession, display and deployment of different forms of capital. Indeed, Bourdieu stresses that the concepts of field and capital are interconnected and dependent on each other, explaining that, "[i]n empirical work, it is one and the same thing to determine what the field is, where its limits lie, etc., and to determine what species of capital are active in it, within what limits, and so on" (Bourdieu & Wacquant, 1992, p. 98-99). Fields are constituted by particular species of capital, and species of capital obtain meaning and accrue currency through their existence within the bounds of specific fields. For Bourdieu, the struggles that take place within fields over resources, stakes and access are all, in fact, struggles over capital. Species of capital, according to Bourdieu, include economic capital (in its different forms), but also "cultural capital, social capital and symbolic capital, which is the form that the various species of capital assume when

they are perceived and recognized as legitimate" (Bourdieu, 1989, p. 17).[3] Within a field, different species of capital will operate and form alliances, or compete for authority with symbolic capital – "found in the form of prestige, renown, reputation, and personal authority" (Everett, 2002, p. 63) – and will thereby construct and organise the hierarchies and power relations of the field. The people who belong to and participate within particular social fields are

> bearers of capitals and, depending on their trajectory and on the position they occupy in the field by virtue of their endowment (volume and stretch) in capital, they have a propensity to orient themselves actively either toward the preservation of the distribution of capital or toward the subversion of this distribution. (Bourdieu & Wacquant, 1992, p. 108-109)

To use Bourdieu's oft-cited metaphor of the field as a game, forms and volumes of capital influence how individuals play the game and their chances within it, but they can also work to "transform, partially or completely, the immanent rules of the game" (Bourdieu & Wacquant, 1992, p. 99).

This thesis examines the "players" within the therapy field as "bearers of capital". Throughout, I conceptualise the struggles between the research participants and other actors, forces and institutions within the field as a struggle over the symbolic power of particular species of capital; players vie for authority and legitimacy within the field and for the ability to define and direct the nature of therapy work. I use Bourdieu's concepts to demonstrate how competing forces have sought to, on one side, maintain, and on the other, usurp and establish, monopoly over the mechanisms of the therapy field's reproduction and the type of power that is effective within this field. The state of the "game" within the therapy field, and the positions held by postmodern therapy practitioners, influence their "*relative force in the game*, [their] *position[s]* in the space of play, and also [their] *strategic orientation toward the game*" (Bourdieu & Wacquant, 1992, p. 99) (italics in original).

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[3] Bourdieu and others expand this taxonomy, identifying other forms of capital, such as "political capital or recognized titles or credentials in institutional contexts" (Prosise, Miller, & Mills, 1996, p. 121); "religious capital" (Swartz (citing Bourdieu), 1996, p. 75); "gendered capital" (Huppatz, 2009); "emotional capital" (Reay, 2000); and others. Bourdieu himself renames cultural capital "*informational capital* to give the notion of its full generality" (Bourdieu & Wacquant, 1992, p. 119) (italics in original). Each species of capital, in turn, can be made up of a variety of subsets; for instance, Everett describes "linguistic capital" as a subset of cultural capital (2002, p. 63).

I use Bourdieu's approach to analysing social fields as a means of organising and discussing the power relations that structure the postmodern therapy movement and the therapy spaces that my participants engage with and work in. Bourdieu conceives of the power relations of the field as fluid and changeable, as participants potentially deploy their capital with the aim of transforming the rules of the game: the game and its rules are not set or intractable; hierarchies are continually contested and resistance is ever-present. This conception of both domination and resistance coheres with the other sources I draw on to develop the various facets of my analysis of the research data.

In examining both the postmodern therapy movement within the therapy field in Aotearoa New Zealand – as represented by my study participants – and its relationship to and interactions with the wider therapy field, I necessarily engage in an analysis of the power relations that are at work within these spaces. In addition to Bourdieu, I utilise other theoretical ideas to undertake this analysis. The early chapters of the thesis focus on describing the features and assumptions of this postmodern therapy movement, and then examining the therapy field from a macro-political perspective, grounding my analysis of the operation of dominant discourses by drawing on the perspectives of my participants. In doing so, I utilise a general cultural studies orientation, critically examining the forces and discourses at play in an attempt to reveal the nature and shape of activity in terms of power, agency and resistance. This analysis draws on a variety of interdisciplinary writings addressing relevant areas of cultural investigation: theories of social movements, Foucauldian-influenced critiques of neoliberalism, Bourdieu's concept of official discourse, medical sociology, and the postmodern critique of the "psy" disciplines.

The last part of the thesis focuses specifically on the possibilities and practices of resistance to the hegemonic discourses and forces within the field. This discussion draws on the ideas of Michel Foucault, as well as other theorists writing from the perspective of critical organisation studies. With an intensifying focus on the narratives told by my participants, as the thesis progresses I take an increasingly micropolitical view, examining the possibilities for acts of resistance in the negotiations enacted by therapists working in the field. Throughout, I focus on the partiality of both hegemony and resistance, and on the ways in which the two are

mutually involved in each other's reproduction: in the act of resisting, participants may draw on and reproduce other hegemonic discourses; likewise, hegemony itself tends to contain within it the space and resources for incipient resistance.

Outline of the thesis

My discussion and analysis is organised into different parts. Part 1 comprises this introduction and my methodology discussion (chapter 2), where I position myself as the researcher, introduce the research participants, and describe the process of data collection and analysis. I discuss how I take a postmodern, social constructionist approach to qualitative research, presenting the knowledge produced in this thesis as tentative, partial, and necessarily influenced by research decisions and the contexts and positions of both the participants and me.

Part 2 – comprising chapters 3 and 4 – provides essential background and contextual information. It is concerned with situating and describing the postmodern therapy movement within the generalised field of therapy, both theoretically and as a peopled movement represented by the research participants. Chapter 3 examines the philosophical and theoretical critiques and ideas of proponents of postmodern therapy approaches. In doing so, it establishes a context for understanding the ideas and assumptions that guide my participants. The first section of the chapter reviews the problems postmodern-inspired critics have identified with traditional therapy approaches and practices. The second section considers how these critiques of therapy have led to the development of a variety of therapy practices that seek to apply the critiques in positive and efficacious ways.

Chapter 4 brings the research participants into focus by examining their self-reports of doing therapy in ways that are informed by the postmodern critique. That is, this chapter grounds the theoretical perspectives of chapter 3 in the working lives of my research participants. It also offers an insight into the mobilisation of therapy ideas from the previous chapter. At the same time, it examines how the participants described and positioned themselves as a distinct group with common objectives and purposes. The chapter reviews how this social movement functions as a collective and how its objectives and purposes become manifest.

Part 3 – comprising chapters 5 and 6 – examines the broad context of the therapy field in Aotearoa New Zealand, in which members of the postmodern therapy movement work and interact. In Bourdieu's terms, the therapy field is seen throughout as a site of struggle, where competing forms of capital are deployed to achieve strategic gains. Chapter 5 describes the arrival of neoliberalism into the therapy field in the late 1980s and the 1990s and the transformation of the public sector that ensued. Participants' transcripts provide accounts of the conflict and tension arising out of the impact of this transformation. The chapter describes some of the key changes that took place in public sector therapy provision from the perspectives of my participants, in particular focusing on the impact of the rhetoric of fiscal restraint and austerity; managerialism and the authority of business practices and knowledge; the imposition of a market model of operations, with attendant demands for measurable outputs and outcomes; increased surveillance and bureaucratic demands; and the loss of professional autonomy in therapists' decision-making. The chapter highlights the difficulties faced by the study's postmodern therapy practitioners in their attempts to practise as they saw fit within the context of a neoliberalised public sector (or, under the new public management, a contract-based quasi public sector).

Chapter 6 ties that discussion to another struggle taking place across the therapy field over the same period, which for the postmodern therapy movement again involved contestation over the meaning and nature of therapy. The chapter describes how, in concert with neoliberal bureaucracy, medical and scientific knowledges have come to enjoy increased authority, to the extent that they represent the official discourse and point of view of the field as a whole. It outlines the expansion of medical and scientific discourses generally within the therapy field, describing the rise of a "new biologism" and scientific methods, and the increasingly dominant role played by the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). The postmodern therapy practitioners in this study, being avowedly sceptical of such discourses, described the increasing prominence of medical and scientific discourses in therapy during the 1990s as a "takeover". I draw on their interview texts to examine the implications of this for postmodern therapy practitioners, focusing on diagnosis and the concept of "evidence-based practice". I also demonstrate how therapy professions are stratified hierarchically in relation to medical qualifications and expertise. Again,

the chapter examines this aspect of the power relations of the therapy field through the use of the concept of capital.

Part 4 – comprising chapters 7, 8 and 9 – examines how the postmodern therapy practitioners in this study described themselves as negotiating their workplaces and professional roles, given the hegemony of neoliberal/managerialist and medical/scientific discourses within the therapy field. It begins with an introductory chapter (chapter 7), which re-caps the course of the thesis thus far, highlighting the clash between the discourses and forms of capital prized by the postmodern therapy movement and those that reign within the wider therapy field. The chapter introduces the theoretical approach I take to my analysis, in the following two chapters, of how the postmodern therapy practitioners negotiated and attempted to resist the oppositional, and often hostile, forces of the therapy field. Despite the seeming inescapability of neoliberalism and the medicalised regimes of therapy, these discourses are not fixed or monolithic, and are open to contestation and subversion. I explain that the following two chapters analyse points of resistance within the therapy field and the discursive strategies used by postmodern therapy practitioners to "play the game" and move between the boundaries of their own self-positions and those prescribed by the field.

Chapter 8 is the first of two chapters that closely examine the "boundary-riding" and resistance strategies of postmodern therapy practitioners. The chapter focuses on "Battlers", "Burn-Outs" and "Blow-Outs", the group of research participants whose experiences of negotiating and resisting the forces of the therapy field involved struggle, tension and disillusionment. It analyses the strategies deployed by these therapists to resist the hegemony of the therapy field and to practise their preferred therapy approaches, and it considers the efficacy and consequences of these strategies. Part A examines therapists' engagement with official discourses and politics and their assertions of professional selfhood as methods of resistance. Part B focuses on the "hidden transcript" of these therapists, which takes shape when there is little space for official resistance within workplaces. Within the informal spaces of their workplaces, therapists exploited the incomplete surveillance of management, or developed ingenious methods to avoid surveillance. They cultivated the appearance of conformity, made strategic use of silence, and played the game and worked the

systems of their workplaces, making strategic use of their tools and discourses. The chapter also discusses the example of one therapist "beating the system" of his workplace. In my analysis of these discursive strategies, I highlight their toll on the personal and professional lives of these therapists.

Chapter 9 examines the second group of postmodern therapy practitioners, whose narratives of boundary-riding and resistance lacked the personal struggle or pain described in the previous chapter and involved greater ease and satisfaction. This group of therapists are labelled as "Infiltrators", "Outsiders" and "Accepters". The chapter analyses several resistance strategies used by members of this group, including the successful use of official politics, the infiltration of mainstream therapy spaces and systems, and the tactic of leaving the public sector for community or private sector work opportunities. I examine how therapists' positions within the medicalised hierarchy of therapy professions influenced how they used these strategies and the success of their application. In addition to my analysis of these resistance strategies, the chapter contains an addendum that considers a number of the therapists' professed abilities to accept and tolerate the partial nature of their resistances and the compromises they made in order to have relatively peaceful working lives. I discuss several cultural discourses that supported therapists to take up deliberate positions of tolerance for contradiction in their working lives, and I suggest that these positions supported these therapists to make boundary-riding both personally and professional sustainable.

I conclude the thesis by considering the significance of the research in terms of the postmodern therapy movement, the general field of therapy in Aotearoa New Zealand, and the wider fields of public sector services. I also position this research in relation to debates about the impact of neoliberalism/managerialism in specific organisational settings. I argue that the trends revealed by my research indicate a situation marked by fractiousness and difficulty alongside pockets of harmoniousness and professional freedom. My emphasis is on the need for mentors and teachers of postmodern therapy approaches to engage more closely with the realities that confront practitioners in the field.

2. Methodology

Introduction

This chapter discusses the theoretical assumptions that guide my research methods. It also introduces me, the researcher/writer, and my study participants, foregrounding our respective social positions in relation to this research. First, I review my approach to the knowledge presented in this thesis, emphasising a social constructionist perspective. Next, I examine how I have "contaminated" the research process, discussing my own narrative in order to indicate some of the positions I occupy as the interpreter and author. I then introduce the participants, explaining the means by which they came to take part in this project, as well as acknowledging those who were not included. I discuss the participants' interests and connections as a group, their demographic details, the professional roles that they occupy, and the impact upon them of their positions within professional hierarchies. I then go on to examine the shifting, multiple degrees and kinds of power wielded by these postmodern therapy practitioners. Following this, I direct attention to the context of the interviews, including descriptions of the actual settings in which the interviews took place. Finally, I outline the technical process of obtaining and organising the research data, describing the functions of interview questions and field notes, and the process for coding interview themes. This chapter should remind the reader of the constructedness of this research and the selectiveness of my narrative. In it, I place myself in the research to draw attention at this early stage to the writing subject, who may otherwise risk being lost from view.

Theoretical approach to knowledge

This thesis is a close examination of how various therapy practitioners attempted to "do" therapy work in new ways and with political awareness within varied workplaces and institutions in Aotearoa New Zealand in the mid-2000s. While I am interested in such big themes as resistance, the critique of psychological models and traditions, and the possibilities of postmodern therapy practices, I am aware of the limitations of this research. The situatedness of the research, including the specificities of context and variations among my participants, betray the possibility of

making grand or all-encompassing statements. My statements and conclusions are partial and shaped and influenced by my participants' and my own social positions, interests, agendas, oversights, shortcomings, and subjective worldviews. In beginning my discussion of the methodology used in this research project in this way, I am acknowledging what is generally unacknowledged in more traditional, modernist and scientific research methodologies, where the "god-trick of seeing everything from nowhere" (Haraway, 1991, p. 189) provides an illusion of transparent, self-evident and absolute knowledge. All knowledge is tentative, subjective and partial; and it is produced – rather than revealed – by its authors: the god-trick is just that, a sleight of voice and words.

My methodological orientation in this thesis is influenced by postmodern, poststructuralist and feminist critiques of qualitative research and the production of knowledge, and by the research practices that have evolved in response to these critiques. These critiques and practices have problematised and raised questions about the possibilities of collecting data and developing knowledge. In varied ways, as Holstein and Gubrium explain, "these alternative perspectives[4] hold that meaning is socially constructed; all knowledge is created from the actions undertaken to obtain it" (2002, p. 112). Knowledge is not absolute, transcendent or fixed; it is not simply waiting to be discovered or revealed. As Patti Lather explains, quoting James Clifford, "there is no final knowledge; 'the contingency and historical moment of all readings' ensures that, whatever the object of our gaze, it 'is contested, temporal, and emergent'" (Lather 1991, p. 14). Knowledge is situated, contextual and always partial. And it is created and formed through the endeavours, interests and positions of the researcher and, in the case of qualitative research, her subjects.

The social construction of knowledge is particularly apparent when a critical gaze turns toward the traditions of qualitative research. The quest for objective, transparent, definitive accounts of "real world" subjects is rife with problems. As Holstein and Gubrium stress in their discussion of knowledge produced from qualitative methods:

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[4] Holstein and Gubrium refer to poststructuralist, postmodern, constructionist, and ethnomethodological approaches to qualitative research (2002, p. 112).

Any interview situation – no matter how formalized, restricted or standardized – relies upon the interaction between participants. Because meaning construction is unavoidably collaborative (Garfinkel, 1967; Sacks et al., 1974), it is virtually impossible to free any interaction from those factors that could be construed as contaminants. All participants in an interview are inevitably implicated in making meaning. (2002, p. 123-124)

It is mythical that a social research process may discover pure, objective, and "uncontaminated" knowledge that is free from unaccounted-for variables. Rather than suggesting a weakness or lack of academic rigour, the collaborative meaning construction that takes place within interviews, which is necessarily particular and partial, *is* the knowledge – *is* the subject under investigation. It is therefore vital to consider *how* the knowledge presented within this thesis is socially constructed alongside whatever claims and arguments I put forward about postmodern therapy practices: the two are inextricable (Holstein & Gubrium, 2002, p. 124; Fontana, 2003, p. 56).

Laurel Richardson (1994) makes clear the possibilities, invitations and freedoms that poststructuralism offers qualitative researchers, reinforcing the importance of understanding the subjective production of knowledge and highlighting a new agenda (in the early 1990s) for writing. She explains that

poststructuralism suggests two important things to qualitative writers: First, it directs us to understand ourselves reflexively as persons writing from particular positions at specific times; and second, it frees us from trying to write a single text in which everything is said to everyone. Nurturing our own voices releases the censorious hold of "science writing" on our consciousness, as well as the arrogance it fosters in our psyche. (p. 518)

Richardson's condensation of what poststructuralism means for qualitative writers informs and steers my own research and writing. By being reflexive and considering the nature of this knowledge production and my place and role in it, I am able to avoid some of the pressures and dangers of traditional qualitative writing. Likewise, in favouring a personal, partial and situated narrative, I am relieved from the pursuit of a complete, authoritative text. This poststructuralist approach encourages a continual questioning and doubtfulness over my own (and others') knowledge claims.

The "contaminating" researcher: a story about me in this thesis

The "contamination" feared by believers in pure science methods is present in part in this thesis because I am neither a detached, neutral observer, nor a mechanical, faultless recorder of information (nor, for that matter, are my participants sterile conduits for information). As the reader and analyser of interview transcripts, and as the writer of this text, I am present throughout this thesis. In concert with numerous other postmodern/poststructuralist researchers (Bola, 1995; Denzin & Lincoln, 1998, 2002; Heenan, 1996; Lather, 1991; Mauthner & Doucet, 2003; Richardson, 1994; Surtees, 2003), Nicola Gavey stresses that:

> Because the reading process is constructive and not neutral, it is important to identify one's positions as a reader in relation to this text (even though such identification is unlikely to capture the nuances and complexity of these positions). (1989, p. 468)

Situating myself in relation to this text reveals some of my agendas and interests. This offers some "understanding of *what* is influencing … [this] knowledge production and *how* this is occurring" (Mauthner & Doucet, 2003, p. 419), and alerts readers to potential tensions in relation to my assertions about my research participants. My voice in this thesis is neither authoritative nor innocent and *who I am* is integral to how I construct knowledge. By situating the writing subject (me), I allow both readers and myself openings to question and engage critically with the claims that I make.

This research process and creation has produced more books or stories than will be written within these pages. There are many possible strands and pathways among the webs of knowledge shaped by the interview conversations, drafted in notes that were abandoned, told to others in stories outside or around this text, or simply formed, or malformed, in my mind but never spoken or written. A whole story could be my autobiography, a rich, layered expose of the germination, growth and development of this research in my life. I could describe, somewhat poetically perhaps, grim rainy weekend days in my fifth floor university office, my head and body filled with tension and questioning about the meaning and purpose of this project. Or how warm conversations over cups of tea with my aunt spurred on my ideas, pointed me in different directions, and then swung back into my professional life. The starting and stopping and starting of the research, what I did in between these times, and the inherently fluid overflow of this project from the confines and "study days" of the

University's PhD programme could all be described and analysed in great detail. This narrative shaped, melded and prompted the questions I posed to the people interviewed for this project, the questions that struck me after the interviews, and the questions that formed the basis for my analysis of the research materials.

While the fullness of this story will not be written or contained here, it will be woven, openly at times but also not so openly or consciously, throughout this document. However, I will also give some highlights here, creating some semblance of a plot, and in the process offer some insight into my multiple positions in relation to this research and to my participants.

The research process began for me in 2004, when I was 28 years old. I began the study with critical questions about the possibilities of therapy as a viable, ethical, socially worthy and desirable activity. I was profoundly uncertain and uneasy about the practices and endeavours of therapy/therapists. My university training encouraged critique of institutions and dominant knowledge systems, such as psychology. I was concerned about the seemingly irresolvable power imbalances in the relationship between therapists and clients, and the critique of therapy as an instrument of social control filled my head and fuelled my scepticism.

My academic concerns both influenced, and were influenced by, my "second job" as a support worker – and later counsellor and manager – at a local, community-based, non-governmental organisation that provided support to people with eating and body image difficulties.[5] I had been involved with this organisation, as both a worker and volunteer, since 2000. In my job, I stood on the cusp of the therapy profession, aware both of the therapy-like work I was stumbling into with clients, and of the professional legitimacy I could gain by "signing up" to counselling/therapy training and becoming an accredited practitioner. Yet I held back, feeling ambivalent. My scepticism of therapy, and my critical awareness of the workings of power within the therapy profession, kept me wary and uneasy about the activities and potentials of the professional life of my "second job".

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[5] I have been involved with this organisation throughout the course of developing and writing this thesis, doing part-time work alongside part-time study. I resigned from my counselling and management roles in September 2011, but remain involved in the governance of the organisation.

So I began researching this thesis and talking with my first research participants from this position of ambivalence and scepticism. I presented and introduced myself to participants as someone with both an identity as a university graduate student with particular disciplinary interests and alliances, and as a possible peer, a professional from within the area of mental health work in Aotearoa New Zealand who was shifting and shuffling in and out of the role of therapist/counsellor. From the outset, I very obviously occupied multiple subjective positions, and, as the interviews progressed, the emphasis on these positions would vary, both in response to the rapport I built with participants as points of contact and similarity were highlighted, and as my own sense of these positions shifted and changed over time.

My initial introductions with participants also had bearing on my subjective positioning. I met some participants at training courses, where I attended primarily as a student and novice counsellor in my work role, but where I simultaneously maintained interest and curiosity as a researcher. My conversations in these spaces and with potential participants involved revealing some of my opinions about therapy and my views in relation to what we were learning on the training course. I had warm, sparky conversations, where commonality and mutuality was emphasised, with people whom I later sought out to interview. Some of my other participants were suggested to me by my research supervisor and were her friends and associates. I introduced myself with reference to my supervisor and in correspondence and on meeting we invariably discussed her. This link undoubtedly influenced these participants' positioning of me, with assumptions perhaps made about the style and orientation of my research because of my supervisory relationship. Other participants were found from within my own professional interest networks, which again positioned our interview relationship in particular ways, possibly creating assumptions from the outset of commonality and alliance.

In between the first thirteen interviews and the last six, I suspended my studies for twelve months and undertook a Masters of Education with a Certificate in Counselling, beginning in 2006. In February 2007, I became an applicant member of the New Zealand Association of Counsellors (and became a full member in 2009). Deciding to suspend my PhD, then, also encompassed a decision to become a counsellor myself, to more decisively, deliberately and professionally *do* what the

people I had interviewed were doing. I increased my workload at my "second job" and began to call myself a counsellor. I shifted positions, although not in the sudden or drastic way that the suspension and subsequent counselling training might suggest. Throughout this entire research project, I have existed at the edge of the therapy world, sometimes stepping in and nodding along knowingly as my interviewees described aspects of their work or experiences; at other times, I have felt distant, on the outside, not understanding terminology or being able to connect personally with participants' comments. Over the two years of interviewing, I shifted to occupy a more concrete position as a counsellor and fellow to some of my participants. In doing so, I shifted in my own sense of the possibilities and problems of therapy and counselling. Influenced to a large extent in fact by many of my conversations with therapy professionals as part of this research, I came to see therapy as more viable. I tempered my critique, at times railing against it, and embraced a kind of pragmatism for myself. I wanted to *do something*, however tricky and problematic, in my work with clients. (I was, in fact, already *doing something* anyway in my work, despite my protests and my suspicions of therapy). And I heard and saw how the people I interviewed did things, how they negotiated tensions, or, at times, carried on in concert with tensions and self-critique. I learned from them, sometimes scribbling down notes or examples of their counselling methods after interviews so that I could take ideas back to my own work with clients. I saw worth in what they were doing, and I wanted to work more competently, effectively, and ethically with my clients.

In the later stages of this writing, as I developed and worked on the second half of the thesis, I noticed a growing relationship between my analysis of my participants' work cultures and my own contemporaneous organisational experiences. As I became more involved in the management of a community organisation in Aotearoa New Zealand, receiving District Health Board (DHB) funding to deliver a mental health service, I became more alert to the impact of external institutional and political forces. Over my ten years of involvement, the contractual obligations accompanying DHB funding grew enormously – while the actual funding itself remained insufficient, from my perspective. Accountability for this funding became a large and detailed project, with the agency needing to demonstrate comprehensively its compliance with growing policies and directives, and there was an increased emphasis on measurable outcomes. I was frequently anxious at the prospect of being audited, which was an ever-present

possibility. I became cynically convinced that the government was content to receive a high-quality, effective service – which was needing to devote more and more of its resources to manage its funding contract – for a minimal cost. Along with the increase in bureaucracy, the contract became increasingly medicalised. We were required to use and engage with psychiatric diagnoses, and to focus the counselling and support services on the single health issue for which we received funding. These requirements forced the organisation to act in ways that were increasingly out of line with its original objectives as a feminist, holistic and politically engaged service.

My own observations and experiences of a publicly funded community therapy organisation in Aotearoa New Zealand over the 2000s piqued my interest in the workplaces and cultures of my research participants. I found similarities in our experiences, and their stories gave me a greater sense of the history and trajectory of the changes I had noticed at my own workplace. As I learned more about the history and theories of neoliberalism and managerialism, applying this to my research material, I also developed an understanding of their application to my own working life. My research enabled me to develop a political analysis of the bureaucratic and institutional forces shaping my work, while my own experiences of struggle and frustration in reaction to the impact of these forces fuelled my interest in certain aspects of my interview transcripts and, to some extent, guided the direction of this thesis.

This story tells of a shift in my positioning over the time of this research and of the multiple positions I occupy both in my relationships with participants and as I write this text. I am variously positioned, as an academic researcher, counselling colleague, community worker, novice, cynic, friend, and stranger. I am an observer on the outside of the research, but also highly involved as a mostly silent subject of the study. I am also Pākehā,[6] highly educated, of middle class background, rather poor, currently 36 years old, and female. Like Ruth Surtees as she describes her own position in relation to her research on midwifery in Aotearoa New Zealand, I hold a "multiply positioned, transient and always mobile perspective" (2003, p. 84). And I acknowledge, as Michelle Fine encourages, that "Self and Other are knottily

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[6] Pākehā is a Māori language term for New Zealanders who are of European descent ("Pākehā", 2012, para. 1).

entangled" in this research (1994, p. 72). In her discussion of "working the hyphen" between self and other, Fine states: "If poststructuralism has taught us anything, it is to beware the frozen identities and the presumption that the hyphen is real, to suspect the binary, to worry the clear distinctions" (p. 80). There are no fixed or total, clear distinctions between my participants and myself. The experience of interviewing and analysing involves continual movement between self and other positions – moments of estrangement and difference, moments of connection and similarity, and the messy, fluctuating space in-between that exposes the fiction of the hyphen.

The participants

This research is concerned with the accounts of therapy practitioners, working in Aotearoa New Zealand, who engage with political and postmodern ideas about therapy. I commenced the research process by formulating an information sheet about my project, entitled "Therapy as Resistance?" (Appendix A). I was interested in talking with people who had been trained in and/or had an interest in modes and theories of therapy that stem from postmodern, poststructuralist and feminist critiques of the field – such as, narrative therapy, solution focused counselling, other so-called discursive therapies, critical psychology, "Just Therapy", and feminist therapies. I wanted to know about how these people posed resistance, how they did therapy differently, and I held assumptions that these were rebellious, "different", critically minded practitioners. Through word of mouth, my own contacts, the resultant snowball effect, and guidance from supervisors, I sought out and approached practitioners whom I thought might be appropriate participants in the project, and requested a one-to-one, in-depth interview.

My information sheet conveyed an agenda of interest in "resistance" to "dominant cultural values, structures and power arrangements", "alternatives" to "mainstream" therapy and psychology, and "critiques" of therapy (Appendix B). In both verbal and email conversations with some potential interviewees, I became aware of the mutable, varied meanings of these words and ideas. Some people expressed strong interest in my project and deemed themselves to be appropriate participants. They expressed misgivings about the counselling/therapy fraternity, critiquing certain apparent dogmatic tendencies, the rise of specialisation and a particular vision of professionalism, and the abundance of different "modalities" and "labels". Yet often,

as we conversed, I felt their ideas and agendas for therapy, despite their critiques, reproduced psychotherapeutic assumptions about "the therapy process" – for instance, "going deep", getting to the "underneath issues", or working solely at the level of the individual with little regard for political and social structural issues. Likewise, I realised that they were unknowing of the particular critical ideas and perspectives that I was interested in. Their view of themselves as "alternative" or "resistant" did not fit with my understandings of these terms and I chose not to include them in the project – which once again highlights the shaping force of the researcher, the narrowing and limiting of meaning and knowledge that takes place as I investigate and undertake this research, reminding us how "all knowledge is created from the actions undertaken to obtain it" (Holstein & Gubrium, 2002, p. 112).

As I sought out potential interviewees, I encountered numerous people who declined my request for them to participate in the research project. For some this was a matter of time and workloads, feeling unable or unwilling to incorporate an in-depth interview into their schedules. However, others had more specific oppositions to participating, which are suggestive of interesting research and methodological concerns that are not taken up here – paths of inquiry that are significant but unyielding or stray too far from my main concerns. For instance, some people spoke of being more interested in "getting on with the job" than reflecting on theoretical issues. Another explained that, while sharing its political stance, "narrative [therapy] jargon still gives me a bad allergic reaction". Such comments were intriguing and stimulated questions that were, however, made difficult to investigate by these people's decisions not to participate. A further reason given by one person for not participating was previous experience of being a subject of qualitative research. This person spoke of feeling alienated and annoyed by the researcher's use of her words, explaining that this made her unwilling to offer her words to research again. Inquiry into this person's experience could yield significant knowledge for the field of qualitative research that, again, is not pursued here. These untaken, unexplored paths of inquiry are reminders of the partiality and sculptural nature of the knowledge produced in and by this thesis.

While five people clearly declined to take part in my research, many others responded warmly and expressed strong interest in the topic, both suggesting and openly stating

at times a feeling of connection and alliance with my interests. I conducted eighteen recorded, one-to-one interviews over the course of my research. The interviewees consisted of nine women and nine men, ranging in age from late twenties to early sixties. Interviews took place in numerous cities throughout Aotearoa New Zealand. The majority of the interviewees were Pākehā/New Zealand Europeans. Two indicated that they were migrants from European countries, one was from Asia, and one self-identified as Jewish. No participants self-identified as having Māori or Pacific Island background. All of the interviewees had undertaken tertiary education of some form and had professional careers in the fields of counselling, social work, psychology and psychiatry. They encompassed a wide range of professional roles, including counsellors, counsellor/social workers, counsellor/nurses, registered psychologists, clinical psychologists, educational psychologists, and psychiatrists. Most of the interviewees (eleven of them) had current or previous experiences of working in the public sector for District Health Board mental health services. Two were involved in counselling/therapy work within medical services within the public sector. Three worked as counsellors within educational institutions. Three worked in non-governmental, community-based counselling and support services. One worked in the public sector as an educational psychologist. Five worked in full- or part-time private practice. Roughly half of the participants had worked as therapists for over ten years, with several being close to twenty years of professional practice. The remaining participants ranged between two and nine years of employment in therapist roles.

All of these people were familiar with the critiques of therapy and psychology that have stemmed from postmodern, poststructuralist and feminist thought. All had a concern about the power relations that operate within therapy settings and activities, and consciously sought to attend to and negotiate these power relations in their own work. All also had an awareness of the inherent interplay between individuals and the social and political contexts of their lives, seeing the problems and distress experienced by clients/patients as discursive, systemic, and political, rather than solely as evidence of individual pathology. Most of the participants had undertaken training courses or attended workshops and conferences focused on the ideas of narrative therapy and/or critical psychology, and many had been supervised or mentored by proponents of these sorts of critical, postmodern therapy ideas.

While all of the interviewees were connected by their interest in critiques of traditional therapy and their involvement and participation in critical, alternative therapy practices, they were stratified and distinguished by both professional hierarchies and by work roles and settings. The hierarchy of professional roles within therapy and mental health work, particularly within Aotearoa New Zealand's public mental health sector, was commented on by all interviewees and had significant bearing on the work that they did (as will be discussed more fully later). Social workers/counsellors within mental health services explained their lowly status on the professional ladder: one man described how his supervisor had said to him, "Cal, you realise when you go there [to a DHB mental health service] your role will be handmaiden?" Clinical psychologists referred to the psychiatrist within clinical teams as being "top dog" and "like a benevolent dictator". Counselling and psychology professionals working within medical health settings spoke of the need for "validation" and to "market psychology" to medical colleagues who perhaps saw psychologists as "some kind of out-there threat". And psychiatrists acknowledged the power accorded to them within clinical teams, with one man explaining, "you've got a bit of mana from just being a doctor". The participants in this project spoke from multiple locations within a hierarchy of therapy professionals. Their different roles within therapy work, and the various settings for their work, also resulted in varied perspectives on and experiences of doing therapy in critical and political ways.

This project is not concerned with a uniform group of therapy practitioners. The interviewees were united by their interests, ideals, and approaches to therapy work, and were constitutive of a significant subculture and social movement within therapy work in Aotearoa New Zealand during the mid-2000s (as will be discussed in chapter 4). They differed, however, in many respects but particularly and most obviously in terms of their professional roles and work/institutional settings. These differences and divergences are significant for the insights they provide about the operations of power within institutions governing therapy and mental health work in Aotearoa New Zealand, and about the possibilities and potentials for deploying postmodern therapy practices in those contexts. Different roles and positions within institutions, and employment within different kinds of institutions, correlate with different accounts and experiences of "working out" how to practise therapy in preferred ways. These differences – along with similarities of accounts and experiences – have significant

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implications for the mobilisation of postmodern therapy ideas in Aotearoa New Zealand.

The issue of "power-fulness" and "power-lessness"

As discussed earlier, I am aware, in conducting this research – in writing about this subject, the interviewees, and myself – that I am trying to "work the hyphen" between self and other. Michelle Fine, as she considers the meanings of "working the hyphen" for qualitative researchers, explains how poststructuralism teaches us to "suspect the binary, to worry the clear distinctions" (1994, p. 80). This suspicion and worry is also relevant to my consideration of power and the positions occupied by the participants in this research. While Fine makes clear the "knottily entangled" (p. 72) relationship between self and other, her article seems limited in regard to who the "others" in qualitative research are, and their relationship to and experiences of power. She describes and critiques qualitative essays that position "subjugated Others as if *they* were a homogeneous mass (of vice or virtue)" (p. 74). Later she mentions the fear she feels when researchers describe their aim as wanting to "help" "Them" (p. 79). And she commends new research agendas (in the early 1990s), where "qualitative researchers have begun to interrupt Othering by forcing subjugated voices in context to the front of our texts and by exploiting privileged voices to scrutinise the technologies of Othering" (p. 79). Fine rightfully targets the othering that takes place within qualitative research and its alliance with the subjugation and oppression experienced in daily life by those who are deemed other. However, her article seems to offer only two positions for the subjects of qualitative research: they are either "subjugated voices" or elite, "privileged voices" who benefit from the technologies of othering. When I consider these positions in relation to my own research participants, I struggle to make them wholly fit. Instead, I find myself concerned with the in-between of these two positions, with the messy blurring of ideas and experiences of power and lack of power, privilege and subjugation.

The voices and positions occupied by the participants in this research project are neither simply "privileged" nor "subjugated"; they fluctuate and shift in and out of the categories of self and other, legitimate and illegitimate, powerful and powerless. The group of people interviewed for this project shared connections through their interest in therapy approaches that diverged from – and opposed – many of the traditional

assumptions of mainstream therapy and psychology. For many, these interests marked them as different, renegade, illegitimate and "odd", and measures were taken by others (and, self-protectively, by themselves) to contain, silence or discipline them (as will be discussed in detail later). Such experiences were particularly common for those who occupied lower positions in the hierarchy of mental health professions: the psychiatrist at the head of a clinical mental health team occupied a different position, accruing and exercising more power and having greater freedoms over actions and words than his social worker colleague. To varying degrees, depending on institutional environments and professional roles, many of the participants in this project experienced othering and censure for their "unconventional" therapy ideas and practices.

And yet, in other moments, these people were elite professionals with formidable power. This was particularly the case in their relationships with clients/patients, who much more easily and obviously occupied positions of subjugation and social marginalisation: as *others*, who were "mentally ill", troubled, distressed, and either seeking professional "help" or engaging in therapy under compulsion. The participants were predominantly Pākehā, educated, white-collar professionals with skills, knowledge and mandates to "help" clients/patients obtain or regain "normality" – become less mad, sad, or socially disruptive, be more productive, functional, acceptable. Their professional identities, regardless of hierarchy, provided levels of comfort and social authority not experienced by many. However, at the same time their powerfulness was complicated by other, simultaneous subject positions. Half of the interviewees were women, one was Asian living and working in Aotearoa New Zealand, some were homosexual, some were men deliberately working against the ideals of hegemonic masculinity, and some had long histories of involvement in social justice movements and led "alternative" lifestyles. While I am most interested in the professional roles of the interviewees, their subject positions were multiple and spoke of shifting, changeable relations to power.

A simplistic binary of powerful/powerless does not work to characterise or analyse the positions and experiences of my research participants. While they might have occupied professional positions of power, they were aware of the unconventionality of their therapy philosophies and practices, particularly within public sector services,

and closely managed their self-presentations in their work settings, aware of potential censure or exclusion. And their professional roles also intersected and interacted with other subject positions, leading to complicated experiences and relations of power. For the participants of this thesis, power was not a simple, innate or fixed possession; instead, power and experiences of oppression and dominance were relative, changeable, and context dependent. Attention to context and the ways in which power and privilege shift depending on the stance and situation of the participant are crucial to the analysis of power relations in this thesis.

Consideration of context

In outlining the participants of this research – their professional roles, work environments, positions within professional hierarchies, and demographics – and in discussing their relations of and to power, I am highlighting the crucial importance of the consideration of context to this research. In their exploration of workplace subjectivities within the British NHS, and the effects of managerialist discourse, Halford and Leonard (2006) stress that attention to "context contributes to a deepening of our understanding of the nature of work subjectivities" (p. 671). They focus particularly on both organisational contexts and the shifting contexts of individuals' everyday lives, revealing the complex and varied relationships between organisation, discourse and individual subjectivity (pp. 670, 671). While my study has not involved close ethnographic explorations of my participants' workplaces, the organisational settings and experiences of my participants, the contexts of their everyday lives, and the contexts of our meetings and conversations are inextricable from the content of our talk. As Halford and Leonard explain, quoting numerous other qualitative scholars,

> interview narratives are not free-floating, constructed in "any old way" (Cameron, 2001, p.174), they are not fabricated at will (Somers & Gibson, 1994) but are "cut from the same kinds of cloth as the lives they tell about" (Denzin, 1989, p. 86). In other words, interviews are "talk and text in context" (van Dijk, 1997a, p. 3), influenced by both the broad and specific contexts in which they are set. (2006, p. 662)

The talk that takes place in these interviews is always referring to, interacting with, or being influenced by the contexts of our talk.

The interview conversations gave hints to the many and different factors that informed or influenced my participants' therapy work experiences and subjectivities. While this thesis pays particular attention to identifying and analysing the dominant forces and discourses that shape the field of therapy in Aotearoa New Zealand, these therapists, as actors in this field, are not simple or passive recipients, existing within a single context. Halford and Leonard point out that "the shifting contexts of individuals' everyday lives provide alternative and competing resources for the construction of self" (2006, p. 670). Throughout the interviews, participants referenced, emphasised, and revealed how the shifting contexts of their lives provided them with resources for their work selves and influenced how they negotiated dominant discourses and did critical, postmodern therapy work. All of the interviews commenced with participants telling me stories of how they had come to do the work that they did, and of the development of their views on therapy. In telling these stories, people foregrounded numerous factors that went beyond their professional training and work experiences. The interviews included talk about parents, overseas travel, Buddhism, Christianity, Quakerism, meditation practices, sexual identity, involvement in social movements (anti-Springbok tour, homosexual rights, Treaty of Waitangi education and activism, feminist groups, men's groups), school experiences, ideas about social justice, books, movies, friends, previous careers, raising children, moving countries, engagement with Māori and Pacific cultures, experiences of medicine, their own mental health issues, partners/spouses, gardening, and more. Therapists' narratives of their work roles and practices, and of their attempts to "do" therapy differently, were interwoven with many extra-work stories and experiences. These demonstrated the breadth of participants' self-construction and the inextricable involvement of the shifting contexts of their everyday lives, both historically and currently, in their work practices. This thesis constructs one particular story from the texts of the participants, paying attention to certain aspects of these shifting contexts as a means of analysing the complex relationships between organisations, discourse and individual subjectivity, and the possibilities of postmodern therapy work in Aotearoa New Zealand. Other stories and threads, involving other resources and discourses, form an undiscussed backdrop to my particular story and could have taken shape if this thesis had taken a different path.

I wish to briefly consider the specific temporal and spatial experiences of these interview conversations, the immediate particularities of this "talk and text in context" (Halford & Leonard, 2006, p. 662). In doing so, I offer brief descriptions and suggest a sense of the feelings of the conversations – the constraints and freedoms of time, the impact of setting on the conversation, insights into the nature of organisations and work culture. These conversations about critical and political therapy practices, and the experiences of practitioners, took place across a range of contexts that had bearing on our talk. Some people met with me in work time at their workplaces. Their workplaces included large-scale institutions (mental health services, hospitals, other public-sector organisations), school and university counselling service rooms, and suburban and urban private practice rooms. These meeting places gave me insight into the environmental and organisational context of the practitioners' work. I sat in the waiting rooms of hospitals and other clinical mental health services, often alongside clients or patients, before being led through to the practitioner's room, sometimes introduced to colleagues along the way. In large-scale organisations, the environments were often institutional (office buildings with front desks overseen by an administrator, offices, corridors, meeting rooms, tea rooms, and signs of numerous other staff) and/or medical (hospitals, or services signposted with the words "mental health", housed in well-known medical sites). Visiting a school, I made my way through throngs of students, seeking directions from visible authority figures, and sat in a counselling suite, with beanbags on the floor and youth-targeted health messages on posters on the walls. University counselling services were accessed through health clinics, where again I sat with other waiting clients/patients. And I found other interviewees in high-rise, glass-encased urban private practice rooms, or in homely suburban houses-cum-counselling practices with garden views.

I was able to experience the organisational settings for these participants' work, and gauge the pace and feel of these systems. Participants often engaged with their work settings as we talked – rifling through their files to show me copies of official paperwork, commenting on the experience of doing therapy in a clinical examination room or the cold of their old institutional building, showing me whiteboard diagrams that they used with clients/patients, lowering their voices during parts of their talk to ensure not being overheard. Within these spaces, time was often limited, as other work duties, including counselling appointments, were scheduled after the interview.

In discussing the increasing "efficiencies" and monitoring imposed by management, one man revealed that he would have to find a way to account for the time spent on our interview. For other participants, I arranged to meet during the early morning, so that their workdays were not interrupted.

Interviews conducted outside of work environments were, understandably, significantly different, denying me an embodied and observed experience of participants' work contexts and making their comments about their organisations less immediate and more descriptive, reliant on recall and retelling. I met with people for interviews in cafés, their own houses, and, in one instance, my house. While time parameters for the interviews were often specified, frequently there was less urgency around time and some interviews were able to continue for much longer than those that took place in work environments. One interview took place at the kitchen table of a family home, cups of tea in hand and signs of family life around us. Another was in a woman's home with her new baby; the interview involved many starts and stops, with baby noise, feedings, and talk, and much laughter between the participant and me. In a café, one participant carved up her muffin to illustrate the carving up of her previous public sector workplace. At my house, the interview took place in my lounge, with noise from my flatmate in the background, and then shared dinner at the end. Interviews outside workspaces were often more lively and broader in their focus than workplace interviews: less pressure on time was also no doubt a factor in this. Participants spoke freely of past experiences working in institutions, voicing criticisms and revealing subversive strategies that perhaps would not have been spoken from inside a current workplace.

The research process

Before commencing the interview process with these participants, I developed a range of questions to orient the focus of the interviews, which matched my initial research interests (see Appendix B). These questions formed a loose structure to the interviews: not every question was always asked, nor did interviews necessarily follow the order of the written questions. The questions often served as starters to areas of conversation, and were followed with a more spontaneous questioning process, sparked by the content of the participants' talk. Numerous questions were encompassed and answered in the course of the conversation, without requiring

deliberate attention. At the start of the interviews I administered a consent form, where participants granted approval for their interviews to be used for research purposes and included in publications, on the basis that anonymity would be assured. Accordingly, in the thesis, the names and identifying details of the research participants have been changed.

After interviews were completed, I wrote "field notes", where I recorded the specific details of the meetings – locations, times of day, the participants' job titles and roles, demographic information – and any other details of note. I wrote my reflections on meetings, including how the interviews "felt", particular things that I had observed or wondered about, how they compared with other interviews, and the feelings that I experienced during and after interviews. In these field notes I also highlighted initial areas of research interest, noting the presence of possible discourses and particular concepts raised by the participants' talk. The interviews largely took place in three time periods: late-2004, mid-2005, and – after I had suspended the study for the 2006 year while I undertook my counselling training – mid-2007. I transcribed the tape-recorded interviews, taking notes of interesting features and issues and developing a rough system for categorising participants' use of discourses. Between the first and second periods of interviewing I focused on developing a coding system for the themes of the interviews; this system grew and developed over the full course of the interview process. I utilised NVivo software[7] for organising and sorting the qualitative data and for developing the coding system. As I developed my analysis of the data, I made connections between the qualitative material and theoretical concepts and literature, shaping the research themes into the current thesis structure and developing my ideas and investigations through the writing process.

My voice as the writer of this thesis – particularly throughout Part 3 – at times shifts from analysis of my participants' texts and talk to a more naïve reading of their words: that is, my narrative involves an interplay between an interpretive reading of their texts and acceptance of contextual information – facts, situations, personal and professional histories – as given. I use this contextual information, from my own position as researcher, to construct and interpret an account of my participants' self-

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[7] NVivo is the name for qualitative research software produced by QSR International.

descriptions. This information, as this methodology chapter makes clear, is shaped by the perspectives, situations and evaluations of the research participants.

Conclusion

This first part of my thesis has introduced the subject of the research and my methodological approach. My intention in this particular chapter has been to furnish my reader with vital contextual information that should be held on to and remembered throughout the reading experience of the thesis. I have sought to describe the "behind-the-scenes" reality that has informed the construction of the researched narrative that will ensue. This seems important to me because without such a close insight into some of the vagaries and uncertainties that I have experienced as a researcher and writer, it may be possible to view my finished product as more polished and assured than I intend. Some of the issues touched on in this chapter have not been pursued as lines of inquiry in the remaining body of the thesis; others (as will become clear) have been of great importance to the research and lead to detailed analyses. Such distinctions point to particular judgements that I have made and to preferences that I consequently exhibit.

Part 2, which follows, comprises two chapters that together situate and describe the participants of this research as members of a broadly defined social movement characterised by a commitment to postmodern therapy practices. Chapter 3 outlines the growth of the postmodern, critical reaction to the traditions and politics of therapy, and describes approaches to therapy that have grown out of this critique. Chapter 4 brings my participants to the fore, using their words to show how the theories explained in chapter 3 have been mobilised in the shape of a particular social movement in the field of therapy in Aotearoa New Zealand.

PART 2

3. Critical Therapy: A Review of Postmodern Approaches

Introduction

The purpose of this chapter is to situate and contextualise my research. This thesis is concerned with the field of therapy in Aotearoa New Zealand, with a particular focus on the experiences of a group of postmodern therapy practitioners. The first part of this chapter describes, through reference to appropriate literature, the critique of traditional therapy inspired by postmodern perspectives, including Foucauldian, feminist and critical psychology theories. I canvass some of the key arguments that have been levelled against therapy over the last forty years. The chapter then considers how this critique has engendered new and innovative approaches to therapy that offer means of practising that potentially lessen some the ethical difficulties highlighted by the postmodern critical perspective. For therapists who subscribe to that perspective, these approaches offer more ethically viable ways of doing therapy. Thus, this chapter sets up a context for understanding the philosophies and theoretical assumptions that guide and influence the participants in this research. As such, it constitutes a backdrop for the discussion in later chapters where I will analyse these practitioners' experiences of pursuing their postmodern practices in the context of health and social services in Aotearoa New Zealand.

"So what's the problem with therapy?" Critiquing the traditions of therapy and resisting the experts

Over the last forty years, developments in cultural theory and criticism have profoundly problematized the traditions, theories and practices of therapy. Poststructuralist, postmodern, and deconstructive ideas, coupled with feminist theories and critiques, when focused on therapy, have produced the claim from critics

that therapy functions as an instrument of social control. These theoretical orientations call into question the supposedly neutral and objective psychological science of the "self", exposing it instead as a cultural invention that enables and perpetuates oppressive power relations. While the term "therapy" encompasses many forms and theories of therapeutic engagement between therapist and client/patient – psychiatry, various psychologies, many different counselling and psychotherapy modalities, social work, nursing – most have relied on and reinforced the liberal humanist construction of the "self". Adherence to the liberal humanist self, from the point of view of therapy critics, results in the de-contextualisation and de-politicisation of people's (clients'/patients') problems, and the promotion of pathological explanations and individual responsibility for such problems. Therapy has also been accused of modelling "normality" on the image of white, heterosexual, middle class men, and either ignoring gender, class, ethnicity, and sexuality differences, or conceiving such differences as pathological. The growing body of critical studies of therapy calls into question the viability of therapy as an ethical and non-oppressive practice and means of advancing political and liberating goals.[8]

Therapy as an instrument of social control

For many writers on and practitioners of therapy, the idea that therapy may function as an instrument of social control has become a significant concern (Bird, 2000, p. xx; Cecchin, 1993, p. ix, as cited in Kaye, 1999, p. 20; Hare-Mustin, 1997, p. 555; Kitzinger & Perkins, 1993; Parker, 1999, p. 2). The works of Michel Foucault have been particularly important for suggesting this idea and have been picked up and extended by many people reflecting on the project of therapy. In this section, I review the arguments of Foucault and his followers in relation to therapy. In an interview in *Technologies of the Self* (Martin, 1988), Foucault reflected on his work over twenty-five years. He explained that his objective had been to show that, "through these

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[8]This discussion of critiques of therapy is general and refers to therapy, psychology and the "psy" disciplines interchangeably and without great attention to the differences among therapies. My intention here is to present the key ideas that form the basis for questioning therapy in general as a social good and a helpful service for individuals. Aspects of these ideas may fit more appropriately with some specific therapies over others: for instance, the discussion of science may resonate most closely with psychology practices, while the liberal humanist conception of "self" may be most apparent in the "growth" therapies, like Gestalt psychotherapy. However, these distinctions are not a strong focus of the discussion as I am more interested in constructing an overall picture of therapy as problematic through the eyes of critics and then considering how these problems form the basis for critical, postmodern-inspired therapy theories and practices.

different practices – psychological, medical, penitential, educational – a certain idea or model of humanity was developed, and now this idea of man [*sic.*] has become normative, self-evident, and is supposed to be universal" (p. 15). In his work, Foucault examined the high-ranking knowledges produced by the human sciences and other authoritative institutions – including, specifically and by extension, the "psy" disciplines. He called for these knowledges to not be taken at face value, but rather to be analysed as specific "truth games" that are inextricably linked to the workings of power (p. 18). For Foucault, the development of normative, self-evident, and supposedly universal understandings of humanity became ways of deploying and exercising disciplinary power and producing individuals who, in turn, regulate themselves.

Foucault contends that this system of disciplinary power is achieved through the objectification of individuals: through their division, classification and subjectification (Rabinow, 1984, p. 12). Individuals are divided both internally and from each other, subject to categorization and scientific classification, and organized around definitions of normality and abnormality. These processes are disciplinary and have bearing on how individuals conceive of, and discipline, themselves. Jana Sawicki (1991) elaborates on Foucault's theories:

> Disciplinary practices create the divisions healthy/ill, sane/mad, legal/delinquent, which, by virtue of their authoritative status, can be used as effective means of normalization and social control. They may involve the literal dividing off of segments of the population through incarceration or institutionalization. Usually the divisions are experienced in the society at large in more subtle ways, such as in the practice of labelling one another or ourselves as different or abnormal. (p. 22)

Psychological theories and practices can be seen to illustrate Foucault's analysis. They involve the division, classification and categorization of individuals – as sane/mad, ordered/disordered, functional/dysfunctional, adjusted/maladjusted, healthy/ill. The authoritative, expert status of the psychologist or therapist – who is involved and invested in this "truth game" – legitimises these categories and their application. The categories are disciplinary as they separate individuals from one another (literally and figuratively), regulating and labelling those deemed abnormal

and teaching others how to practise, or recover, normality – to discipline and regulate themselves.

Viewing psychology and therapy through Foucault's lens draws attention to numerous specific disciplinary and normalising techniques, which operate in cumulative ways. Disciplinary writing and documentation, for instance, play an integral part in the traditions and practices of psychology and therapy – assessments, formulations, psychometric tests, intake forms, reviews, the assignment of diagnoses, therapy notes, case-files, statistics, and reports to institutional bodies are all features of therapeutic encounters. While the requirements for documentation and writing vary, depending on therapy role and institutional location, case-files and note-taking, in some form, are ubiquitous across the field of therapy. Foucault describes how documentation shifted from the eighteenth century, from heroised chronicles of powerful men to new subjects of description – the child, the patient, the madman, the prisoner (1984, p. 203). Such writing and documentation makes each individual into a "case":

> a case which at one and the same time constitutes an object for a branch of knowledge and a hold for a branch of power. The case is no longer, as in casuistry or jurisprudence, a set of circumstances defining an act and capable of modifying the application of a rule; it is the individual as he may be described, judged, measured, compared with others, in his very individuality; and it is also the individual who has to be trained or corrected, classified, normalized, excluded, etc. [*sic.*] (p. 203)

From Foucault's perspective, these methods of documentation and writing involve therapists in the objectification of individuals, as they separate them and examine them closely, with a professional gaze and pen. As therapists collect and collate certain forms of information, they identify and isolate abnormality and produce authoritative written accounts of individuals, justifying discipline and normalisation. This view of therapists' writing and documentation is reinforced by Michael White when he critiques "the modern instrument of power that we call the 'file' or the 'casenote'" because of the central role that it has played in the facilitation of social control and subjugation (1995, p. 46). Therapeutic writing and documentation, from this critical perspective, make therapists agents within power relations that work to discipline and normalise individuals in specific ways, reinforcing a supposedly fixed, universal model of humanity.

The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* of the American Psychiatric Association is often considered the example *par excellence* of the disciplining and normalising technology of psychology and therapy. Originally a medical-psychiatric textbook for diagnosing mental disorders, the *DSM* is omnipresent within the institutions of therapy and psychology. With each edition, more disorders are "discovered", diagnoses are revised, and medical-psychiatric-psychotherapeutic professionals are provided with a more thorough guide to the signs and symptoms of mental disorders. It is the key diagnostic tool within psychiatric, psychological, and psychotherapeutic services. The *DSM* has come under the critical attention of many scholars and critics of therapy (Ivey and Ivey, 1998; Kaye, 1999; Marecek, 1997; Simon, 1994; Ussher, 2000; Wood, 2004). Marie Crowe, for instance, uses Foucauldian methods of analysis to reveal how the *DSM*, fourth edition (*DSM-IV*) (American Psychiatric Association, 1994), as it defines mental disorders, also defines and constructs normality. Crowe explains, citing Foucault, that the *DSM-IV* "is basically a classificatory system which aims to see, to isolate features, to recognize those that are identical and those that are different, to regroup them, to classify them by species or families" (2000, p. 69). The *DSM* provides practitioners with the ability to isolate, examine and classify people who are deemed "abnormal" and, in concert, define and reify features, behaviours, attributes and ideas that constitute "normality". As they use and apply the *DSM*, therapists operate this disciplinary technology, privileging psychiatric discourse as they frame and interpret clients'/patients' mental distress. Therapists engage in the exercise of a disciplinary power over individuals, bestowed with the authority of the *DSM*.

Crowe goes on to discuss how psychiatric discourse results in the individualisation of people's mental distress:

> A key premise in the definition of mental disorder is that a syndrome *occurs in the individual* which suggests that it is caused by some fault within the individual.
> It excludes the possibility that it may be a response to external events. (p. 72)

Numerous writers reinforce this claim that the *DSM* individualises and decontextualises people's problems, ignoring and erasing the impact of social positioning and the experiences of people's everyday lives and assigning individual responsibility for abnormality (Marecek, 1997, p. 546; Simon, 1994, p. 131; Ussher, 2000, p. 210). The "normality" that is constructed by the *DSM*, wielded by many

therapy practitioners, and deemed the responsibility of individuals to attain and possess, is revealed by Crowe to be consistent with dominant, western cultural values. Crowe explains that the parameters set for "normal" and "abnormal" in the *DSM* are "set in relation to the following behavioural attributes: productivity, unity, moderation and rationality" (2000, p. 72). Individuals are expected to play a productive role within society, to conduct themselves with moderation and self-control, and to perceive reality in ways that are consistent with the conventions of rationality (pp. 72, 74), regardless of social circumstances or cultural backgrounds and beliefs. As an instrument of discipline and normalisation, the *DSM* utilises expert examination and classification of individuals and views problems or distress as individual defects requiring individual self-control and correction. Individuals are guided to direct their energies and their gaze inwards, regulating and disciplining themselves to redeem or avoid the stigma of "abnormality". Again, this analysis holds that as administrators and practitioners of the *DSM,* therapists are complicit and active in the individualisation of mental distress and the reproduction of dominant, western cultural values.

Writing, documenting, and gathering information for the formulation of classification and expert opinion take place within a particular, ritualised relationship and exchange between therapist and client/patient. The ritual of this relationship and exchange, according to therapy critics, again works to discipline and normalise individuals and to arrange particular relations of power, where the therapist occupies a position of power and the client/patient is subordinated. More specifically, the therapy ritual has been analysed and exposed as taking the form of a modern confession. Over the last one hundred and fifty years, "[t]he act of confession was reformulated as a therapeutic exercise rather than penance, as was the case with the secular confession; the truths of the confession were categorized as normal or pathological" (Lupton, 2003, p. 31). Foucault describes this therapeutic exercise as

> a ritual that unfolds within a power relationship, for one does not confess without the presence (or virtual presence) of a partner who is not simply the interlocutor but the authority who requires the confession, prescribes and appreciates it, and intervenes in order to judge, punish, forgive, console, and reconcile; a ritual in which the truth is corroborated by the obstacles and resistances it has had to surmount in order to be formulated. (1990, pp. 61-62)

This format for "therapy" produces a power relationship where the dominance and authority of the therapist are reinforced. From the position of expert, confidante and hearer of secrets, the therapist formulates meaning, categorises the client/patient's talk, and brings forth the "truth" of their confession. The client/patient's new-found self-knowledge, as interpreted by the therapist/expert, can then become a "technology of the self", a means by which they effect operations on their "own bodies, souls, thoughts, conduct, and way of being so as to transform themselves" (Martin, 1988, p. 18) – the aim being the production of self-regulating, docile individuals. For Foucault, the obligation to confess is "so deeply ingrained in us, that we no longer perceive it as the effect of a power that constrains us" (1990, p. 60). Therapy, as an institutionalised site and practice of the confession, from this perspective, creates power relations that privilege and authorise therapy experts while constraining individuals receiving therapeutic "help".

Ian Parker comments that "Foucault's (1977, 1981) work has been valuable … in showing how the twin tendencies of discipline and confession lock people together in such a way that the discipline of psychology becomes seen as a necessity, and is then able to pose as a solution" (1999, p. 9). Psychological and therapeutic explanations of the self have become "commonsense", and the disciplinary and normalising practices of therapy – such as disciplinary writing and documentation, the use of the *DSM*, and the dynamics of confession – are widely presented as logical, necessary and benign. Nikolas Rose explains that:

> The apostles of these techniques proffer images of what we could become, and we are urged to seek them out, to help fulfil the dream of realigning what we are with what we want to be. Our selves are defined and constructed and governed in psychological terms, constantly subject to psychologically inspired techniques of self-inspection and self-examination. And the problems of defining and living a good life have been transposed from an ethical to a psychological register".
> (1990, p. xiii)

The processes that have been examined in this section work on the behaviours, experiences, dreams and aspirations of individuals, as therapists – as the "apostles" – use psychological discourse and disciplinary techniques to explain and treat the problems of living a good life. Self-inspection, self-discipline and regulation, and psychological forms of self-knowledge are demanded of individuals for the

achievement and maintenance of "normality". Psychological/therapeutic knowledges and practices are "intimately bound up with programmes, calculations, and techniques for the government of the soul" (Rose, 1990, p. 9), encouraging, consequently, the social control of populations.

Critiquing the science of therapy

While the previous section reviewed the claims that therapy functions as an instrument of social control, numerous critics have focused their attention more closely on analysing the scientific knowledge that informs or influences many therapy theories, approaches and interventions. From a poststructuralist/postmodern perspective, the science of therapy is viewed as a social construction and cultural paradigm, rather than as objective, "discoverable", authoritative knowledge. Critics have observed that scientific knowledge of the human body – biomedical accounts of mental distress, bio-physiological language – now dominates the field of therapy and directs approaches for understanding and treating "madness" and people's mental distress. They critique the centrality of scientific and biomedical discourses in therapy for its perceived limitations, effects and implications: the science informing therapy is considered narrow, reductionist, individualising, and affirming of social exclusions. The positivism and hypothetico-deductive methodologies of the "psy" disciplines, and the implied claims of objectivity and reliability, are also exposed as social constructs, which constrain individuals receiving therapy. Much critical attention has also been given to the relationship between the scientific methods and approaches of therapy and the "psy" disciplines and commercial and corporate interests, revealing an alliance between bio-medical accounts of people's mental distress and medical and pharmaceutical interventions.

The earlier discussion of the *DSM* put forward the argument that, instead of being a benign, "helpful" handbook, the *DSM* is in fact instrumental in bringing about the social control of populations. Other writers from the fields of critical psychology, cultural studies and feminist criticism have focused their attention on the science of the *DSM*, questioning its authority and revealing its social construction. Jeanne Marecek (1997), for instance, explains that "[t]he ebb and flow, fads and fashions, in the history of disorder suggests that diagnoses are inventions, not discoveries" (p. 546). The production of new editions of the *DSM* involves the collaboration of

eminent psychological experts, the prestigious scientist-practitioners of therapy. New editions produce new mental disorders, new formulations and descriptions of existing mental disorders, and, occasionally, the removal of some mental disorders (such as "homosexuality"). This process is commonly regarded and heralded as evidence of "medical progress" and increased knowledge and precision over time.

However, as Mary Wood, in reference to schizophrenia, explains,

> if we step back and take a wider historical perspective, it becomes clear that the discussion of symptoms involved in diagnosis, as well as the symptoms themselves, have changed over time depending upon changing frames of reference within the field of psychiatry as well as in the larger society. What looks like progress in psychiatry only makes sense within the particular contexts of contemporary beliefs and institutions. (2004, p. 199)

Wood highlights the fundamental relationship between diagnosis and symptomatology, and social and political contexts, reinforcing John Kaye's claim that "the changes in DSM categories over the years … follow changes in socially constructed attitudes and mores" (1999, p. 22). In their critique of the *DSM* and the categories of "normal" and "deviant", writers like Marecek, Wood and Kaye unground the fixed, stable scientific status of these concepts, revealing instead how this science is shaped and influenced by prevailing sociocultural ideas and beliefs. This critique undermines the linear, progressive narrative of neutral, discovered scientific truths about the minds, feelings and behaviours of humans and opens therapy and the "psy" disciplines up to analyses of cultural biases and assumptions.

Many therapy critics have discussed and analysed the privileging of biomedical knowledge and scientific methods within the "psy" disciplines and therapies. Dwight Fee (2000), for instance, explains how "this is a time when biomedical and otherwise reductionist explanations and understandings of mental disorder are dominant in scholarly, scientific, and psychotherapeutic worldviews and practices" (p. 1). Fee goes on to stress that

> the pervasive viewpoint is that the only way that mental illnesses can be recognized as "real" – and hence worthy of funded research, insurance coverage, [and] rigorous study … – is when they are anchored in the language of bio-physiology or possibly some other deep-seated individual factor. (p. 1)

The *DSM* has been enshrined within dominant therapy theories and practices and within institutions with interests in mental health. At the same time, scientific discourse has currency – both literal and figurative – and individualising accounts of human phenomena dominate the discussion and treatment of psychological problems. This means that biomedical explanations for and approaches to mental distress are often regarded as the most legitimate and have a profound and pervasive impact on the nature of therapy services.

The dominance and privilege of biomedical explanations and the authority of the discourse of bio-physiology are critiqued and lamented by many critics. Fee's statement suggests that such explanations and approaches focus intently on the bodies and minds of individuals, excluding the social and political contexts and realities of their lives (see also Ussher, 2000, p. 208; Read, 2005). Jeanne Marecek regards the language of bio-physiology and the scientific knowledge base of psychology, when compared to other forms of knowledge, as wanting – "its depictions of psychic life mechanistic, lifeless, piecemeal, reductionist, thin, even implausible" (Marecek, 1997, p. 550). The discourse of bio-physiology is only one means of describing and making sense of people's minds, bodies, behaviours, and psychic lives; its dominance results in the exclusion of other forms of description and sense-making and the reification of particular dominant cultural ideas and values. Specifically, Fee describes how these ideas and values take shape in binary terms:

> psychiatric discourse is one of the scientific networks that has contrived its view
> of mental disorder through opposites and contrasts – health/pathology,
> normal/abnormal, rational/irrational – which serve to justify conceptual binaries
> and real-world exclusions. (2000, p. 11)

For Fee, the science of the "psy" disciplines, in its governing structure of opposites and contrasts, is implicated in the perpetuation of binary meaning systems within western culture. Such meaning systems fix and totalise ideas, experiences or identities, relying on the contrast between a privileged, legitimate, "normal" concept and its denigrated, illegitimate, "abnormal" other. Fee sees these systems as instrumental to the operation of power relations, including and bestowing power on some, while excluding and denying power to others.

Echoing the sentiments of Fee and Marecek, but focusing more closely on the positivist paradigm of the science that supports the "psy" disciplines and mainstream therapy, Jane Ussher compounds the critique of this science. Ussher explains that the commitment to scientific objectivity underpins the whole of the positivist/realist endeavour (2000, p. 215). Much of the prowess and authority of the science that informs both the research and clinical practices of the "psy" disciplines results from practitioners' claims of rigour, neutrality, impartiality, and, consequently, the discovery of unmediated "truths". However, Ussher explains, in reference to the psychological research that informs many therapy assumptions and practices:

> The fact that women's accounts of mental health problems are considered to be biased or "subjective" – yet researchers' are not – illustrates the absence of reflexivity in positivist/realist research. Yet, as has been argued elsewhere (e.g. Billig, 1991; Harding, 1987; Hollway, 1989), the ideological stance of researchers affects the research questions they ask, the epistemological stance and methodologies they adopt, and the interpretations of the data collected. (2000, p. 215)

The privileging of the scientific knowledge of the psychology or therapy "expert" over women's (and men's) own knowledge or accounts of phenomena – or over other forms of knowledge – is in large part enabled by the professed objectivity of these experts. Ussher claims, however, drawing on the works of other science critics, that such objectivity is a fallacy, a myth that sustains the perceived authority of science and its practitioners. The research informing the "psy" disciplines is shaped and influenced by the researcher her/himself – by her/his worldview and orientation and approach to the subjects of the research. Marecek puts it succinctly when she says that it is a myth that, "as a science, psychology stands apart from the culture in which it is embedded" (1997, p. 549). Awareness of or reflection on the subjectivity of the researcher is absent from most psychological research. The critique of the objectivity proclaimed by scientific endeavours problematises and ungrounds both the research produced by the "psy" disciplines and the treatments and interventions born from this research.

Poststructuralist, postmodern and feminist critics have analysed the scientific knowledge and assumptions that shape the theories and practices of the "psy" disciplines and much therapy as social constructs, which have specific effects –

creating and legitimising the concept of "mental illness" through the discourse of bio-physiology; focusing on the bodies, minds and behaviours of individuals and excluding their social worlds; offering only one, privileged, explanation for phenomena; reinforcing binary oppositions and legitimising social exclusions; and accruing authority and legitimacy through the "objectivity" of science, while hiding researchers' subjectivities. Despite these critiques, bio-medical accounts of mental illness still dominate, and the "psy" disciplines assume authority and expert status because of their scientific standards and methods. Consequently, critics argue that bio-medical accounts dominate the fields of therapy and mental health work – as will be discussed in detail in Chapter 6 – and "provide the basis for the widespread use of medical interventions, in particular psychotropic drug use" (Ussher, 2000, p. 213). Defining and perceiving mental illness as a phenomenon born from within individual, context-less bodies suggests that treatment should operate also on these individual bodies.

The scientific knowledge of therapy research and interventions has produced a merger with medicine and commercial and corporate interests that seems both reasonable and inevitable. Fee explains the effects of this merger:

> As bio-technological and psychopharmaceutical machineries propagate, bodies and subjective life (disproportionately women's) become new sites of economic interchange and pharmaceutical investment, creating new relationships between "symptomology" and the flows of electronic and capitalist exchange vested in that very distress. (2000, p. 5)

Fee argues that the mental distress experienced by individuals receiving therapeutic treatment or services – more often women – is vied for by bio-technology and pharmaceutical companies as a means of profit-making. John Read reinforces this argument, noting the huge presence of the drug industry at psychiatry conferences (2005, p. 596). The process of identifying mental disorders and illnesses, and their classification in bio-physiological terms, lend themselves to the "solutions" (paid for by individuals, insurance companies, or state health care services) produced by these giant commercial industries. The profusion of commercial, corporate and bio-medical interests in people's mental distress in turn reifies (and, arguably, exploits) bio-medical explanations and accounts of this distress, occluding other meanings or forms

of knowledge and drawing individual bodies and subjectivities into a network of capitalist exchange. Therapists, then, become actors in this process.

Constructing the "self" in therapy

Critical attention has also been directed at how the "self" figures and is understood and talked about within therapy, and on the effects and implications of such ideas; feminist and poststructuralist critics writing in the 1980s and early 1990s, in particular, took aim at therapy's treatment of the "self". Therapy and the "psy" disciplines are understood to "fall within the *liberal humanist* tradition, which is so pervasive in Western society" (Kitzinger, 1987, as cited in Gavey, 1989, p. 461, italics in original). This tradition, and its discourse, "instantiates the notion of people as rational autonomous individuals possessing a fixed identity, an essential self vested with agency and a consciousness which is the cause of their beliefs and actions" (Kaye, 1999, p. 22). The liberal humanist self is regarded as the unique core of a person, free from outside influence, and as a consistent, coherent entity that is "central to the production of meaning" (Bird, 2000, p. 27). Therapy – comprising psychotherapy, psychologies, and, most obviously, the "growth therapies" initiated by Carl Rogers – is seen to adhere to and reinforce this understanding of the self. Feminist writers Miriam Greenspan (1983) and Celia Kitzinger (1991a; 1991b) explain that the liberal humanist ideology and conception of the self shapes the idea of "personal growth through therapy" (Greenspan, 1983, p. 122). Therapy supports the autonomous, responsible individual to "grow" and transform her/his self; for Greenspan, the message of humanist therapies is this: "You can change social reality by transforming yourself; you can transform yourself by being in therapy; you can pull yourself up by your own bootstraps and fly, fly, fly" (p. 140). The individual is the agent of change within such therapy and, through self-development with the aid of the therapy, can change how they conduct themselves within, and experience, the world, relieving themselves of problems or mental distress. Kitzinger echoes this idea when she explains how therapy, including feminist therapies, "asserts the autonomy of the individual and his or her rights to equality, freedom of choice and personal self-fulfilment" (1991a, p. 52).

The way in which the "self" is constructed and discussed within therapy – as rational, essential, autonomous, consistent, and remedied through personal development and

transformation – is critiqued by many for being instrumental in sustaining oppressive power relations: individuals are blamed for their suffering and held responsible for changing their circumstances, while the social, political and cultural contexts of their lives are ignored. Celia Kitzinger and Rachel Perkins claim that, in "[t]urning the spotlight on the "self", psychology plunges the world out there into darkness" (1993, p. 114). When the world out there is in darkness, the internal, personal world, mind and body of the individual becomes the focus. John Kaye points out that, just as psychological and psychiatric discourses treat the individual as the locus of pathology, "humanistic discursive repertoires make the individual the locus of responsibility" (1999, p. 22). Consequently, therapy has been accused of "victim-blaming" (Allwood, 1996, p. 20; Kitzinger, 1991b): if the individual self is autonomous and the source of change and power in one's life, then "victimization … [is] seen as evidence of collusion" (Kitzinger, 1991b, p. 123). Kitzinger goes on, critiquing therapy's victim-blaming of women and lesbians in particular, to declare that "[t]he notion of the free, autonomous, self-fulfilled and authentic woman possessed of a personal power innocent of coercion … is simply an individualist myth which actively obscures the operation of power" (p. 124). The liberal-humanist self within therapy is viewed by critics like Kitzinger as a construct that obscures the power relations of the "outside world" and their relationship to individuals, and instead demands that individuals "heal" and change themselves to achieve relief from problems or distress. Nicola Gavey concludes that, although "liberal humanist values are not unworthy, the absence of metatheoretical concerns about power render them insufficient" (1989, p. 461).

Therapy is accused not only of ignoring "the world out there" and therefore depoliticising and individualising people's problems, but also of redefining political terms and co-opting political language, and making it, instead, a language of the "self". The therapy concerns of "rights to equality", "freedom of choice", "liberation" and "empowerment" are seen as making the language and ideas of political social movements into a therapeutic language, operating at the level of the individual. Kitzinger and Perkins describe this as "psychology's colonization of our political terrain" (1993, p. 72). They give the example of the word "power", which in therapy

    is reformulated as an awareness, an affirmation, a belief that you already have

    power, albeit power that the culture does not recognize. All that is necessary is to

pursue psychological programs that enable us to "feel more comfortable about being powerful". (p. 41)

For Kitzinger and Perkins, there is a distinction between the "feeling" of power at a personal level, and the exercise and experience of power at a social level and within the systems and institutions of everyday life. They accuse therapy – and therapists – of ignoring this distinction. According to them, individualising and privatising power – making it a psychic phenomenon – while simultaneously evoking the words and spirit of political rebellions, offers a vision of power that is both limited and limiting. Therapy's vision of power is fundamental to Kitzinger and Perkins' claim in *Changing Our Minds* that therapy is "bad for women", taking women away from public, political action to a private, therapeutic engagement with their solitary selves (and the therapist) instead.

Critics of therapy, inspired by postmodern, poststructuralist and feminist theories dispute mainstream therapy's figuration of the self and offer an alternative understanding of selfhood. The liberal humanist self of therapy, with its individualising, decontextualising and depoliticising tendencies, is depicted as an invention, rather than the truth of human identity. Gavey explains that, in "contrast to the humanist assumptions of a unified, rational *self*, poststructuralism proposes a *subject* that is fragmentary, inconsistent, and contradictory" (1989, p. 465, italics in original). Such an approach dispels the idea of a unique and "true" "core" to each individual, both untouched by social and cultural forces and wholly coherent. Instead, identity is fluid and multiple, and created in relationship to social contexts. Kitzinger and Perkins echo these ideas and further deny the humanist self of therapy:

We are simply unable to believe in this autonomous free-floating "self," for the "self" only comes into existence within a context. Individual and society are not formed and defined apart from one another, "interacting" as though each constitutes and inhabits the very core of what passes for personhood. There is no core "real self" lurking beneath layers of social experience. There are only stories we tell about who we are, who we have been, and who we might become – stories that are structured by the culture in which we live. (1993, p. 111)

Finding therapy's language of the self unconvincing and essentially problematic, Kitzinger and Perkins instead put forward a view of the self, or subject, as culturally and socially constructed and understood. The therapeutic quest to dig beneath the

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layers of an individual to uncover, know and re-form their "true" self is regarded as an enterprise grounded in a fiction. Such discussions and analyses challenge the liberal humanist assumptions of therapy and its discourse of selfhood.

Therapy and othering

In subscribing to the critiques of therapy detailed above, many theorists and critics argue that psychological and therapeutic practices depoliticise and decontextualise people's problems. They view this as effecting the reproduction of hegemonic power relations, reinforcing dominant cultural hierarchies and values. Critics have paid particular attention to the ways that the institutions and practices of psychology and therapy have treated those who are traditionally socially marginalized – women, non-whites, gays, lesbians, transgendered people, the poor, people from non-western cultures, and other "others". Therapy has been accused of being complicit with the continued oppression of marginalised groups and, further, of creating new forms of oppression that focus specifically on the bodies and mental health of individuals. While research and practices on the margins of mainstream therapy have been growing and taking form over the last few decades – feminist therapies, for instance – some still see the perpetuation of dominant cultural biases within therapy. This section firstly considers the development of the feminist critique of therapy over the past forty years, and then uses this to introduce a discussion of therapy's involvement in othering more generally. While the feminist critique exemplifies broad patterns, it also reveals the dynamism of exclusions and inclusions: the section concludes with a more recent critique of feminist therapy as itself perpetuating othering based on class, race and socio-economic standing.

Writing in the early 1980s, Miriam Greenspan, in *A New Approach to Women and Therapy* (1983), articulated a critical feminist analysis of therapy traditions. Following from her analysis of statistics detailing psychiatric treatments in the United States, she made the claim that "it is largely men who label the variety of psychological problems of those who seek therapeutic help and largely women who are seeking help" (p. 6). She went on to describe the picture of the then mental health system as one of "Man as Expert and Woman as Patient" (p. 6). For Greenspan, the male expert in mental health wielded power as he treated women: "His judgements are impeccable. His rare spoken words are highly expensive. He is smoothly

authoritarian and aloof as a god" (p. 40). Such an arrangement within the arena of mental health seemed to replicate neatly many "commonsense" patterns of patriarchal culture of the time: women occupied the passive and pathologised position of patient, while male mental health experts, who had accrued knowledge, qualifications, and professional status and power, occupied a superior vantage point from which they categorised, classified, and treated their women patients. Throughout her book, Greenspan argued that the "problem" of female mental illness, and its seeming widespread prevalence, was not in fact about pathology: the symptoms of such

> illness … are, for the most part, the systematically socially produced symptoms of sexual inequality. The problem is a matter of how women are seen and treated both inside the mental health system and in the surrounding society that it mirrors. (p. 7)

According to Greenspan's argument, the mental health system of her time was implicated in the perpetuation of patriarchal gender relations.

Many other feminist critics have described a relationship between therapy and oppressive gender relations, explaining female mental illness as a consequence of social oppression and condemning what they see as therapy's wilful ignorance of this as complicit in maintaining the status quo. Jane Ussher, in her book *Women's Madness* (1991), catalogued the perspectives of numerous feminist critics. For example, Juliet Mitchell argued in her book *Psychoanalysis and Feminism* (1974) that,

> there seems overwhelming justification for the charge that the many psychotherapeutic practices, including those that by the formal definition are within psychoanalysis, have done much to re-adapt discontented women to a conservative feminine status quo, to an inferiorized psychology and to a contentment with serving and servicing men and children. (As cited in Ussher, 1991, p. 170)

According to this feminist argument, women deemed "mad" or "abnormal" – and therefore outside the norms of acceptable femininity – and who seek or are compelled to receive therapy, have tended to be subject to interventions that are designed to return them to a normative, submissive, traditionally feminine position within society. Jeanne Marecek (1997) critiques historical psychiatric diagnoses – such as nymphomania, hysteria, and masochism – for enforcing "conformity to norms of

female domesticity, subordination, and subservience to men's sexual needs" (p. 544). However, such specifically "female" diagnoses are not confined to history: Marecek also examines the more recent growth in diagnostic categories for premenstrual difficulties – such as premenstrual syndrome, late luteal dysphoric disorder, and premenstrual dysphoric disorder. She comments, in relation to these diagnoses, that "if women's anger, depression, and discontent come to be interpreted as medical or psychiatric symptoms, difficult and distressing life experiences may be disregarded" (p. 544). When viewed from a critical feminist perspective, therapy may work to pathologise women by disregarding the social significance of their symptoms and operating in ways that enforce hegemonic gender norms.

Many critics have argued that therapy, in addition to reinforcing gender biases, reproduces other social biases. For instance, Weatherall, Gavey and Potts (2002) highlight how conventional psychology has been critiqued for its "androcentric and ethnocentric biases" (p. 531). Therapeutic resources in most post-industrial societies have been largely designed by white, middle class intellectuals and practitioners. Charles Waldegrave, from the Family Therapy Centre in Lower Hutt, Aotearoa New Zealand,[9] explains that these resources

> probably work well for like people, who have reasonable access to resources and place great stress on individual freedom. They have not been successful however, in substantially transforming the lives and lot of those whose cultures are marginalised, poor and, until recently, women. (Waldegrave, 2003a, p. 64)

The biases of conventional psychology and therapy, and the delivery of inappropriate therapeutic resources to non-white, non-middle class, non-male clients, so critics such as Wilkinson and Kitzinger argue, mean that psychology and therapy have participated "in constructing and perpetuating Otherness" (1996, p. 160).

Therapy's involvement in the construction and perpetuation of otherness is demonstrated persuasively by Michelle Fine in her article "Coping with rape" (1989). In examining the clash between psychological models for coping with injustice and the coping methods employed by a poor, urban, sole-parent, African-American

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[9] The "Just Therapy" approach was developed and instituted at the Family Therapy Centre in Lower Hutt, Aotearoa New Zealand. The centre offers an alternative form and practice of therapy that addresses issues of social justice and "takes into account the gender, social and economic context of the persons seeking help" (Waldegrave, 2003b, p. 4).

woman in response to being raped, Fine reveals how "our [psychology's] literature legitimates existing power asymmetries" (p. 189). Her analysis demonstrates how, in adhering to psychological literature and models, psychologists end up prescribing "as *optimal* those ways of coping which are effective for high power persons" (p. 190, italics in original). Consequently, she argues, psychology reinforces "the recipient's lower power position", denigrates their own coping methods, and derogates them if they dismiss psychological methods of coping as inappropriate or ineffective (p. 194). The criticisms posed by Fine and others expose the gender, class and racial biases (among others) that are entwined with the science of psychology and benevolent, helpful practices of therapy. Therapy, from this critical perspective, perpetuates social othering and is implicated in the reproduction and reification of dominant cultural hierarchies and exclusions.

It is not just mainstream therapy and psychology that have been accused of constructing and perpetuating otherness. Critics have also turned the spotlight onto feminist therapies, which have evolved since the 1970s in response to mainstream therapy's treatment of women. Kitzinger has been a particularly vocal critic of feminist therapy and psychology. She and Perkins argue in *Changing Our Minds* (1993) that feminist therapy is unable to escape the problems posed by the power difference between therapist and client, where the therapist occupies a superior position with the potential to manipulate clients in accordance with her own view (pp. 97, 98). In Kitzinger's mind, feminist therapies have not escaped the tradition of othering that is seen in more mainstream therapy. For instance, she claims that feminist psychology's assumptions about women reveal ethnocentrism, noting that the "supposedly generic women of most feminist psychological theorizing turn out, in fact, to be white, western, middle-class, able-bodied and heterosexual" (1991, p. 52). The tendency for women to be treated as a homogeneous category within feminist therapy, and for this category to be theorised by academic feminists who are predominantly white, middle class, and western (Wilkinson & Kitzinger, 1996, p. 12) has led to critiques of feminist therapy as continuing to utilise and engage in processes of othering. It seems that the dominance of processes and practices of othering within the tradition of therapy impacts even on seemingly alternative and socially aware forms of therapy.

Turning critique into practice: the growth of political, postmodern therapies

As the previous discussion detailed at some length, therapy has been extensively criticised and problematised by critics over the last four decades. Their claims and charges question the authority but also the viability of therapeutic endeavours. In the face of these accusations, therapy seems largely untenable. Critics have persuasively argued that therapy works as an instrument of social control, harnessing both scientific discourse and the humanist concept of the self to depoliticise and decontextualise people's mental health problems and to individualise responsibility for having and changing such problems. Therapy and the "psy" disciplines are seen, through the lens of critical theory, as disciplinary institutions, working to produce self-disciplining, self-regulating individuals who conform to normative values and ideals. These disciplines thus maintain the status quo – or that at least is their social objective according to this Foucauldian perspective – reproducing dominant cultural power relations, and in turn perpetuating social othering. These lines of argument suggest an antithetical relationship between therapy and political goals or aspirations; therapy appears incompatible with the pursuit of social justice, the redress of oppressive power relations, and the inclusion within "normal" cultural life of those who are socially marginalized and excluded. Indeed, critics like Kitzinger and Perkins (1993) – both trained psychologists – condemn therapy across the board, asserting its "badness" for women, and conclude that politics and therapy are irreconcilable. Likewise, Jeffrey Moussaieff Masson (1994), an ex-psychoanalyst and fervent critic of therapy, in his polemic *Against Therapy*, documents the multitude of abuses conducted in the name of therapy and asserts that the entire profession of therapy is corrupt (p. 296). Such arguments undoubtedly promote discomfort and doubt about the politics and ethics of doing therapy work and could, understandably, lead many politically minded theorists and therapists to conclude that involvement in therapy is futile and untenable. Indeed, these arguments informed my own ambivalence and uncertainty about the uses and ethics of therapy.

Throughout her career, Jane Ussher has voiced and reinforced feminist and social constructionist critiques of therapy/psychology as pathologising, depoliticising and disciplinary. Yet she has also consistently highlighted the limitations of such critiques as a form of practice and as, on their own, adequate responses to the lived experiences

of distress expressed by women who seek therapeutic help. In a 2000 article she explained her relationship to critical theories and analyses of mental health and women's madness, and reflected on the development of her own position:

> I felt that I could only take part in critical analysis or deconstructionist debate. However, I no longer believe that this is enough, for myself at least. Critical thinking is essential; deconstruction of madness as a concept must be done. Yet we cannot ignore the pain and suffering experienced by women – and men – who are deemed mad. We cannot dismiss mental health problems as linguistic constructions or mere justifications for regulatory control; we need to offer something more concrete than critique for women who come forward for help. At the same time, we need to address the fact that postmodern and feminist thinking is not having the impact it should on mainstream research and clinical practice; the fact that it is invariably dismissed or ignored. Rather than wringing our hands at the injustice of this situation, *we need to offer a way forward*. (2000, pp. 208-209, italics added)

Rather than discarding therapy outright, Ussher's political and pragmatic concern for the women and men who seek help from therapists informs her continued investment in theories and practices of therapy and psychology. Ussher calls for a way forward, from within therapy and psychology, that responds to *both* critical and feminist thinking about the political meanings and power relations of therapy *and* the lived experiences of women and men with the development of modes of practice and, to quote Mary Parlee, "*doable* alternatives" (Ussher, 2000, p. 216); critique, in itself, is not sufficient.

Ussher's description of the tensions she experiences in relation to the critique of therapy would, I imagine, resonate with many of the therapists and theorists who have grappled with these issues and yet have not been able to dismiss or discard therapy – which includes the therapists examined in this thesis, as well as its author. A significant number of theorists and therapists, in response to – or in spite of – these charges, have persisted with therapy but have developed and innovated the discipline in ways that address the charges and attempt to do things differently. Such therapists and theorists resist the either/or bind – therapy *or* political engagement and critique – and instead propose and enact "doable alternatives", offering a way forward from within therapy. Over the last four decades – often in concert with the critique of

therapy – a growing body of therapy practices and ideas has evolved, offering alternatives to mainstream and traditional therapy assumptions and practices. These practices and ideas are born from poststructuralist, postmodern, feminist and social justice theories and operate from the premise that both mental health problems and selfhood are socially constructed and that therapy requires engagement with the social and political contexts of clients. While they are diverse and varied, and some have taken shape as specific modalities – for example, narrative therapy, solution-focused therapy, discursive therapies, critical psychology, "Just Therapy", and feminist therapies – my discussion is less focused on the differences among these alternative approaches and more on how, in general, they re-form therapy in response to critiques and find ways to engage with political concerns and agendas.

Many of these new therapies, inspired by critical theory and concern for social justice, consciously and concertedly work against the individualising, pathologising and depoliticising traditions of therapy. They respond to a demand, articulated here by Kaye (1999), that therapists view people's mental health problems as inherently connected to their social and political contexts:

> While it would be somewhat utopian to expect psychotherapy to attempt to find solutions to the injustices of the world, it is surely not too much to ask that therapists engage with issues of social context, together with the role of social inequities in the causation of psychological distress. It would also be remiss for therapists not to take these issues into account in their own work, for as Judith Cross (1994) points out, if we ignore the role played by social inequity, we may inadvertently be acting to ask our troubled consultees to adjust to the unjust. (p. 20)

Recognition and exploration of the role played by social context and inequity in a person's mental health problems is required of therapists if they are to work as something other than agents of social control. From the point of view of politically oriented and critical therapies, mental health problems are not individual possessions or discrete pathological states: they involve an interaction of social, cultural, and political factors and forces with the bodies and minds of individuals.

Practitioners of these alternative and reflexive therapies enact a politicised, contextual and de-pathologising view of clients' mental health problems in numerous ways. For

instance, Jane Ussher, in seeking a "doable alternative" to traditional modes of therapy, and to the potential paralysis of critique, has developed a material-discursive-intrapsychic model and methodology (Ussher, 2000; 2002; 2006), which informs her therapeutic practice. She explains that a material-discursive-intrapsychic approach to mental distress "would recognize the 'materiality' of mental health problems as they are experienced by women, intrapsychic pain and defenses, and the discursive construction of madness and femininity" (2000, p. 208). Other theorists and therapists pay similar attention to the interaction of social discourses with material and intrapsychic experiences of individuals and consciously seek to de-pathologise in their therapy work. Syliva Blood (2005) approaches her clinical work with women experiencing body image issues "from the view that women's anxiety about their bodies is a product of social power relations, rather than individual pathology" (p. 135). And Colleen Heenan (1996) explains that she works "with clients who are attempting to understand the interrelationship between the ways in which they are socially, culturally, historically and personally positioned in relation to others and themselves" (p. 56). These approaches recognise the complexity of the possible meanings that are made of people's mental distress, and attempt to shift the focus from individual deviancy or failure to the cultural context of people's lives and the oppressive power relations and discursive arrangements that promote distress.

For many therapists seeking to undo or move away from therapy's pathologising, individualising and depoliticising traditions and to do therapy differently, the concept of deconstruction is integral. Rather than an abstract theory, in therapy deconstruction becomes a practice and mode of operation. Johnella Bird explains that the concept of "practical deconstruction"[10] in her therapy work reflects

> a particular engagement with language and meanings which allows us (therapist and client) to attend to politics and power within the therapeutic conversation. …
> We engage with practical deconstruction of everyday ideas and practices when the meanings given to commonplace roles, attributes, relationships and words are not taken for granted. (2000, p. 70)

For Bird, therapy involves questioning what has been taken for granted and investigating and negotiating meaning with clients. For example, supposedly

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[10] Bird explains that she has taken and adapted this term from *Deconstructing Psychopathology* (1995), by Ian Parker, Eugenie Georgaca, David Harper, Terence McLaughlin and Mark Stockwell-Smith.

self-evident and "truthful" diagnoses like "depression" or "anorexia", roles of "man" or "daughter", or concepts such as "strength" and "weakness", are deconstructed and given critical attention within the therapeutic conversation, rather than being taken as givens.

The concept of deconstruction as a therapeutic practice is reiterated by Ian Parker (1999) in his discussion of postmodern-inspired therapies. He explains that

> the task of the deconstructing therapist, and just as much so the deconstructing client, is to locate the problem in certain cultural practices, and comprehend the role of patterns of power in setting out positions for people which serve to reinforce the idea that they can do nothing about it themselves. (p. 3)

As detailed in the first part of this chapter, critics have argued that the model of mental illness that sees problems as the innate, internal, personal, and potentially biological possessions of individuals encourages self-blame and a belief in the inherence and fixedness of problems. The deconstructing therapist works against this model, again questioning taken-for-granteds and assumed truths and encouraging exploration of cultural practices so that problems are understood and experienced in different ways. Such conversations with clients/patients are oriented around undoing the passivity and resignation encouraged by pathological accounts of problems. They are intended to support clients/patients to experience agency, competency and an active subject position, so that they are able to develop a preferable account of themselves and their situation: this is described as a "reconstruction stage" by narrative therapy innovators Michael White and David Epston (Ussher, 2006, p. 60).

The narrative therapy strategy of "externalising" represents a particular engagement with language and meaning that both attends to politics and power within the therapeutic conversation and enables the deconstruction and reconstruction of clients' problems. Narrative therapists encourage clients "to objectify and, at times, personify the problems that they experience as oppressive", linguistically shifting the problem from an internal entity or possession to something external to the person or relationship that has been characterised as the problem (White & Epston, 1990, p. 38). Viewing problems objectively and as separate from the client/patient enables conversation about

the nature of the problem and the client/patient's relationship to it – for instance, the effects of the problem; its history and context; the people, situations and ideas that support or undermine the problem; actions and practices that the client may take to transform the problem; and so on.

Narrative therapy proponents argue that therapists' externalising conversations with clients/patients undermine the dominant cultural practice – both within the traditions of therapy and the wider cultural context – of having internalising conversations, which individualise responsibility for problems and encourage personal feelings of deficit, "abnormality", and failure. White declares that while internalising conversations "de-politicize", externalising conversations "re-politicize" (1995, p. 48). Using the issue of abuse as an example, he explains that an objective for a therapist in an externalising conversation is a collaborative "renaming of the dominant plot [the client's story of the problem] away from personal culpability and towards 'domination', 'exploitation', 'servitude', 'erasure' and 'torture'" (p. 48). When problems are renamed and reframed, the therapist can invite discussion of the tactics of power involved in abuse and people's frequently concomitant self-abuse, and attempt to re-situate problems in local relationship politics (p. 49). The therapist deliberately orients conversations towards the goal that the client/patient will develop different accounts and understandings of his/her problems and experience freedom "to object and to dissent" (p. 49). The therapeutic strategy of externalising is an example of innovations within the field of therapy that have been developed in reaction to the traditions and practices of conventional therapy. It is a linguistic strategy that therapists use to counteract the internalisation of problems. In doing so, they seek to both re-politicise and de-pathologise clients' experiences of mental distress, and to reframe the story of problems in ways that are freeing and that enable agency and action.

Therapies developed from critical theory, intent on a project of "practical deconstruction", necessarily extend this deconstructive, questioning approach to the concept of the self. Viewing the humanist concept of the self as a mythic construct that tyrannises individuals – who are charged with the task of being "authentic", "whole", "real", and wholly responsible for all that befalls and redeems them – these

therapies offer an alternative conception of the self. For instance, Johnella Bird's theory and practices of therapy are founded on the concept of the "relational I". The "relational I", says Bird, "is a direct challenge to the Western cultural construction of self, which presupposes an autonomous self-regulated self" (2000, p. x). For Bird, "the 'I' is never singular. The 'I' is known and experienced always in relationship" (p. 7). The "I", then, exists within a context, in relation to people, history, ideas and experiences. This conception of the self means that individuals are neither wholly the source of, nor to blame for, mental distress or problems that they experience; there is no core, essential self that exists in isolation from the context and relationships of a person's life and that needs to be searched for and "discovered". "The world out there", from Bird's perspective, is inextricable from "the self".

The concept of the "relational I" informs how Bird uses language in her conversations with clients. Inspired by the narrative therapy strategy of externalising, Bird has developed a style of talk termed "relational externalising" that avoids and subverts the humanist concept of self:

> When we use relational externalising talk we imply through our use of language that people (clients) are not totally the identified concern, feeling, life event, or diagnosis. This style of talk enables us to research the institutional and other supporters of the development of this concern, feeling, life event, or diagnosis. The relational externalising conversation thereby challenges the idea that the self is the sole regulator of life events and the meanings attributed to these life events. (p. 8)

A conversational style that inquires about and researches the self *in relationship to* concerns, feelings, life events or diagnoses, and pays particular attention to people's relationships to the social, historical and political contexts of their lives, disrupts the pathologising habit of therapy/psychology; mental distress or concern is only one aspect of a person's experience and life and is not evidence of a unique, personal malady for which they are responsible. The aim of such a conversation is to avoid individualising or privatising people's concerns or problems; instead it encourages connections, interactions and an engagement with and awareness of the world, even in the private space of therapy. Bird theorises that, in challenging and moving away from the conception of "the self" as autonomous, individual and self-directed, new possibilities for explanations of both the self and problems or mental distress emerge:

"Engaging with the *self in relationship* creates conceptual space within which alternative explanations for life concerns can be explored and considered" (2000, p. 11, italics in original).

Sylvia Blood conceives of the self as shifting and inherently contradictory and works with clients in ways that introduce an alternative view of selfhood to the humanist self that is so naturalised within western cultures. From her research and clinical work with women around body image issues, she notes that the "idea of a true self or 'the real me' informs women's fantasies about who they will be when 'thin'" (Blood, 2005, p. 127). This idea of being inauthentic or not achieving "realness" while their bodies are in their current state, fuels women's distress around body image and demonstrates the oppressive potential of the "true self". Blood explains how,

> [w]hen women are exposed to ways of talking and thinking about themselves and their experiences, that attend to the shifting and changing nature of subjectivity, they can begin to see that there is no one "true self" or "real me". Women often become curious about how they feel in different social situations and with different people. (p. 127)

Blood's therapy work encourages women's awareness of a range of bodily experiences and "they begin to notice how their experience of their bodies is contradictory, shifting from moment to moment, particularly in different social situations" (p. 130). Such an awareness, Blood argues, "makes it possible for women to understand and experience their contradictory impulses without judging themselves as 'mad' or 'bad'" (p. 134). It also undermines experimental psychology's understanding of body image as a "consistent and stable" construct (p. 131), offering an alternative, and seemingly freeing and non-pathologising, model of body image. Bird and Blood represent a new approach among some therapies towards conceiving of and understanding the self. For therapy practitioners inspired by the critique of conventional therapy traditions, the self is multiple, shifting, contradictory and always relational, and their therapy practices mobilise this postmodern sensibility.

The critique of therapy detailed in the first half of this chapter asserts that there is a problem with the therapist's power – and the client/patient's corresponding lack of power – in the therapy exchange. Indeed, for the critic Jeffrey Moussaieff Masson (1994) the problem of the therapist's power is evidence of therapy's corruptness as an

institution and is both inescapable and irreconcilable (pp. 210-211). Issues of power and the therapist's privileged position have been of great concern to theorists and practitioners who have sought to challenge therapy traditions and conventions and to create and practice politically aware and engaged forms of therapy. The therapist's high-ranking, expert position in a dynamic where s/he acts as confessor – hearing the secrets of often socially marginalised people and then appraising, judging and categorising their words and minds – is undoubtedly problematic for therapists (including both my research particpants and me) with interests in social justice and the redress of oppressive power arrangements.

Numerous theorists and therapists have sought to address this issue and offer therapy practices that can potentially prevent or subvert the therapist's abuse of power. Early on in his book *Re-authoring Lives* (1995), Michael White encourages therapy practitioners to read outside the discipline of therapy, suggesting in particular texts from the fields of social theory and critical theory. He explains that this reading "helps us to consider the various ways that we are, or might be, reproducing dominant culture within the therapeutic discipline" (p. 12). Therapists are encouraged to consider how they may function as agents of social control and to engage with the idea that their therapy work with clients may – or perhaps inevitably will – involve the reproduction of dominant cultural values, assumptions and practices. The call for therapists to consider their power and their potential to reproduce dominant culture is reinforced by Glenn Larner (1999):

> The ethical challenge in psychotherapy is to minimize the therapist's potential to violate the other through therapy, which is an issue for the "post-modern" as much as the "modern" therapist. This is the potential violence of theory, authority, expertise and technology to override the client's contribution to their life narrative. (p. 48)

White and Larner's statements suggest that the power and influence that therapists have over their clients' life narratives must be continually acknowledged and reflected on, and actively minimised.

This kind of reflexivity is lauded as integral to challenging the power dynamics of conventional therapy and minimising the therapist's "potential to violate the other through therapy" (Larner, 1999, p. 48). In response to her own questions about how

therapists might escape the influence of dominant discourses and question their own non-conscious ideology, Rachel Hare-Mustin (1997) suggests that therapists develop "self-reflexivity". She explains that this means

> trying to provide a special vision that can challenge the assumptions of dominant discourses rather than merely going along with them. It also means that the therapist's own influence, the therapist's authority, must be acknowledged rather than denied. Some therapists are moving in this direction, questioning their own views and questioning why those are the questions they are asking. (p. 570-571)

Therapists are encouraged to address and acknowledge the authority they inevitably wield, rather than ignore it. Instead of reproducing the fiction of the objective, neutral, value-less expert practitioner, therapists are incited to continually question and reflect on their own views and values, and on their words and actions in their work with clients. Ian Parker stresses that "we are always already embedded in a particular set of perspectives, operating from within certain positions when we try to understand ourselves and others" (1999, p. 4). Rather than finding the "correct" standpoint, being a reflexive and critical therapist "means understanding how we come to stand where we are" (p. 4).

Theorists and therapists have developed "new practices of accountability" (Parker, 1999, p. 8) in order to challenge dominant discourses, minimise their potential to violate their clients' life narratives, and include the therapist "as a reflexive critical participating actor" (p. 8). Such practices have been concerned with "opening up psychiatric practice [and broader therapy practice] to make it visible" (p. 8). An example of these practices can be found in Michael White's discussion of client case-notes. Recognising the function of case-notes as a "modern instrument of power" (White, 1995, p. 31), White makes suggestions for how therapists might do their writing differently and prevent "us from engaging in the sort of practices that make it possible for the file to have an independent [from the client] life" (p. 47). He suggests numerous possibilities: "we might restrict ourselves to the visible recording of what the therapist considers to be particularly significant verbatim comments"; have clients write their own notes; compare the therapist and the client's notes; forward therapy notes to the client so that they can engage with them and together the client and therapist can confer and correct them; write notes in the form of letters (p. 47). Such suggestions represent an attempt by therapists to mitigate the oppressive effects of

note-making and record-keeping. They invite participation from clients in the creation of the record of their therapy and, crucially, make the therapist more accountable to the client in regard to her/his writing by providing opportunities for the client to verify or challenge the writing. Such practices are designed to de-mystify therapy and provide clients with insight into the therapist's orientation and the practices and purposes of therapy: therapy becomes not simply something done to them by a professional with expert and rarefied knowledge.

Other practices of accountability and attempts to undermine the authority and power of therapists can be found in both the use of clients' own language and descriptions, and in the curious, questioning stance of the therapist. Throughout deconstructive, postmodern and feminist therapies, in response to extensive critique, psychological knowledge and discourses no longer occupy a hallowed position. For instance, Bird explains that she holds "psychological theories to one side as one possible explanation for life events" (2000, p. 74). Instead, the language used and meanings made by clients are of much greater interest to her: "Exploration of people's (clients') lived experience by using the language of lived experience supports us to move beyond the shorthand of diagnosis and categorisation" (p. 8). The language and descriptors resonant with and chosen from the client's own lived experience form the basis for Bird's therapeutic talk, rather than the authoritative, objectifying, expert language of the "psy" disciplines.

As she listens to and utilises the language of her clients, Bird's primary mode of conversation takes the form of questions and wonderings. Questioning and wondering, she explains,

> reduces the risk of therapists imposing their meanings on people (clients). … The nature of such questions implies that we (therapists) are wondering and exploring possibilities. This allows for an acknowledgement of the power relation within the therapeutic relationship, while privileging collaboration rather than imposition and expert knowing. (Bird, 2000, p. 28)

Through her attention to and use of the language and meanings utilised by clients/patients in the therapy exchange, and her own use of questions rather than interpretations or instructions, Bird attempts to revise the practice of therapy. She seeks to address the problem of the therapist's power and attempts to lessen the extent

of this power by working with clients/patients in ways that are collaborative and attentive to their own understandings of their lives and problems. The use of clients' language and the strategy of questioning and wondering are integral to numerous other therapeutic approaches – such as narrative therapy, solution-focused counselling, and "Just Therapy" – and represent a significant departure from the conventions of therapy and the "psy" disciplines.

The first half of this chapter detailed the postmodern critique of the project and practices of therapy; the second half has broadly outlined some of the responses to this critique that are embodied in the work or writings of postmodern theorists and postmodern therapy practitioners. The therapy practitioners interviewed for this study all subscribe to the general postmodern orientation articulated in this chapter. They have been inspired by both the postmodern critique, and the response it has generated. In my interviews with them, they expressed their desire to find and utilise in their practice "doable alternatives" (to use Ussher's phrase) to traditional therapeutic approaches. However, the aim of this chapter is to do more than simply introduce the theoretical and methodological concerns of these participants. It also foregrounds the ideological conflict that they perceived (to varying degrees) within their working contexts as they endeavoured to work in the ways that they believed were appropriate. That is, despite the flourishing of postmodern therapy ideas that this chapter has canvassed, these ideas and the practices they promote remain generally marginal within the wider therapy field. The following chapter will introduce this study's participants, and will describe their postmodern orientations. From there, the thesis will analyse the tensions that they perceived between their orientations and those predominating in their work environments. Finally, their negotiations of those tensions will be discussed.

4. Applying Postmodern Therapy in Aotearoa New Zealand: Situating the Participants

Introduction

In a scene from Richard Kelly's 2001 film *Donnie Darko*, Lillian Thurman, played by Katherine Ross, sits motionless, expressionless, in her office, looking intently at the teenage Donnie. The room is cluttered, with books and numerous pictures on the walls, and she sits in an armchair while Donnie sits on a couch. Eventually Donnie utters, "I made a new friend". Lillian responds promptly with the question, "Real or imaginary?" Donnie says that the new friend is imaginary. With a sigh and some snappiness, she asks, "Would you like to talk about this friend?" As Donnie tells her more about his friend she follows his answers with direct, abrupt, inquiring questions, requesting more detail. She sits in her seat, legs crossed, hands clasped, her face at times frowning.

Lillian is Donnie's therapist. And Donnie, the film's protagonist, is a disturbed, apparently hallucinating young man, whom we follow as he experiences reality-bending phenomena suggesting the imminent end of the world. Donnie's history of strange behaviour has seemingly resulted in his parents' arranging professional psychological treatment for him with Lillian. Lillian, we learn, is also the source of the medicine bottle of pills that Donnie is meant to take on a regular basis. In subsequent scenes in the film, Lillian probes Donnie's apparently unconscious mind with hypnosis, discovering more about Donnie's imaginary friend and revealing his anguish and distress at the impending demise of the world, as well as inadvertently prompting uncomfortable (for us and Lillian) revelations of his thoughts of girls and sex. In the two scenes of hypnosis, at the sound of Lillian's hand-clap, Donnie breaks from a trance, disoriented and confused by the physical state and situation he awakes to: it seems that Lillian and we as viewers have been privy to the secrets of Donnie's mind without even his knowledge of this. At a later point in the film, Lillian meets with Donnie's parents, without Donnie, and gives them her appraisal of him. She tells them that Donnie is experiencing "what is commonly called a daylight hallucination",

explaining that "this is a common occurrence among paranoid schizophrenics". In response to Donnie's tearful mother's question, "What can we do?", Lillian informs them that she would like to do more hypnotherapy and increase Donnie's medication.

When I met with Cal in his counselling room – a spare, small room, its one window shaded by a blind, outfitted with two leather chairs that we occupied – we talked a little about representations of therapists in film and television. He explained that while he had not seen the therapist from the television show *The Sopranos*, "I do know that *Donnie Darko* movie gave me the screaming shits when I saw Katherine Ross!" We both laughed at his pronouncement and he went on to say:

> Cal: You know, she was my idol, she was the most beautiful woman on the planet when I was twenty.
>
> Kate: Uh huh [laughs].
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> Cal: And suddenly she's transformed, as an actor of course, into this character who is talking to this young man, and I don't know what it was like for him, but watching her working scared the shit out of me. And I kind of wanted to go into my work after that with a promise to myself that, whatever I did, I'd try not to do that.
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> Kate: What was "that"? What was scary about it?
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> Cal: I just remember her asking him things that seemed to be so unhelpful, or so confirming of this wrongness, and he seemed to be, um, all the time being mistakenly identified as being wrong or bad or odd. I just thought Donnie Darko was a fabulous fellow and I wished I could have asked him some stuff, you know, just to kind of balance what she was asking him. But what she seemed to ask him just seemed to intensify the darkness that he lived with.

Cal went on to explain that he wasn't sure if he fully understood the movie, and to stress that Katherine Ross is "a bloody good actor", but that

> there was something just deeply scary about the role that she took, which seemed to be, I suppose it was probably a bit all knowing, a bit too brilliant. I think she acts really well and I think it was just too scarily, brilliantly portraying the tradition of therapy that says "therapist knows best".

Katherine Ross's incarnation of a therapist brought out Cal's feelings of discomfort and uneasiness in reaction to some of the traditions of therapy – albeit represented in

film – suggesting that his intentions in his own therapy practices differed significantly from what Lillian Thurman did in her time with Donnie Darko. He explained that his feelings of fear in response to the film's image of a therapist were sparked by Lillian's style of questioning; her questions, he argued, seemed to identify and confirm Donnie's distress as evidence of him being "wrong or bad or odd". Cal viewed her questioning as unhelpful, as having the effect of intensifying the "darkness" that Donnie was already living with. Cal was also troubled by the idea that Lillian occupied a position as an "all knowing" and "brilliant" therapist. He found something deeply wrong and problematic about the "tradition of therapy that says 'therapist knows best'", vowing to do his best never to replicate Lillian Thurman's therapy style in his own work. Instead of seeing darkness, pathology, and dysfunction in the character Donnie, Cal described him as a "fabulous fellow" and was seemingly curious to learn more about him. He suggested that he would embark on a different style of questioning in a therapeutic conversation with Donnie – asking questions that would seemingly be oriented away from wrongness, badness, or oddness, and from the intensification of darkness, and that would not be asked from a position of "therapist knows best".

Cal's problems with the therapy represented in *Donnie Darko* echoed many of the arguments put forward by the therapy critics and proponents of postmodern therapy approaches and practices discussed in the previous chapter. His fears, discomfort and criticisms were also shared by the other therapy practitioners interviewed for this study. These therapists all balked at the approach and attitude to therapy work that is captured in the representation of Lillian Thurman. They identified themselves in opposition to the therapy habits of pathology, context-less individuals, and depoliticised conversations, and were troubled by the presumption that "therapist knows best".

This chapter looks closely at how the therapists interviewed for this study described and positioned themselves as a distinct group with particular interests. Despite being a relatively loose and diverse group of practitioners, these therapists were all linked through their involvement in a social movement within the field of therapy in Aotearoa New Zealand. Inspired by both postmodern critiques of therapy and the theories and practices proposed by postmodern therapists, this movement challenges

the canon and traditions of therapy and the "psy" disciplines: therapists actively sought to undermine the *Donnie Darko* model of therapy. Spicer and Böhm (2007), quoting Tarrow, broadly define a social movement as "collective challenges by people with common purposes and solidarity in sustained interaction with elites, opponents and authorities" (p. 1673). Proponents and practitioners of postmodern therapy practices in many respects fit this definition. This chapter examines the nature and features of the postmodern therapy movement, as represented by the research participants. Following the definition above, it first describes how I have linked these therapists together as a social group, demonstrating their collective interests and shared associations. It then considers the common objectives and purposes articulated by the therapists during interviews. The chapter brings to life the postmodern critiques and therapy practices discussed in the previous chapter, illustrating how these theoretical ideas informed the talk and reported activities of the therapists. The following chapters of the thesis will then focus on the final aspect of that definition, analysing the interactions of these postmodern therapists with elites, opponents and authorities within the wider therapy field in Aotearoa New Zealand.

Collectivity and group identity

As detailed in chapter 2, the therapists interviewed for this study all shared a general interest in postmodern approaches to therapy. Despite the differences in their professional roles and training paths, they had all at some point encountered critiques of traditional therapy practices and developed interest in postmodern models, which in turn had influenced their political and ethical orientations. In their talk, they frequently made references that connected them to a wider social movement and illustrated a sense of collectivity, even when this was physically absent from their immediate work settings. For instance, across many interviews, therapists referred to or invoked therapy theorists and teachers, highlighting both the influence these mentors had had on the therapists' practice and the communal nature of their project. The participants mentioned (often with first name familiarity) Michael White, David Epston, David Denborough, Johnella Bird, Taimalieutu Kiwi Tamasese, Ken and Mary Gergen, among others.[11] For example, Harry – a nurse/counsellor working for a

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[11] The late Michael White is often credited as the founder of narrative therapy, and was co-founder of The Dulwich Centre in Adelaide, Australia, an independent centre involved in narrative therapy, community work, training, publishing, supporting practitioners in different parts of the world and co-hosting international conferences.

DHB mental health service – explained that "Johnella's been very influential for me in terms of trying to move beyond binary thinking". The theoretical ideas that Johnella Bird articulates in her books and teaching influenced Harry's orientation to his work as a therapist; she remained a figure in his consciousness, her ideas brought to life as he remembered them. Some therapists had had close contact with Australasian theorist-practitioners – such as White, Epston, Bird and Tamasese – and indicated that at times they had experienced a mentoring-type relationship: Cal (a scoial worker/counsellor) and Danny (a psychiatrist) both recounted instances where they had contacted David Epston for advice about their therapy practices within work settings where narrative therapy was not the norm. Psychically and physically, these therapists remained connected and united with the postmodern therapy movement.

They also sought out spaces for connection and relationships with other similarly oriented therapists, forging and maintaining collectivity and group identity. Group identity could be asserted by attending training workshops and conferences where presenters discussed critical perspectives on therapy and taught postmodern-inspired practices: for instance, when Harriet – a psychologist – attended training courses on social constructionist ideas at an international critical psychology conference, she felt like she was "coming home". The talk of many of these therapists also frequently referred to more intimate collegial and peer relationships, again illustrating how postmodern therapy has taken shape as a movement within the wider therapy field in Aotearoa New Zealand. Some therapists were able to find conversation and collegiality with other postmodern therapy practitioners in their workplaces. For instance, Jac described the orientation of her counselling centre workplace, explaining

David Denborough is a teacher, writer and community practitioner at the Dulwich Centre.

David Epston co-authored several early narrative therapy texts with Michael White, and is a co-director of The Family Therapy Centre in Auckland, Aotearoa New Zealand.

Johnella Bird is a co-director of The Family Therapy Centre, Auckland, and the author of several books. She and David Epston developed a comprehensive teaching programme and super-vision practice at The Family Therapy Centre.

Taimalieutu Kiwi Tamasese is the coordinator of the Pacific Section of the Family Centre, Wellington, Aotearoa New Zealand. She is one of the founders of "Just Therapy", and is a writer and presenter.

Ken Gergen is an American professor of psychology and a major figure in the development of social constructionist theory and its applications to practices of social change. He has published extensively on this subject throughout his career.

Mary Gergen is an American professor of psychology. Her academic work originates at the intersection of social psychology, feminist theory and social constructionist ideas. She has published extensively and has co-authored books with Ken Gergen.

that she felt "very fortunate to work in an environment where our team leader is a feminist woman who is also very informed by Johnella Bird's work and post-structuralist ideas, and that's pretty much the way that our team works". For other therapists, collegial relationships and participation in the postmodern therapy community had to be sought outside of their work setting. Several therapists mentioned their involvement in narrative therapy interest groups, which met regularly to share ideas and provide collegial support. Others established peer supervision groups, which enabled Sam – a clinical psychologist – and interested colleagues to discuss the ideas and concepts put forward by theorists in books "using language that we're comfortable with". Ruth, also a clinical psychologist, maintained a peer supervision and support group with colleagues she had trained with ten years earlier, which meant she could participate in conversation with people with the same training background about "how we're coping in our different systems that we're working in and dealing with power relations and being effective as an individual practitioner still". The talk that took place during my interviews with individual therapists was "peopled" with others who shared their orientations and offered support and inspiration. References to teachers, mentors and peer groups gave the impression of participants' involvement in a communal project.

Common objectives and purposes

The remainder of this chapter details some of the key ideas and objectives generally shared by the research participants. It illustrates their mobilisation of some of the theoretical ideas and concepts discussed in the previous chapter – ideas and concepts that they have learned from influential teachers and mentors and that are discussed and developed in their communal gatherings. While my discussion is condensed and does not capture the fullness of these individual practitioners' ideas about therapy, my intention is to highlight their connections to indicate the flavour of the postmodern therapy movement in Aotearoa New Zealand.

Reservations about biological/physiological conceptions of mental health
In keeping with postmodern approaches to psychological knowledge and assumptions, the therapists in this study all expressed uneasiness with – and often outright opposition to – genetic and biological explanations for individuals' mental health concerns; similarly, they felt discomfort with the assignation of psychiatric

diagnoses. For instance, as a clinical psychologist, Pat explained that he comes across "lots of people who have been diagnosed with this supposedly genetic disorder – and I say supposedly because I think a lot of the research that makes assumptions about the genetic basis of mental illness is really flawed research". Having explained this scepticism, Pat went on to describe his view of the effects and implications of diagnosing "lots of people" with genetic disorders:

> So these assumptions about the genetic cause of mental illness I think become so strong that once people have got those diagnoses it follows through to: "well it's enormous, so we really want you to use medication". That's the thing they can hope for, is to manage the illness. There's no sense that they could ever be someone who wouldn't have that illness, and so a whole lot of possibilities are not considered.

Pat viewed genetic explanations for mental illness as growing the problems experienced by people seen by therapists, making them seem monolithic, static, and inherent to the individual's person and body. He echoed Dwight Fee's claims in the previous chapter, linking the bio-medical conception of psychology to the management of "illness", often through the use of pharmaceuticals.

Frances expanded the critique of biological and pathological conceptions of people's problems by saying,

> if you're working in mental health, you know, on a disease model then you are definitely adjusting people so that they fit into society [that is] unchanged [laughs], with all its injustices and lack of valuing of people. That's never suited me.

From Frances's critical perspective, a disease model in therapy work narrows the therapist's focus to the individual, returning them to the unexamined and "unchanged" social and political contexts that may be the source of their distress. She directly implicated therapists operating from this model with the perpetuation of social injustice. Frances and Pat's statements are indicative of the general orientation of therapists involved in this study: postmodern critiques of psychological science, and therapy's involvement in perpetuating the status quo, informed their observations of the therapy field in Aotearoa New Zealand and their own conceptualisations of client/patient issues.

Depathologising: externalising problems

These therapy practitioners proposed and actively pursued an alternative to the genetic disease model, taking up postmodern therapy practices aimed at depathologising people and their problems. In particular, more than half the therapists made specific reference to the narrative therapy practice of externalising (discussed in the previous chapter). For Harriet, who encountered narrative therapy in the late 1980s, there was "relief, with the narrative approach, to be able to externalise rather than pathologise". By externalising people's problems and difficulties, therapists sought to counter and undermine therapy practices that viewed problems as "belonging" to individuals and indicative of some sort of pathology. Another participant, Kerry, experimented with externalising practices when she and a colleague both worked at an alcohol and drug centre in the mid-1980s:

> We were employed to be family therapists and we were interested in developing ways of working with people who are struggling with alcohol and drug issues, so stepping outside the dominant stories around disease or weakness, or genetics, genetic weakness, and looking at externalising the relationship between people and alcohol.

Referring also to alcohol, Sam explained how externalising the relationship between a person and a problem involves "creating an alliance with the client against whatever they were up against … [and] separating the person from the addiction". These therapists used the practice of externalising as a means to avoid pathologising their clients/patients. Harry explained his aim in using externalisations in his conversations with clients/patients: to "give folk a little breathing space from the blame, the guilt or the shame that they might have internalised around struggling with an issue". Postmodern therapy practitioners used the strategy of externalising to mitigate any suggestions that individuals were at fault and to blame for the problems they experienced.

Contextualising problems

In their project of refusing and actively challenging pathological accounts of clients/patients, the therapists in this study were understandably interested in the influence of the "outside world" on these people. They objected to therapy practices that individualised or depoliticised the concerns of clients/patients. For instance, when Jac and I discussed her entry into counselling work, she explained how:

I think from the beginning I was very clear that most models of therapy wouldn't suit me at all. Like I wasn't in the least bit interested in psychodynamic therapy, and this idea that, um, well in brief, that the problem is located within the person. I think through all of my work [before becoming a counsellor], I think what I knew but probably couldn't articulate was that people's experiences were located within context.

The idea of focusing deeply on the unconscious content of an individual's psyche, without attention to their context, did not fit with Jac's view of selfhood as being contextual and relational. Like Jac, the other therapists in this study operated from the assumption that people's experiences were located within social and political contexts, rather than within individual bodies or minds. Therapists saw the "outside world" as being integrally involved both in people's experiences of psychological problems and in the therapy that was aimed at alleviating or finding alternatives to problems.

Depathologising therapy and deconstructing problems

Implicit in Frances' earlier comment that adjusting people to fit into an unchanged society had never suited her was the suggestion that she had different goals for her therapy work. Likewise, therapists' use of externalising suggested a specific goal of doing therapy in a non-detached manner that engaged with political and social realities. Therapists described their practice as being informed by an awareness of cultural forces that encourage pathologising, self-blaming accounts of individual distress, and of therapy's potential to reproduce such accounts. Pat detailed his sense of the impact of pathologising, self-blaming explanations on clients. He also described how he responded to and worked with the social and political contexts of people's lives during therapy, attempting to unground dominant explanations for their difficulties:

Most people, in my experience, come to therapy thinking they've got problems because they're bad, somehow or other they're bad, they're bad people, very bad. Bad because they're genetically flawed. Or more likely they're bad because they're lazy or stupid or selfish or whatever. And often those understandings of themselves, those beliefs about themselves, have been learnt in their communities, families, society as a whole in general. And it's very convenient for families and societies that they can blame themselves because then it's just an

individual problem. And so, often in working with people to help them have a more okay relationship with themselves, it involves challenging, questioning how they got the ideas that they've got.

Pat depicted himself as not taking the ideas and explanations proffered by clients – or families, society, science – for granted. By inquiring about how ideas come to be held, within the context of people's communities, families and societies, he sought to complicate simple ideas of "wrongness", "badness" and individual responsibility. The therapists in this study, representing the postmodern therapy movement, shared an orientation of "practical deconstruction", with which they attempted to attend to politics and power within therapeutic conversations (Bird, 2000, p. 70). By paying attention to where the ideas held by clients/patients came from and how they had developed, therapists pursued their aims of politicising and depathologising therapy.

Recognising the problem of power

Alongside the objective of using therapy to depathologise and politicise clients'/patients' difficulties, postmodern therapy practitioners also perceived the traditional power relations of therapy as problematic. They were troubled by – to use Cal's description – the "therapist knows best" traditions and assumptions of therapy, and by the powerfulness of the therapist role. Sam's recollections of his early experiences as a clinical psychologist, for instance, illustrated feelings of discomfort and unease at the power accrued in his professional role:

> I can still remember the first day I was given the WAIS, which is the Wechsler Adult Intelligence Scale, you know, this little suitcase box thing, and I felt so big and so strong and powerful that I could do this testing on people. And [for my research at the time] I finished up giving hundreds of these things, and realised that I actually hated it – sitting administering a psychological test, and getting a figure that represented something that I knew about them that they didn't know, and that I could use to influence or make some decision about them, supposedly for their good, but it was still an experience of power. And I reflected a lot on whether it was actually helpful for them. I realised how alienating it was, how alienating a practice it was between me and the client. And, so all of those things got me realising how much I didn't like some of the practices that psychologists were meant to be engaged in.

Sam went on to explain how, when he looked back on many of the interventions that he was trained to do, "they were really coming from positions of me knowing best … [and] I guess I became increasingly uncomfortable". Having command of an instrument that tested and measured people's intelligence, by means unknown to the subjects and for the purpose of professional decision-making about their ongoing care, suggests a therapy dynamic where the therapist wields significant power over clients/patients. This dynamic troubled Sam and, from his observation, alienated his clients. He explained that these sorts of experiences in his early career as a clinical psychologist "got me wondering about what other ways I could be involved in doing therapy that I guess honoured the expertise of the person I was talking with".

Other practitioners in this study shared Sam's self-consciousness and discomfort about the powerfulness of the therapist role. They all acknowledged, in varied ways, that the power differential between therapist and client/patient was unavoidable. Kerry, for instance, declared, "it is a power relationship, of course it's a power relationship". She explained how,

> for a long time I liked to think that it wasn't, or that it was a totally equal power relationship, but then I had to get a bit more honest with myself and acknowledge that actually there is this power relationship there.

Speaking to Frances, I was posing a question about "the potential for a power differential between you and the person who's sitting with you", when she interrupted me to say "Oh more than potential. It's a fact. And I do quite a lot of things to minimise that, but I never forget that it's there, because if I forget then I'm likely to misuse it". Both Kerry and Frances represented themselves as practitioners who acknowledged and maintained awareness of the power they inevitably experienced or were bestowed with in therapy work with people. They regarded this as vital to their work.

Recognition of the powerfulness of the therapy professional was also apparent in Alex's description of his role, as an educational psychologist, in relation to the young people who he was called on to work with. He explained that he tried

> to keep in mind "I'm part of the problem". As soon as I'm linked to this, every time I walk into the school, every time the young person has to meet with a psychologist, they are defined in a certain way. … And, you know, my ideal

practice, one of the beliefs that I guess I hold is, "how do we try to actively work against what is the cultural norm?", which is, you know, school invites a psychologist to confirm their knowing, which is this child is bad, mad, or sad.

In recognising and remembering that "I'm part of the problem", Alex illustrated in more detail the power wielded by therapists. From his critical perspective, simply by virtue of his professional role as a psychologist, he was already implicated in defining children in pathologising, essentialist ways. In turn, he suggested that institutions – in this case, schools – may engage therapy practitioners to regulate cultural norms, as arbiters of abnormality and supposed enforcers of normality. Alex expressed his ambition to work actively against this power dynamic. Kerry, Frances and Alex presented awareness and recognition of the operations of power in therapy work as vital elements of their therapy practice. They were, in Frances' words, intent on *doing things to minimise that power*.

Negotiating power in practice

Reflexivity

As discussed in the previous chapter, the concept of "reflexivity" has been foregrounded by many theorists who propose new, postmodern and politically motivated therapy practices. Reflexivity calls on practitioners to self-consciously address and acknowledge the power they are bestowed with and wield. It requires them to continually question and reflect on their own views and values and the positions from which they form their perspectives. The above discussion in itself indicates how therapists in this study utilised reflexivity, remembering and reflecting on the power relationships of therapy. The principle of reflexivity could also be seen in their descriptions of the thinking and reflection that they engaged in as they worked therapeutically with clients/patients. Several therapists reinforced the importance of reflecting on and questioning their own beliefs and values, and the ways in which they themselves engaged with dominant cultural discourses. During our conversation, Alex told me about his work with a child whose mother had gang involvement. This information had been conveyed to him before he had actually met the mother: "Before I even got to that case I could feel my own stereotypes about gangs being there. So how do I question my own stereotypes?" Alertness to the influence of stereotypes and assumptions about gangs motivated Alex to find ways to question these stereotypes and assumptions. He described how he deliberately met with people who could

inform him more about gangs and therefore help to dispel the preconceptions that he had noticed within himself.

Harry described how reflecting on "Pākehā, male, middle class privilege" was

> an ongoing thing really, isn't it? I would like to think that I'm continually sort of looking at how I come across, and how I operate, and how I act in terms of whether I kind of collude and go along with that privilege, or whether I do something about it, or whether there are other positions, you know?

He represented himself as striving to maintain continual awareness about the positions of power and privilege that he occupied, not just by virtue of his therapist role, but also as a result of class, race and gender. Alex and Harry's examples suggested a continual practice of self-reflection and observation of their thoughts, feelings and actions in their therapy work. Pat echoed their examples, and the intentions behind them, when he talked about his strong awareness of "the ease with which the mental health profession turns a blind eye to the way they are involved in reproducing the status quo, and I don't ever want to forget that". The practitioners in this study, as these examples illustrate, saw themselves as deliberately, concertedly and reflexively working against the idea of themselves as agents within a therapeutic hegemony merely reproducing the status quo.

Honouring clients'/patients' expertise

Therapists indicated that there were other practices that supported them to attend to and attempt to reconfigure the inevitable power relations of therapy. In my earlier discussion I described how Sam's realisation about the power he displayed and exercised as a clinical psychologist led him to become curious about ways of doing therapy work that "honoured the expertise of the person I was talking with". Throughout my interviews with therapy practitioners, they often referred to the expertise and knowledge of the people they worked with. They positioned themselves as researchers and inquirers, but not experts in regard to their clients'/patients' difficulties, or as the providers of "answers" to these difficulties. Jac explained that,

> therapy wants to, and tends to, move towards the expertise of the therapist, having an idea and knowing, you know, what shape the person's life should be taking. Whereas I don't have an idea what shape the person's life should be taking.

From this postmodern therapy perspective, the shape of people's lives is something to be directed by individuals themselves, and not defined or directed by a therapist with expert knowledge. The non-expert stance adopted by many of the practitioners interviewed for this research involved asking questions, as Cal explained, for which "I genuinely don't know the answer". Curiosity, interest and investigation apparently coloured their therapy exchanges.

Practitioners described various methods by which they sought to prioritise clients'/patients' knowledge and expertise in therapy work, and thereby to undermine the assumption that the therapist possesses superior expertise. For many, the way that they used language and terminology in regard to people's problems was particularly significant. Using, as Harry put it, "the client's name for their trouble" – rather than a psychiatric description – and "honouring a client's description of their situation" was a strategy for asserting the importance of clients'/patients' knowledge and expertise in therapy. Harry gave the example of using the client-generated term "eating hassles", instead of the clinical terminology of "eating disorders". Cal talked about a situation where he had worked with a family where the child was struggling with what is clinically described as "encopresis". His strategy for resisting the imposition of a clinical description – taking his lead from the narrative therapist David Epston – was to inquire about "preferred" and "experience-near descriptions":

> I generally do what I was inspired and encouraged to do by David Epston. And he said "well, what I do is I kind of say to them, well, in this conversation that I'm having with you which description would you prefer?" Or look for an experience-near description. And they might say "the shitty thing". And I'd imagine I'd say to a child and their parent: "what are we going to call it? We could call it encopresis or we could call it the shitty thing, because encopresis comes out of the book and shitty thing comes out of what we've been saying".

The theory behind these linguistic strategies is focused on evading the imposition of clinical, psychiatric labels – labels that "come out of the book" – and instead using clients'/patients' preferred descriptions. Cal portrayed himself as validating and utilising his clients' descriptions, arising from their own experiences, and giving them choice over the nature of their conversation. Client expertise and input is sought, while some of the apparatuses of therapeutic authority are disabled.

Transparency

In their efforts to negotiate and limit the traditional workings of power in therapy relationships, postmodern therapy practitioners emphasised transparency as a goal in their therapy work. Previous examples already suggest the operation of degrees of transparency in therapy sessions: Cal's description of himself asking what to name the problem indicated a desire to collaborate with clients/patients and be up-front about the terms for the conversation. Benjamin spoke about his preference for transparency in his therapy work:

> The kinds of therapy that I guess I prefer would be therapy that is transparent, so clients know what you're doing, and can see where you're coming from and can pick up those therapy tools and techniques and stuff and just use them themselves. I see that as a lot more empowering.

Benjamin's words suggested a strong interest in therapy being "empowering" for clients/patients. Empowerment was linked to clients/patients knowing and understanding what was happening and the motives behind a therapist's questions or suggestions, and being able to take up skills learned in therapy. Benjamin was intent on demystifying therapy and subverting the image of the silent, appraising therapist – like Lillian Thurman – who subjects clients to procedures or experiences "for their own good" but without their knowing or explicit consent.

For many, the ideal of transparency also extended into the realm of therapeutic writing and file-keeping. Practitioners spoke of the importance of having clients/patients know about and participate in what was written about them in therapy. Some described sharing their written notes with clients/patients and disclosing and discussing other documents linked to the "case". Alex explained that, if he "had a magic wand",

> I would not document anything without agreement. Well, I get agreement, I mean I get consent for documenting what I do, but what I would really love to be able to do is say "I'm only going to write things on this file with you either present or that you participate in. There will be nothing on those files that has not been written with you and that you have not been party to".

Alex seemed influenced here by Michael White's critique of therapy case-notes as "a modern instrument of power" (1995, p. 46). He suggested that transparency in regard to documentation and the participation of clients in the creation of documents would

be his ideal way of working. This ideal undermines professional secrecy and discretion and aims to include clients in more of the processes of therapy. Again, it opposes the Lillian Thurman image.

Minimising displays of power

As the above discussion indicates, acknowledging and trying to lessen the effects of professional power was a deep concern of the postmodern therapy practitioners in this study; equality was an impossible goal, but they consciously sought to work with and where possible reduce the effects of their power. While the examples discussed so far detail some deliberate strategies used by therapists, throughout my conversations several therapists spoke of their own, more personal efforts to subvert or avoid displays of power and authority in their work with clients. For instance, Frances described how,

> from the beginning, when I go out to greet someone, I do things like not show up with the file and a clipboard [both laugh], and make sure that I am light when I meet people, warm, and that I use some self deprecating humour to defuse that [client's experience of her power].

Frances consciously performed and conducted herself in particular ways to try to soften the inevitable power differential between therapist and client/patient. Her description depicted her as deliberately eschewing some of the signs and instruments of a traditional therapy professional role – such as the file and clipboard – and rejecting the demeanour of a clinical, formal, reserved practitioner.

Sam described similar personal strategies for addressing power relations within his therapy work with clients/patients. He explained how his therapy practices have developed over his career as a clinical psychologist, and pointed out that, now,

> one of the things that I make a very clear point of doing is introducing myself and something about me first of all. And I ask, I inform them that I'm open to them asking me any questions that they'd like to about me, or about how this works or why I'm doing it, and I put that out there before we even talk. And my reason for that is that if someone's going to be very open about what's going on for them, one, I want to model that, and show that I can talk about me. But much more it's an attempt to equalise the situation just a tiny bit. The purpose isn't for me to talk about me but in the past I would be almost invisible, I would be just a

psychologist and anything about me would be inappropriate, and I think I've

shifted a long way from that now.

Over his time working as a therapist, Sam had deliberately moved himself from being invisible and out of bounds as a subject of inquiry, to being more personally visible in his work with clients/patients and available – to an extent – as a subjective person with particular life experiences and opinions. His increased visibility was motivated by a desire to "equalise the situation just a tiny bit", to disrupt the one-way model of client/patient disclosure and exposure while the listening, appraising therapist's personal world is sealed and barred. Both Frances and Sam's awareness of the power relations inherent to therapy prompted them to formulate practices within their therapy work in an effort to lessen – even "just a tiny bit" – the display and extent of their power.

Conclusion

The purpose of this chapter has been to articulate practical ways in which therapists sought to incorporate an understanding of the critques outlined in the previous chapter into their work. In looking at these practices as part of a social movement within the therapy field in Aotearoa New Zealand, I have introduced the participants in this study and described their membership in this movement. In particular, I have canvassed some of the key objectives, assumptions and methods that characterise this postmodern therapy movement. The chapter presents the aspirations and ideals of these therapists but, importantly, does not consider their application in practice: this research does not appraise how fully and consistently these approaches were actioned, and in combination with what other factors, or the experiences of clients/patients who encountered these therapists. The inquiry is restricted to how the therapists present and talk about themselves and their therapy practices.

This chapter both illuminates and grounds the practical implications of the critiques described in the preceding chapter; it also forms the backdrop for the remaining chapters of the thesis. The next part (chapters 5 and 6) describes the dominant discourses and socio-political forces that shape the therapy field in Aotearoa New Zealand. This account draws on published research, interwoven with analysis of the descriptions given, and observations made, by my study participants as they reflected on their experiences of working in that field.

PART 3

5. Neoliberalised Therapy

> Galileo said that the natural world is written in the language of mathematics. The neo-liberal ideologues want us to believe that the economic and social world is structured by equations.

<div align="right">

Pierre Bourdieu, *Acts of Resistance*

</div>

Introduction

This chapter examines the field of therapy in Aotearoa New Zealand through an historical and political lens, and then employs this analysis to consider how the practitioners gathered in this study were positioned within the field. In particular, I am concerned with the interactions between the specific field of therapy and the wider forces and forms of state governance that were operationalised in the late 1980s and early 1990s, and that have had an enduring impact throughout the 1990s and 2000s on all aspects of Aotearoa New Zealand society. The talk of the therapy practitioners gathered in this study, and especially those who had had long careers as therapists, emphasised upheaval and transformation within the field of therapy as neoliberal discourse gained legitimacy and steadily widened its reach. The rise of neoliberalism, and the implementation of its attendant practices in Aotearoa New Zealand over the late 1980s and the 1990s, profoundly transformed the workplaces and activities of therapists, particularly those working directly within the public sector. For therapists working within the more recent period of the 2000s, neoliberal discourse is now embedded within therapy institutions and informs much of the "commonsense" logic of the operations of these institutions. This transformation was a source of conflict and tension for many of the participants in this study, revealing the field of therapy to be a site of continuous struggle over competing discourses and species of capital. The previous chapter introduced these therapists as members of a particular social movement within the wider therapy field, aimed at mobilising postmodern and politically engaged approaches to therapy work. Yet in practice this aim proved

difficult, as this chapter demonstrates. In their work situations they found the terrain of therapy within Aotearoa New Zealand conflicted and often, from their positions as postmodern therapy practitioners, contradictory and obstructive. For many, negotiating the forces at play within the therapy field involved discomfort, tension, frustration, and alienation.

The rise of neoliberalism in Aotearoa New Zealand: a brief history

Throughout my conversations with therapists, particularly those who were working in the 1990s, frequent mention was made of changes and shifts in the public systems and institutions involved in the provision of therapy. These changes and shifts seemed to be particularly concerned with funding and the activities of services in relation to finances. An example of such talk took place in my interview with Kerry, a social worker/counsellor who had had a long career working both within the public sector and in private practice. During our conversation, Kerry explained to me that, by the early 1990s, the options and possibilities for obtaining public funding to develop independent services no longer existed. In the early 1990s, Kerry, with a group of counselling colleagues, had been interested in establishing a narrative therapy centre for women:

> It was still in the days when public funding was more possible, and we wanted to have it as a free service for the people who were coming to us and for us to be paid salaries. That's the sort of thing we wanted to do. Unfortunately it was like we were just past the wave – by now we're going into the early 90s and there's been a whole shift. And we talked to lots of existing agencies about how they got their funding and all that, and it became clear that we weren't going to be able to do it, set up another agency at that stage historically and to be able to fund the work.

When I mentioned to Kerry that other people I had interviewed had also referred to significant social and political changes that took place between the 1980s and the 1990s, she explained that "it's like the whole weight came down and, it was almost like that backlash stuff". Kerry's talk identified a rupture in the agendas that structured public counselling and therapy services between the 1980s and the early 1990s; she described a shift from an era where "public funding was more possible" and people could potentially receive state support to establish independent and special focus agencies – such as a narrative therapy centre for women – to an era where such

funding was restricted. According to Kerry, within the space of only a few years the potential shapes and forms of publicly funded therapy services had been curtailed, ushering in an era that she likened to a "backlash".

The "whole weight" that came down in Aotearoa New Zealand during the late 1980s and the 1990s has been the subject of much critical and historical analysis and discussion (Barry, 1996; Janiewski & Morris, 2005; Kelsey, 1997; Larner & Craig, 2005; Larner, Le Heron & Lewis, 2007). The shift that Kerry refers to in respect to the funding of therapy and health services was the product of radical economic and social reforms that were introduced by the fourth Labour government (1984-1990) and pursued by the successive National government (1990-1999). Described as the "New Zealand experiment", the Labour government introduced and applied a model of "pure neo-liberal economic theory" that was "continued with equal, if not greater, fervour by a National [Party] government thereafter" (Kelsey, 1997, p. 1). The reforms of the late 1980s and the 1990s profoundly transformed the economy, government activities and operations, state services and institutions, and the social, economic and working lives of many New Zealanders. With these reforms, neoliberal discourse received official sanction and, through the machinery of state apparatuses, was able to be established as a hegemonic discourse.

In brief, the ethos of the Labour government's reforms in the latter half of the 1980s centred on the belief that Aotearoa New Zealand needed to be opened up to the global market-place and that the activities and services of the state sector needed to be organised and managed along the lines of corporate business. The overriding assumption held by policy-makers in this period, according to Robin Gauld (2001), was "that markets are the 'natural' place in which services – public or private – should be delivered. Driving this was a belief that markets, and the competition and incentives they facilitate, are intrinsically efficient and innovative" (p. 43). Market creation in the public sector, under this ideology, involves the "corporatising, privatising or contracting out of services" (Gauld, 2001, p. 44). In the late 1980s, the Labour government began restructuring many state services along these lines, commercialising services, instituting business models of operation and "entrepreneurial discipline" (Kelsey, 1997, p. 4), and, where possible, selling off assets and operations to outside investors. The introduction of market rationality and

managerialism[12] to the state sector, coupled with both the project of "rolling back" the state and the policy of fiscal restraint, foreshadowed inevitable changes to state funded social services, and, in turn, to the working environments of many therapy practitioners within public systems.

While the Labour government initiated the neoliberal-inspired economic and social reforms, it was not until the election of the National government in 1990 that the implications of these reforms for state funded social services took shape. Upon election, faced with a fiscal crisis, "the new government announced that substantial cuts in public spending would be required, particularly in social services" (Gauld, 2001, p. 81). This project of fiscal restraint within social services gives context to Kerry's comment about being "past the wave" to receive public funding for a narrative therapy centre for women. Financial austerity was the goal of the National government, leading to restrictions on funding for social services and the move to shut down expensive state operated health and welfare institutions. Jane Kelsey describes the effects of the state's withdrawal from social and welfare services and the policy of fiscal restraint in this sector:

> Institutions for the mentally ill, elderly and young closed their doors in the name of community care. Women were called upon to perform a traditional role as volunteer carers to fill the void left by the state. Māori were assumed to have tribal and family support systems to fall back on. Churches and charities were expected to cover the government's withdrawal from social and income support. (1997, p. 5)

The retreat by the state from social and welfare services, coupled with funding cuts to those services that the state continued to provide, profoundly changed the nature of Aotearoa New Zealand society. In the early 1990s, options for therapeutic, social and welfare support became more and more limited, and increasingly became the domain of charities and non-governmental organisations. Over the 1990s, some of these charities and non-governmental organisations would formalise their uptake of the

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[12] "Managerialism" refers to workplace technologies that are
designed to realise the objectives of neo-liberal programmes of government. As a distinctive set of technologies and practices, managerialism can be seen as a product of the intersection of neo-liberal political rationalities and business management prescriptions for organisational change to meet the competitive challenge of a global economy. (MacKinnon, 2000, p. 298)

duties and services of the state through the government's "contracting out" model for service provision.[13]

The funding cuts and the state's retraction from social and welfare service delivery were compounded by and conjoined with the National government's proposed health reforms, which were announced in 1991. Many therapy practitioners in the public sector worked for services that came under the mantle of health – such as mental health services, community counselling services, child and family services, and alcohol and drug treatment. National's health reforms "brought to the New Zealand health sector more radical change and greater exposure to principles of marketisation and managerialism than any other state-funded health system in the world" (Gauld, 2001, p. 4). The health sector underwent enormous restructuring, which involved the institution of various charges for services, the contracting out of services, and hospitals being reorganised along business lines, with management positions assigned to people with business, rather than health, knowledge and experience. The National government's overarching policy of financial austerity and efficiency fed into all of these structural reforms of the health system (Fougere, 2001; Gauld, 2001; Kelsey, 1997).[14] As a consequence of the reforms, professionals working within public health services, including numerous therapy practitioners involved in this study, experienced processes of restructuring and reorganisation of their services – all with financial austerity and efficiency as their key drivers – along with new managerialist modes of operation, accountability and organisation.

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[13] The expansion of the "contracting out" model, and the principle of privatisation over the 1990s, resulted in the emergence of a wide range of private providers. Barnett and Barnett (2005) note that "[t]his has been notable in community support and mental health services and in the development of Māori and Pacific providers" (191). While the impetus for this model of service provision – contracting out services to specific groups, including both the not-for-profit and for-profit sectors – was undoubtedly about the neoliberalisation of state services, the model also enabled the development and legitimacy, for instance, of kaupapa Māori social services designed and delivered by iwi groups, as well as other services developed and led by consumer groups. These sorts of services, born from their specific communities and led by community leaders and practitioners, represent considerable development in the field of social services in Aotearoa New Zealand and are an important, if unintended, by-product of the economic reforms.

[14] Despite the omnipresent discourses of "efficiency" and austerity, the restructuring of the health sector and the National government's attempts to transform health services into competitive businesses were enormously costly. Kelsey (1997, p. 378) explains that by 1996 the government had spent $1.3 billion propping up indebted CHEs (Crown Health Enterprises). Barnett and Barnett (2005) also detail the financial consequences of the health reforms:

> Instead of substantial savings as anticipated from the introduction of competitive and commercial incentives, overall public expenditure on hospital services *increased* and the efficiency gains (measured largely by indicators unrelated to patient benefit) were less than expected. (p. 184)

In 1999, a "centre-left" Labour government was elected, promising a new reform agenda and an end to the neoliberal pursuits of the previous decade. In 2002, the Prime Minister, Helen Clark, boldly declared that "neoliberalism is over" (Larner, Le Heron & Lewis, 2007, p. 224). However, Larner and Craig (2005) refer to the fifth Labour government's reign as the "third phase" of neoliberalism in Aotearoa New Zealand. They describe this phase as "characterised by a 'partnering' ethos … in which discourses of 'social inclusion' and 'social investment' sit awkwardly alongside more obviously neoliberal elements such as economic globalisation, market activation and contractualism" (p. 407). Despite Clark's proclamation and the development of potent social discourses by this government – suggesting a retraction from neoliberalism – neoliberal discourse simultaneously endured and continued. The radical changes undertaken and institutionalised over the previous decade had taken firm hold in collective discourse. Barnett and Barnett (2005) observe that, despite the new wave of reform under the Labour government from 1999 to 2008, "certain elements of the 1993 reforms and their legacy remain" (p. 192). These elements include the "presence of ongoing public hospital deficits, resulting in the need for high levels of service rationing" (p. 192). Fiscal restraint, and the accompanying policies of efficiency and limited services, appear to be par for the course for the health sector. The policies of the Labour government throughout much of the 2000s "continue[d] to draw on highly economistic language" (p. 229). Managerialist practices and objectives could be seen in the "continued emphasis on contractualism and a narrow, market-contested output accountability regime" (Larner & Craig, 2005, p. 420), for both state services and those services that are contracted by the state. Labour continued to expect public services to operate in the manner of businesses and to require "entrepreneurial discipline" (Kelsey, 1997, p. 4) from workers within these services.

This potted history of the "New Zealand experiment" and the rise of neoliberalism within Aotearoa New Zealand canvasses the policies of governments throughout the late 1980s, the 1990s, and the 2000s, particularly in respect to the provision of social services. I now turn my focus more specifically to what the neoliberal reforms of this period have meant for therapy practitioners and the institutional settings of their work, and examine more closely the relationship between discourses of neoliberalism and the field of therapy. Therapy practitioners who were working during the era of radical

neoliberal reform – from the late 1980s and throughout the 1990s – had to contend with a changing, "reformed" institutional environment that, for many, as the discussion in the next section will illuminate, was at odds with their own goals and aspirations as therapists. By the 2000s, many of the tenets and policies of the reformers had been institutionalised and had become the "commonsense" logic of the state sector and of publicly provided therapy services: neoliberalism had been established as a hegemonic discourse. Using the descriptions and stories of the study participants, I critically analyse the operations and implications of this discourse within the therapy field of Aotearoa New Zealand. The terrain of therapy work is entwined and necessarily engages with key principles of neoliberal discourse, including fiscal restraint and austerity; managerialism; and the authority and legitimacy of business knowledge. As the therapists in this study detailed their grappling with the pervasive influence of neoliberalism on therapy work, they identified shifts in, and conflict between, the forms of capital that govern and delimit the field and that wield symbolic power: their own capital was frequently "trumped" by "neoliberal capital".

The quantification and commodification of therapy time

As discussed above, the economic and social reforms of the 1990s drew strongly on neoliberal discourses of "fiscal restraint" and "efficiency". Following these discourses, the state sought both to withdraw from the provision of social services and to impose the logic and methods of the competitive business world onto those services that they continued to provide and those with government contracts. The alliance between policies of fiscal restraint and the discourse of efficiency, which achieved omnipresent status in Aotearoa New Zealand over the late 1980s and the 1990s, resulted in a shift in the governance and operations of services provided or funded by the state. Danny MacKinnon, discussing similar processes that took place in Britain during the 1980s and 1990s, explains this shift:

> The nascent "enclosures" formed by professional expertise within the public
> sector have subsequently been breached by a series of calculative technologies
> embedded in specific practices such as budgetary management, audit and
> targeting (Clarke & Newman, 1997). These technologies depend upon the
> authority and apparent objectivity of disciplines such as accountancy, economics

and management which have risen to prominence in the 1980s and 1990s (Rose, 1996a). (2000, p. 298)

While MacKinnon's work concerns the arena of local governance in Britain, within Aotearoa New Zealand the neoliberal policies of fiscal restraint and efficiency similarly involved the introduction of "calculative technologies", with a focus on quantitative measures and standardised services, into the field of therapy. In particular, the work and activities of therapy have increasingly been subject to processes of calculation and quantification, a development that challenges the expertise and authority of therapy professionals. By virtue of their education and training, professional memberships and roles, and experience within the "enclosure" of therapy, therapy practitioners possess specific forms of "cultural capital" (Everett, 2002, p. 62). As members of the therapy profession, they also accrue and can call upon particular forms of "social capital": "the powers and resources that stem from networks of relationships" (p. 63). These forms of capital, within the shifting field of therapy, are forced into competition with other, newer forms of economic and cultural capital.

Among those therapists interviewed for this study who were working throughout the 1990s, frequent mention was made of the lack of resources within publicly funded services – primarily the resource of time. Numerous therapists commented on how, during the period of radical economic and social reform, public therapy services reduced their scope, focusing primarily on short-term contact with clients/patients, referral on to other services, and speedy discharge. During the mid-1990s, Frank worked as a counsellor at a public sector alcohol and drug service that had narrowed the focus of its work with clients in these ways. He explained how, when he was able to do therapy work with clients/patients:

> It couldn't be more than six sessions. It was interesting because they didn't make any distinction between the nature or the extent of the problems. So someone could have absolutely, um, multiple, outrageous drug addiction issues with a million other major psychological and social issues and they would get the same six sessions as someone who maybe a couple of times drunk a bit too much over the weekend and maybe got caught drunk driving and needs to change these habits. So there was no distinction and everyone had to be fixed in six sessions.

Within this publicly provided alcohol and drug treatment service, the therapy work that took place between therapist and client/patient was calculated as requiring six sessions. Under this model of service provision, time was a commodity to be rationed and both clients/patients and therapists were subject to a standardising logic: six sessions should be sufficient for everyone "to be fixed".

Frank's words represent a tension between the then newly introduced managerialist rationale within the organisation – limit costs, calculate the cheapest ways to provide services, turn the work of the organisation into visible equations – and his professional identity and expertise. Frank critiqued the "inefficiencies" of this service, pointing out that standardised, time-limited therapy services were not helpful for, nor designed to meet the needs of, particular groups of clients/patients. In the telling of this anecdote, Frank displayed his professional authority and capital as a therapist: his knowledge and experience of the diversity of issues experienced by clients/patients of alcohol and drug therapy services; and his knowledge of and ability to appraise and classify "drug addiction issues" and other "major social and psychological issues". These forms of cultural capital informed his proposition that a more "realistic" and "helpful" model of operations would acknowledge differences between clients/patients and the consequent need for varied amounts of therapy time to be provided.

Frank's comments referred to the 1990s and to the advent of "calculative technologies" within the field of therapy. The rationale of limited therapy time – where therapy work becomes a numerical measurement – and the under-resourcing of public therapy services were mentioned by nearly all of the therapy practitioners who had worked in public sector services, and seemed to be a natural condition of work within this sector. Within more contemporary public therapy services, conflict and tension between managerialist practices of calculation and standardisation, and the knowledge, expertise and ideals of therapy practitioners, continued to structure the therapy field. Pat was a clinical psychologist who was working for a community mental health service when interviewed in 2006. He also spoke of time restrictions on his therapy work. He told me how, within his service, he was expected to help clients/patients with at times long histories in the mental health system, and with complex problems, "overcome depression in 10 weeks":

And it's like, well, yes, we could work with these people and could use cognitive principles and therapeutic principles but it's not likely to be in 10 weeks. It just takes a while. And because there's so little psychology time and psychotherapy time available in the public system, there's just a limit to how much of that can be done.

Like Frank, Pat critiqued standardised, time-limited therapy by invoking his professional knowledge and expertise. He challenged the construction of therapy as both commodified time and a uniform, standardised and quantifiable activity. Drawing on his knowledge of working with "these people" – people with complex problems and long histories within the mental health system – Pat explained that therapy "just takes a while".

Charlotte, a clinical psychologist, also described and critiqued the workings of fiscal restraint and the principle of time-limited therapy that operated within her mental health service workplace. She again highlighted tension between these organising principles and her own knowledge and experience of therapy work. Charlotte described how her workplace managed client/patient "caseloads": "there's a huge pressure on caseloads and things, it's ridiculous the amount of caseloads people have got. So, yeah, pressure on time is massive, and not being able to establish that relationship". When I asked her where the pressure on time came from, she answered that it is a result of "caseloads": "So, you've got more and more cases coming in so there's kind of pressure to wrap cases up and finish them, you know, because you've got the pressure to pick up more and more and more people". Fiscal restraint within public services, and the goal of quickly discharging service users, stretches the capacities of workers. From a neoliberalist view, such stretching encourages greater efficiency and a more economical service. However, for Charlotte, as a therapist this model of therapy provision was "ridiculous" and meant subjecting workers to huge pressures. She identified the establishment of a "relationship" between therapist and client/patient as something that was sacrificed under the time-limited regime of her workplace. In doing so, she drew on a strong tradition of therapeutic discourse, which positions the relationship between therapist and client/patient as essential to the work

and benefits of therapy.[15] Her concern for the "relationship" within her therapy work displayed the cultural capital she accrued through her education and training as a therapist and again highlighted friction between the authority of this capital and the neoliberal discourses that have infiltrated the field of therapy.

As Charlotte, Frank and Pat described and commented on the imposition of standardised time-frames for therapy work within their services, they drew on, displayed, and reproduced a specific body of knowledge and series of statements – a discourse (Foucault, 1972) – about therapy: therapy needs to respond to individual needs and contexts; therapy can just take a while; therapy requires the establishment of a therapeutic relationship; and, implicitly, what therapy is and how it should be done is best defined by those with legitimate therapy expertise. These statements demonstrated Charlotte, Frank and Pat's command of a specific form of cultural capital, a "therapeutic capital", that they had obtained through their educational and professional credentials, their skills and knowledge of the therapy field, and their professional status. However, as the above discussion demonstrates, therapeutic capital did not have significant sway or currency to prevent the reorganisation of public therapy services and the institution of rationed, standardised and commodified therapy time. The following sections further explore the encroaching forces of neoliberalism within the therapy field and the changes wrought by these forces to the workplaces and practices of therapists. In turn, my discussion examines the struggle between different forms of capital for symbolic power within the field.

A market model of therapy: the ascendancy of "outcomes" and "outputs"

As detailed earlier, the reforms put in place by the Labour and National governments in the 1980s and 1990s were designed to bring market rationality and the practices and structures of the competitive business world into state operated and funded services. In their appraisal and analysis of the rise of the New Right in Aotearoa New Zealand in the 1980s and 1990s, Dolores Janiewski and Paul Morris declare that "efficiency, personal responsibility and accountability featured as the cardinal values of this market faith" (2005, p. 1). In 1989, before the end of their reign, the Labour

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[15] Carl Rogers, for instance, the widely acclaimed "father" of person-centred counselling and an important figure in the development of humanistic therapies, believed "that the therapist's primary effectiveness is through the therapeutic relationship" (Niolon, 1999).

government passed the Public Finance Act as an instrument for restructuring the public service along corporate business lines and institutionalising the values of efficiency, personal responsibility and accountability. With the passing of this Act, neoliberalism, as a form of cultural and economic capital, was legally consecrated. This involved conferring upon this "perspective an absolute, universal value, thus snatching it from a relativity that is by definition inherent in every point of view, as a view taken from a particular point in social space" (Bourdieu, 1989, p. 22). The consecration of neoliberalism as an absolute, universal value and its elevation to an "official discourse" (Bourdieu, 1989, p. 22) had the effect of transforming how public departments or Crown agencies obtained and accounted for public funding, moving away from an emphasis on *inputs*, "or the amount of money a department or Crown agency could secure, to identification of and accountability for *outputs*, or goods and services" (Kelsey, 1997, p. 142). Kelsey explains that:

> These outputs would form the basis for the department or agency's corporate plan, and its annual budget. Ministers would buy outputs from the state agency for a certain price to achieve the government's desired *outcomes*. An outcome was defined in the Act as "the impacts on, or the consequences for, the community of the outputs or activities of the Government". (p. 142)

The language of "outputs" and "outcomes" became integral within the public sector and intrinsic to how service providers conceptualised their activities, measured the value of these activities, and sought and accounted for state funding. It remains a governing doctrine today.

Throughout the 1990s and 2000s, therapists within public services, as evidenced by the participants in this study, have increasingly been subject to and required to engage with the outputs and outcomes model and to account for themselves and their work with clients in accordance with these terms. As it has been progressively colonised by the official and seemingly self-evident discourse and forces of neoliberalism, the field of therapy has shifted and transformed in ways that trouble many of the therapists in this study. These changes challenged the authority of therapists over the meaning of therapy, provoking criticism and opposition from my participants.

Several therapy practitioners described how the outcomes and accountability measures required within their workplaces imposed structures and forms of

engagement with clients/patients that were at odds with their own therapy practices and ideals. For instance, Alex, an educational psychologist working in the public sector, described "the whole thinking about outcomes" within his service as:

> "We set a goal here, we start here, we do that, we make it happen here", which is a very different philosophical way of coming at the world from seeing that what we do is construct our world through the world of language, things come into being in the way in which we talk, some things are much harder to bring into being than others, and so on. But, the belief that I alone can create those realities is very naïve in my opinion.

Alex critiqued the presumption that outcomes, designed and implemented by the practitioner, are reached through a linear, step-by-step process. He rejected as "naïve" the idea that the therapy practitioner can solely create the meaning of therapy work with clients, both in advance or outside of engagement with clients, and during therapy sessions. His critique drew on his command of therapeutic capital, particularly postmodern and social constructivist therapy ideas and approaches. These approaches informed his claim that we "construct our world through the world of language", rather than through rationalist systems built around simple cause-and-effect scenarios. Alex's words suggested a collaborative and negotiated approach in his work with clients, with appreciation for the simple fact "that some things are much harder to bring into being than others". This approach differed from the expert-led power relations implicit in his account of how the outcome model is institutionalised within his workplace. As a practitioner, Alex wanted to engage in therapy work on very different terms and with very different objectives from those that stemmed from neoliberal management approaches.

Alex talked further about how the outcomes approach functioned within his workplace:

> You know, the Ministry will say "of course it's never linear, blah, blah, blah". But actually, the way that they evaluate it and the way in which we are called to evaluate it in group-supervision is very linear. And to actually keep going, trying to go through this [the outcomes model], the way in which they've structured it, is so hard, to actually use that process.

Alex pointed out that the requirement to undertake therapy work that fitted within the government-directed, outcomes-focused model in place in his workplace – in addition

to being at odds with his approach to therapy work – was in practice "so hard" to actually do. Robin Gauld reinforces and contextualises Alex claim that the outcomes-focused processes within his workplace posed difficulties and were unwieldy. In his appraisal of the health reforms in Aotearoa New Zealand over the 1990s, Gauld questions the transferability of neoliberal methods to the arena of health care, "where outputs, outcomes, multiple objectives and motivations are particularly difficult to identify and measure with any accuracy" (2001, p. 51). Alex contended that therapy, like other health services, does not reduce simply to a linear process that is predictable and easily measured and documented. His critique of these neoliberal methods within his workplace highlighted conflicting and paradoxical meanings of neoliberalism: neoliberal discourse, as discussed earlier, is characterised by talk of "efficiency, personal responsibility and accountability" (Morris & Janiewski, 2005, p. 1), but, from Alex's point of view, neoliberal practices obfuscate the reality of therapy work, attempting to simplify the complexities of therapy and constrain therapists, in turn misrepresenting therapy and subjecting therapists to time-wasting and inappropriate processes.

The inherent difficulties involved in accurately identifying and measuring the outcomes of the activities of state operated and funded services have meant that many services have turned their attention to other, more easily measured indicators of productivity and value for state money. In her analysis of the introduction of the Public Finance Act (1989) in Aotearoa New Zealand, Jane Kelsey explains that, within the state sector, "outcomes were almost impossible to specify or measure with precision. That meant outputs, which commodified policy advice, regulation and service delivery, became the primary reference-point" (1997, p. 144). Throughout the state sector, including public therapy services, the demand for "measurable outcomes" has frequently been translated by services into a focus on outputs, which are much easier to measure but, in turn, increasingly commodify and simplify the services provided.

At the alcohol and drug service that Frank worked at during the mid 1990s, assessments became the measure of the service's outcomes and the focus of the work done by practitioners:

The thing is, of course, with a lot of therapeutic work it's very difficult to measure kind of outcomes. It's easy to measure outputs. So when I came to work at this place, the focus was very much on assessments, because that was something that you could measure, like you could measure how many assessments you'd done in a year, and like if the next year you did a hundred more then you could be deemed to be far more efficient and having a higher output and therefore you were meeting the main economic sort of framework, which that sort of system was based on. So there was this whole focus on assessments, but not much beyond.

Frank's description of this organisation's focus on assessments as the measurable output, or "good", produced by therapists illuminates two functions of neoliberal, managerialist technologies within the field of therapy. Firstly, the necessity to measure and quantify the "outputs" of therapy further reveals the operation of "calculative technologies" (MacKinnon, 2000, p. 298) within the therapy field. Instead of trusting therapists, endowed as they are with expertise, qualifications and professional opinions – their "therapeutic capital" – to deliver effective therapy services to the public, therapists are forced to "prove" their effectiveness in economistic, calculable terms. Assessments, in Frank's workplace, were the means by which the service could quantify and demonstrate its value – to prove that the practitioners at the service were doing *something*. Under this model, therapists are forced to operate under the logic of corporate business, providing appropriate figures and statistics to calculate and make visible their work.

Secondly, and in concert with this first function, Frank's words demonstrated how therapists within neoliberalised public services increasingly became subjects of new forms of surveillance and control. The necessity for therapists to "prove" their worth, and the methods of calculation and reporting required to fulfil these forms of accountability, can be seen as evidence of the workings of a "new panopticon" (Davies, 2003, p. 91). Bronwyn Davies, drawing on the work of Mary Schmelzer, explains that the old model of the panopticon, invented by Jeremy Bentham and theorised by Michel Foucault (1995), involved "(more or less) benign leaders who could rely on our own internalised gaze to monitor our own work" (Davies, 2003, p. 92). However, in new managerialist, neoliberal worksites "we have the multiplied

gaze of the workers on each other, their gaze shaped by the politics and practices emanating from management" (p. 92). Davies goes on to explain that:

> The multiplied gaze infiltrates and shapes the way work is understood. Little or no attention is paid to the actual effects on the work that this new panopticism might have, other than to monitor the meeting of institutional objectives. As long as objectives have been specified and strategies for their management and surveillance put in place, the nature of the work itself is of little relevance to anyone. (p. 92)

The management-imposed practice of collecting and collating the numbers of assessments performed by therapists at Frank's workplace, with therapists understanding that assessment rates were the measure of the service's, and their own, outcomes and worth, worked to normalise and regulate the activities of therapists – or, more accurately, worked to have therapists normalise and regulate themselves. While the original panopticon envisaged a visible architectural structure bringing about self-regulation, under the new panopticism of neoliberalised public services, workers can rank and compare themselves with each other and are all already aware of the agency's objectives and expectations, their multiplied gaze "finely tuned to the inflow and outflow of funding" (p. 91). The necessity to have "the numbers" for ongoing funding, coupled with the effect of the multiplied gaze of colleagues as each therapist's assessment numbers are recorded and compared from year to year, sets up a model for self-disciplining, self-regulating practitioners. Frank's appraisal of how assessment measuring functioned within his service also illustrates Davies' claims about the primacy of surveillance methods and management-determined objectives and strategies. As Frank detailed, "there was this whole focus on assessments, and not much beyond": meeting institutional objectives became the focus, and the reality of the work done by therapists, in all its complexity, was of little relevance to the organisation.

The reduction of therapy work into a primary focus on measurable, commodified activities, in relation to which therapists are compared and their worth calculated, again challenges the authority and expertise of many therapy professionals, particularly those with interests in postmodern and political therapy ideas. After detailing the importance of assessments as measureable outputs at his alcohol and drug service workplace, Frank critiqued this, pointing out that:

Hey, it might be nice to have assessments, but assessment doesn't really do anything for the person. It may give some indication of the nature and extent of their problems, and may give some indication of how they could be helped, but it doesn't go much beyond that.

According to Frank, what was being measured and regarded as the "good" produced by the alcohol and drug service was not actually of particular therapeutic value to the client/patient. Like Alex, through his criticism of the outcomes process, Frank saw neoliberalism as paradoxical: practices of measurement and calculation, as modern forms of surveillance, predicated on the goal of efficient, accountable public services, resulted in inefficiencies, as clients/patients did not actually receive useful therapeutic help. Managerialist understandings of therapy "work" and Frank's own understanding of this "work" differed markedly: Frank viewed effective therapy work as requiring more than just psychological assessments.

Both Frank and Alex's statements about the workings of outcome-focused processes and practices within their therapy service workplaces illustrated how business and management logic have come to play important roles in the structure and activities of public therapy organisations. Therapists' work, and workloads, as they struggle to fulfil the requirements of these organisations, have likewise been transformed. Workers are required to undertake various forms of reporting and monitoring of their activities and to feed into the service's measurement and catalogue of outcomes and outputs. Services are also subject to frequent review and restructuring: methods of surveillance are common features of this model of operations. In a discussion of neoliberal systems and their reporting mechanisms, Bronwyn Davies (2005) emphasises that these mechanisms are "very costly and devour an enormous proportion of shrinking funds, thus requiring an increase in the amount of work each worker is expected to do" (p. 10).

Many of the therapists included in this study remarked on the amount of work involved in processes of accountability, reporting, and outcome and output measurement. For instance, Ruth, a clinical psychologist working within a public hospital setting, explained that in her work, "there's an increased focus on justifying your presence through statistics and outputs and measuring effectiveness, so we've got to put a lot of work into that area as well". In order to fulfil institutional

requirements and, in many respects, to retain their jobs, therapists are required to "put a lot of work" into the area of administration, reporting, and outcome and output measuring – an area of work that has grown significantly over the last two decades. Ruth's example demonstrates the symbolic power of neoliberal discourse and forms of capital, which take shape in management strategies, statistical data and various forms of measuring tools. Therapists find themselves required to increase their knowledge and command of these practices in order to participate within the field of therapy and "justify their presence".

For many participants in this study, the demands of neoliberal, state-operated therapy institutions, and the consequent increased workload, conflicted with their professional identities as therapists. In interviews, many therapists described these demands as obstructing them from utilising their professional knowledge and skills – their "therapeutic capital" – making it difficult for them to do what they considered to be good and effective therapy work. Frances was a social worker and counsellor who worked for a community mental health service throughout the 1990s. She told me how she would frequently stay at work after 5pm "making therapeutic books for kids, those kinds of things". When I asked whether there was time for this kind of work within her working day, she responded quickly, saying:

> Oh absolutely not, no, no, no, no. No (laughs). It got to the point there where just keeping up with reporting and, um, written reporting and feeding statistics into the computers was rivalling the time you would spend face-to-face with clients. So putting considerable effort into things like therapeutic letters and therapeutic books for kids, no, no, no (laughs).

Frances' laughter and repeated utterances of "no" emphasised the idea that having dedicated time within work hours to write therapeutic letters or create books for kids was a farcical notion. She depicted a workplace where administration and recordkeeping were prioritised, while her knowledge and expertise as a therapist – the ability, for instance, to create therapeutic books and letters – were sidelined and comparatively less valuable.

Alex echoed Frances' description of her public sector therapy workplace. During our conversation, he talked about a meeting that he would be attending after the interview, and explained that, "if I actually tried to meet all the requirements of this organisation

I would not have time to do the kind of work that I need to do for this meeting to be successful". From these descriptions, it seems that organisational requirements, under managerialist, neoliberal, "business-like" public services, occupy so much of these therapists' time that actual therapy work can be sidelined and compromised. For postmodern therapy practitioners, restrictions on time and resources, stripped back and standardised therapy services, and the managerialist fixation with measurable outcomes and outputs conflicted with their therapy knowledge and expertise. Negotiating the neoliberalised therapy service involved struggle for these practitioners, as they tried to find ways to incorporate their knowledge – such as the value of therapeutic books and letters – into a system in which other forms of capital dominate.

Gap between management/policy makers and practitioners

> Management discourse enables people with no knowledge of the specifics of practice to have power over it.
>
> Andrew Brighton, "Management speak: A master discourse?"

The last two sections of this chapter have cited numerous criticisms from therapists about the entry of neoliberalism and the "market-model" into the therapy field. Repeatedly, therapists in this study, invoking their therapeutic capital and authority, critiqued "fiscally austere", "calculable", "efficient" and "accountable" policies and practices as being at odds with and obstructive to good, effective therapy work. These criticisms, while strongly expressed during the interviews, appeared to have little bearing on the organisation and structure of the therapy field: the therapists' complaints and points of debate referred to an order that, in many cases, was already instituted. Within these publicly provided therapy services, therapists' voices and their capital had little sway over the structure and activities of the organisations, echoing Bourdieu's observation that "speakers lacking the legitimate competence are *de facto* excluded from social domains in which competence is required, or condemned to silence" (as cited in Prosise, Miller & Mills, 1996, p. 124). The legitimate competence to define and organise the therapy field – and to *speak* on these matters – belonged, increasingly, to those with management and business skills and prowess. The capital possessed by these "players" in the field mostly "trumped" therapists' capital and wielded symbolic authority and dominance.

The legitimacy and symbolic power and authority accorded to management and business professionals within the therapy field, and the subordinate status of therapists' knowledge and skills, are consequences of government-led objectives to "neoliberalise" public services. Numerous commentators observed that the economic and social reforms of the late 1980s and the 1990s changed the nature of how state services were managed, with the elevation of business and corporate management knowledge and professionals. For example, when the National government reorganised hospitals into Crown Health Enterprises (CHEs) in 1993, boards of directors and chief executives were chosen for their managerial skills and few had any professional experience of health and disability issues (Kelsey, 1997, p. 121). Commenting on the health reforms of the 1990s, Robin Gauld explains that,

> in accordance with the heavy influence of managerialist thinking of the time, there was an attempt to replace "health" managers (those with experience in the sector) with "business managers, and to isolate health professionals and the health workforce from the decision-making arena. (2001, p. 90)

This shift in the sorts of people chosen to manage, structure and make decisions about public services is consistent with the operations of neoliberalism. Bronwyn Davies (citing Nikolas Rose) explains that "new managerialism" (the techniques of neoliberalism) "is characterised by the removal of the locus of power from the knowledge of practising professionals to auditors, policy-makers and statisticians, none of whom need know anything about the profession in question" (2003, p. 91). "Legitimate competence" to manage, structure and make decisions about public services has shifted away from professional practitioners and been bestowed upon business managers and those who both speak the language and uphold the objectives of neoliberalism. These changes stratify the therapy field, legitimising neoliberal forms of capital over therapeutic capital, a power arrangement that – as I have repeatedly emphasised –many therapists experienced as oppressive, begrudged and were frustrated by.

Several therapists detailed the workings and effects of this power arrangement within the therapy field. During our conversation, Alex, an educational psychologist, described an example of how policies and directives for therapists were created within his institution. He gave his perspective on a recent process where a new policy was

developed that was designed to direct practitioners' work with a particular client group:

> Um, that's come from the Ministry [the decision to institute the policy], they have co-opted some people from the field to be involved with that, that's been top down. We've been asked to implement that, and not only implement it but we have been told that certain practices will be required for that, which, in my view, not only cut across how creative we're able to be but also, um, there are ethical questions about what's happening which aren't even considered.

Alex described his perspective on the power relations that structure his work system and his own position within them. He depicted the "Ministry", made up of policy-makers, as having authority to command him to implement a policy that was at odds with his professional knowledge and judgement. The policy obstructed his ability to be "creative" in therapy work and conflicted with his understanding of the professional ethics in relation to therapy work. Alex's words conveyed suspicion and mistrust of the decision-makers within his workplace: people from the field were "co-opted", suggesting that their selection was partial and that, rather than representing genuine collaboration between practitioners and policy-makers, they were simply incorporated into the status quo model of decision-making.

When I asked Alex about the possibilities for giving feedback on the problems he perceived with the policy, he explained that, for the people devising the policy, "there's pressure on them to steer this project through within a time line to meet the demands that are being made on them", which meant there was little room for practitioner feedback. When "efficiency" and business-like operations are expected of public sector services, scarcity of time is likely a frequent phenomenon. In this instance, scarcity of time justified "top-down" decision-making, without the involvement of practitioners. Alex went on to critique this process of decision-making within his workplace, demonstrating a lack of trust in the skills and knowledge of managers and policy-makers:

> I mean anyone who's done any work around organisational change will know, a) it is really difficult to create that change within a couple of years, or in such a large group, and b) a top-down approach, like this, is doomed to failure. I mean the mind still boggles that they believe this process can work. And I suspect it's a

sort of power and control mentality, there is almost a group-think that "we are in control and we can manage systems in this way."

Again, Alex's words asserted his command of particular forms of cultural capital – his knowledge and experience of theories of organisational change. He used this capital to critique the knowledge of the policy-makers and their processes for instituting the new policy, declaring it to be "doomed to failure". Despite the authority of his critique, as an experienced, qualified and knowledgeable therapy practitioner, within the neoliberalised public therapy service Alex lacked legitimacy – "seventeen years [of working as a therapist]", he explained, "means absolutely nothing". In describing the operations of management and policy-makers as a "sort of power and control mentality", Alex implied that a rigid, autocratic model of power relations structured his work environment. He occupied a position that Bourdieu and Wacquant describe as the "dominated dominant" (1992, p. 81): despite his qualifications, status, knowledge and experience, and his membership in the professionalised middle class, in "the struggle for positions" (Swartz, 1996, p. 79) within the therapy field, Alex was dominated by those wielding more potent forms of capital – namely, bureaucratic and management credentials.

Frances echoed Alex's portrayal of the management and decision-making within public sector therapy services, describing oppressive power relations and a personal toll, for both therapists and clients/patients, of neoliberal management. As the community mental health service that she worked for over the 1990s and early 2000s was increasingly restructured and reorganised along the lines of a corporate business, Frances reached the conclusion that the new model of operations

> did not work very well for the clients, because it's not about them. It meets the organisation's needs. And the organisation's tasks are dictated by social policy and politics, you know, government funding, and none of that's got anything to do with the people who walk through the door. So they are fodder, just as are the workers in that system. Ever since we ceased to have a "personnel department" and gained a "human resources department", then workers ceased to be anything except something to be exploited or as a cost to be minimised. So they're a cost, a necessary cost, you know, rather than a valued and supported resource or asset. Um, and the clients are "volumes". So it's got nothing to do with them, it doesn't meet their needs very well at all.

Frances' appraisal of the workings of her workplace reinforces Davies' comment (quoted above) that under the new panopticism of neoliberal systems, "as long as objectives have been specified and strategies for their management and surveillance put in place, the nature of the work itself is of little relevance to anyone" (2003, p. 92). Frances perceived the complex, human dimension of therapy work – in terms of the experiences of both clients/patients and therapists – as being of little relevance when the system was focused on its own needs and operating along the lines of a competitive business. She drew on economic language to illustrate her perception that clients/patients and workers alike were dehumanised under the neoliberal management agendas of her workplace: therapists were a "human resource", a "necessary cost" to be "minimised", while clients/patients were seen simply as "volumes". Frances concluded that clients/patients and therapists were simply "fodder" within an impersonal, alienating and exploitative system.

Frances' description brings to life Harry Hall's (2004) warning that organisations that prize "standardisation" and "efficiency", and that focus on methods and instructions, rather than individuals, create,

> an environment where personal satisfaction and fulfilment are subsumed by the organization and clearly become secondary or even tertiary concerns. The impersonality brought on by the elevation of efficiency as the *sine qua non* of organizing, dehumanises the worker and dissociates him or her from colleagues. (p. 47)

The human "cost" of the impersonal, neoliberalised therapy service, as Hall warns and Frances proclaimed, is therapists who feel like they are simply fodder – dehumanised cogs in a machine that cares little for their needs or interests.

Conclusion

This chapter examines the profound and transformative impact that neoliberalism has had on the therapy field in Aotearoa New Zealand over the last twenty-five years. With the legal consecration of neoliberalism and its incorporation into state bureaucracy over the late 1980s and the 1990s, the discourse and capital of neoliberalism have taken on symbolic authority: "efficiency", "accountability" and "measurable outcomes" are seemingly benign and unarguable social "truths" comprising our "commonsense" understandings of organisational imperatives.

However, for many of the therapists in this study, the entry of neoliberal discourse and capital into the therapy field was not experienced as a benign or progressive development. Instead, it has provoked struggle and conflict within the field over the forms of knowledge that have authority and legitimacy. Swartz (1996), discussing Bourdieu, explains that:

> The struggle for position in fields opposes those who are able to exercise some degree of monopoly power over the definition and distribution of capital against those who attempt to usurp those advantages. In general, Bourdieu sees this opposition occurring between the established agents and the new arrivals in fields. (p. 79-80)

The chapter demonstrates the shift in the power arrangements of the therapy field in Aotearoa New Zealand, which has seen the weakening of professional power and a reduction in the value and currency of therapeutic capital. With the "new arrivals" into the therapy field from the worlds of corporate business and management, the balance of power shifted markedly, with neoliberal capital in many respects usurping therapeutic capital and being promoted to a position of authority and legitimacy.

This chapter has catalogued the impact that the proliferation and elevation of neoliberal capital has had on the meaning of therapy: therapy time has become a standardised, rationed commodity; therapy must produce measurable outcomes; therapy services should be organised and managed along the lines of a competitive business; and those with authority to *speak* about how therapy services should operate are largely managers, policy-makers and business people. Throughout the chapter, I have highlighted the contestation over these meanings of therapy, as postmodern therapy practitioners, invoking their own forms of capital, have vigorously critiqued the neoliberal practices and forms of knowledge that increasingly govern the therapy field. However, their representations of their experiences frequently involved dispossession, domination, alienation and frustration: their therapeutic capital lacked the requisite legitimacy to enable them to be involved in defining and determining the organisation of public therapy services. They occupied subordinate positions within workplaces structured by neoliberal principles, where new forms of surveillance worked to regulate their activities.

The power relations within the field of therapy, whereby fluency in, and command of, neoliberal forms of discursive capital accords bearers symbolic authority over the workings and activities of the field, are by no means an absolute or universal process. The authority and legitimacy of neoliberal capital fluctuates within different institutional settings, particularly in settings removed from the "heart" of the neoliberalised public service; while some practitioners included in this study were directly employed by public health or welfare services, others worked in the NGO sector, education services or private practice, where the force of neoliberal capital and discourse could perhaps be tempered. Therapists too, as later chapters of this thesis will discuss, attempted to resist, subvert and negotiate neoliberal forces within the therapy field. Power arrangements within the field were thus not total; nor were these the only struggles over legitimacy taking place, as the next chapter will illustrate. However, neoliberal discourse and capital are dominant, authorised forces that play a profound role in structuring the terrain of the therapy field in Aotearoa New Zealand. It is from within this field that the practitioners in this study were attempting to *do* postmodern-inspired, politically engaged therapy work – work that, as this chapter has demonstrated, was frequently constrained by neoliberal objectives and operations because of its perceived lack of currency and value.

6. Medicalised Therapy and the Fetish for Science

Reflection: Kate's year of counselling training, 2006

So the counselling approach they're teaching me is called "Solution-Focused." It's based on the idea that we construct ourselves and our world through language, and that traditionally the talk of therapy has been focused on problems – dissecting problems, labelling problems, measuring their effects, inquiring about their histories and origins, and, in the process, growing problems, making them big and turning them into "things" that exist inside people. Our lecturer explains that "problem-talk", even when there's a goal of alleviating the effects of problems, often leaves people feeling depressed and powerless, with little vision of life without these problems. So instead, they instruct us to focus our talk on solutions to problems, on clients' goals and desires, on the successes and achievements in their lives, and on the times in their lives that are free from the effects of the problems. As we do this, clients, rather than counsellors, are to be regarded as the experts in relation to problems and potential solutions and our job is to be curious and elicit their knowledge, expertise and ideas. We are to avoid dissecting problems, and are to steer conversations away from talk of deficiency or dysfunction on the part of our clients. This approach, they tell us, will make problems less oppressive, less big; will energise clients and make them aware of their abilities and agency; and will quickly – for this is "brief therapy" – bring about changes for clients. Through strategic use of language and a collaborative approach, we are to encourage clients to construct and experience a new view of themselves and their worlds.

And yet, for many of us, as we start to practise this method of therapy in various settings, it proves difficult to avoid both problem-talk and the expert-role. Many of us are required by our workplaces or placement agencies to rigorously appraise and label problems at the outset of therapy relationships with clients. One classmate complains to me about the multitude of tests that he must continually subject his clients to: appraising their intelligence, diagnosing any psychiatric disorders, cataloguing and evaluating the extent of their problems over time. The tests occupy all of the time in the first session and regularly reappear over the course of the

counselling, repeatedly directing his own and the client's attention to the anatomy of their problems. In my own workplace, where I introduce and practise these new counselling skills, my colleagues and I grapple with the conflict between the organisation's vision of an accessible, non-medical, feminist counselling and support service for people affected by food and body image issues, and the contractual requirement that we provide "treatment" to those individuals with "eating disorders". The terms of this contract position us as experts delivering "treatment" while our clients are subject to the classificatory system of the DSM-IV, a move that immediately emphasises their "problems" and labels them as pathological. The solution-focused, non-expert talk that we practise in class proves hard to speak and maintain within our workplaces, which seem perpetually interested in problems and to require the expertise of experts.

I'm left feeling angry at the disconnection between what I'm taught in the classroom and the reality of the workplace. My training feels naïve and overly idealistic, even though I mostly like the sound of it. Along with my anger, I find myself feeling inadequate and critical of the compromises that I have to make in my work. I want to open things up in my counselling work, have space for my clients to explore, define, and potentially redefine, their own meanings and values. And yet the requirements of those who fund us threaten to narrow the focus of my work with clients. I feel constrained, uncomfortable and troubled. I feel torn between what I'd like to be doing and what I'm supposed to be doing. And what I actually end up doing in my work with clients feels jumbled and uncertain.

Introduction

I begin with a reflection on the counselling training that I undertook in 2006 as a means of highlighting a paradox that will be explored more deeply within this chapter. Throughout Aotearoa New Zealand, there are numerous therapy-training programmes that teach trainee therapists critical and postmodern-inspired therapy modalities.[16] As discussed in Part Two, these modalities and approaches seek to

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[16] For instance, the University of Canterbury's M.Ed Certificate in Counselling teaches solution focused counselling; Massey University offers a Postgraduate Diploma in Discursive Therapies through its School of Psychology; Waikato University's Master's of Counselling degree includes narrative therapy and social constructionist perspectives on counselling; Unitec's Bachelor of Social Practice (Counselling) teaches narrative and collaborative approaches. The Clinical Psychology

resolve some of the problems of therapy by taking a de-pathologising approach, and contextualising and politicising the difficulties affecting individuals. They require therapists to be reflexive and constantly alert to the power relations of therapy. And yet, for students and proponents of these approaches – including my classmates and me, and the participants in this study – the realities of workplaces frequently confound and complicate our ambitions. The tasks required of us in our workplaces often seem to position us as scientific technicians: at various times, we may measure and examine clients/patients with the aid of psychological tests, apply or discuss psychiatric diagnoses, or determine appropriate categories for our clients/patients, ticking boxes as we do so. Like doctors, many therapists are instructed to provide "treatment" to people suffering from pathological disorders. Despite our ambitions and ideals, we are pulled into a system that frequently requires therapists to comply with medical and scientific methods for explaining, "treating", and managing the problems experienced by clients/patients.

This chapter will discuss how medical and scientific knowledges have come to wield symbolic authority within the therapy field and to have considerable impact on the work of therapists. These knowledges inform an official point of view within the arena of mental health in Aotearoa New Zealand; Pierre Bourdieu defines an "official point of view" as "that which is the point of view of officials and which is expressed in official discourse" (Bourdieu, 1989, p. 22). Bourdieu, drawing on Aaron Cicourel, explains that official discourse fulfils three functions:

> First, it performs a diagnostic, that is, an act of knowledge or cognition which begets recognition and which, quite often, tends to assert what a person or a thing is and what it is universally, for every possible person, thus objectively. It is, as Kafka clearly saw, an almost divine discourse which assigns everyone an identity. In the second place, administrative discourse says, through directives, orders, prescriptions, etc., what people have to do, given what they are. Thirdly, it says what people have actually done, as in authorized accounts such as police records. In each case, official discourse imposes a point of view, that of the institution. … This point of view is instituted as [the] legitimate point of view, that is, a point of

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programme at Auckland University also included critical psychology among its courses during the 1990s.

view that everyone has to recognize at least within the boundaries of a definite society. (p. 22)

Within therapy institutions in Aotearoa New Zealand the official point of view has become increasingly medicalised and "scientised". Medical and scientific knowledges and discourse have been made to fit the three functions of official discourse outlined by Bourdieu. As therapists like my classmate and me apply or discuss psychiatric diagnoses with clients/patients, we assume roles where we assert what a person *is*, assigning an officially recognised identity: an identity as someone who is mentally ill. The tests that my classmate administers and his catalogue of clients/patients' problems over time inform the "treatment" decisions permitted within his agency, determining what clients/patients have to do, "given what they are". And as we record information about clients/patients and our work with them, supplying this information to the official bodies that require it and adding it to our agencies' records, we produce authorized accounts of these individuals and the therapy work. Medical and scientific practices enable the classification, instruction and documentation of individuals, fulfilling the functions of official discourse and, in turn, facilitating the control and regulation of the population. These practices, as they comply with and reproduce official discourse, are "instituted as [the] legitimate point of view", seeming like the natural and inevitable requirements of official institutions.

The official discourse that structures the fields of therapy and mental health in Aotearoa New Zealand enshrines medical and scientific knowledges into the formal workings of the health and welfare systems. This chapter discusses the rise of these knowledges and the symbolic authority and legitimacy granted to things medical and "scientific" within therapy services that are subject to official discourse. I examine the implications of increasingly medicalised, "scientised" therapy services for postmodern therapy practitioners. Many of these practitioners have experienced the ascendancy of medical and scientific knowledges within therapy institutions as an aggressive takeover and an assault on their agency and autonomy as therapists. They have increasingly found themselves required to engage with psychiatric diagnoses and subject to the rhetoric of "evidence-based practice", despite their own critiques of these concepts. The rise and expansion of medical and scientific discourses within the therapy field coheres with and further cements the existing, officially sanctioned, occupational hierarchy. Among therapy practitioners, power relations are frequently

organised by an occupational hierarchy that privileges those practitioners who possess medical and scientific capital and credentials. Those without these forms of capital or appropriate credentials lack legitimacy and are granted less license in their therapy work. Medical and scientific knowledges and discourses both influence and organise the working lives of therapists. In turn, therapists, as my own account above and the following discussion reveals, have found themselves governed by and acting as agents for a medicalised, "scientised" official discourse. For these postmodern therapy practitioners, the institutional spaces of therapy were conflicted and complicated, and their necessary engagement with official discourse was a source of professional and personal struggle. These therapists, as the following chapters in my thesis will explore, were forced to negotiate these potentially oppressive and obstructive spaces and to develop various strategies of subversion, resistance and compromise.

Medical authority and the expansion of the "science" of therapy

The conflict outlined above – where students trained in postmodern therapy approaches find themselves compelled to test, measure and diagnose clients/patients – results from the expansion of the science of "mental health" within the field of therapy and from the authority within the field it has thus accrued. Within mental health services, psychiatry – operating within an illness framework – is the dominant discourse (Rogers and Pilgrim, 2005, p. 2) and plays a fundamental role in how therapy work is talked about, organised and practised. Over the last fifty years the anti-psychiatry movement has thrown "doubt on the validity of the concept of mental illness and the benevolence of psychiatric intervention" (Samson, 1995, p. 78; see also Masson, 1994; Szasz, 1961, 1970). As detailed in chapter 3, postmodern and poststructuralist thought has likewise been used rigorously to critique and problematise psychiatry (Fee, 2000, p. 4; see also Foucault, Martin, Gutman and Hutton, 1988; Foucault, 2001; Turner, 1997; Crowe, 2000). Ironically, as Colin Samson points out, at the same time that anti-psychiatry and postmodern perspectives have developed and taken shape,

> the psychiatric profession has marched on defiantly, and often oblivious to these critiques, with a "new biologism" in which biochemical, genetic and psychological causes of mental illness have become the predominant focus of treatment and research. For many mainstream psychiatrists a biological and scientific foundation is the *only* valid approach in psychiatry. (1995, pp. 78-79)

Postmodern theories and the claims of the anti-psychiatry movement have shaped entirely new bodies of knowledge about therapy and stimulated discussion and interest among therapists. Yet, as Samson asserts, they have had limited impact on mainstream psychiatry. Instead, the forms of knowledge that reign within the mental health sector are particularly concerned with the biology and psychology of individuals, and with the scientific practices and "discoveries" that illuminate the biological nature of "mental illness" and "provide the basis for the widespread use of medical interventions, in particular psychotropic drug use" (Ussher, 2000, p. 213; see also Rogers & Pilgrim, 2005, p. 2; Moncrieff, 2008). The "chemical imbalance" theory of psychiatric disorders, for example, which has been vigorously promoted by both the psychiatric profession and the pharmaceutical industry in recent decades, holds that "psychiatric disorders are caused by abnormalities of neurotransmitter chemicals in the brain … and that abnormalities of different neurotransmitters cause different psychiatric disorders" (Moncrieff, 2008, p. 242). This theory has gained widespread popularity, homing the focus of mental health science onto the brain chemistry of individuals and, concomitantly, promoting the use of pharmaceutical treatments.[17]

Psychiatry's dominance and command within mental health services, coupled with the "new biologism" of the late twentieth century, which continues unabated in the twenty-first century, privilege medical and scientific discourse and practices. "Science"[18] increasingly functions as a badge of authority and legitimacy within the arena of "mental health", and many professionals are therefore at pains to assert their

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[17] Likewise, the entry of the pharmaceutical industry into the field of sexology has seen the rise and dominance of sexuopharmaceutical research, which treats "sexual dysfunctions as asocial matters of physiology and bodily function" (Tiefer, 2000, p. 279), thereby justifying pharmaceutical interventions. In doing so, the complexities of the psychosocial context of sexuality are ignored (p. 278; see also Potts, 2002).

[18] My statements about "science" in this chapter, rather than referring to a total body of knowledge or a single entity, are concerned with a discourse of science that is spoken and invoked by officials and within the public discourse of psychiatry, psychology and "mental health". It refers to assertions about what constitutes "the scientific", "good science" and "scientific rigour". In many respects it coheres with Patti Lather's observation of how the United States federal government constructs "science" in respect to education:

The effort by the federal government to legislate scientific method is an attempt to muscle through a "fantasized normal science" toward improving educational practice. It is a kind of bullying that is grounded in the search for a normative philosophy of science that disallows the complexity and messiness of practice. (2005, pp. 13-14)

Similarly, the discourse of science discussed in this chapter is in many ways a "fantasized normal science" that offers an extremely simplified version of "science".

scientific prowess. Within clinical psychology training programmes, for instance, prospective practitioners are taught that their role is to be a "scientist-practitioner" (Barnett, 2004, p. 35); critics claim that this training model, as it is currently most commonly deployed, focuses predominantly on the scientist, rather than practitioner, role (p. 35). Glenn Larner, writing at the beginning of the twenty-first century, observed that the scientist-practitioner model has also become more dominant throughout psychology literature (2001, p. 36). Practising psychologists, as well as many other therapy professionals, are encouraged to conduct their therapy work from the position of a medical scientist. Accordingly, many therapy professionals, seeking to be aligned with psychiatry and identified as scientists, utilise medical and scientific terminology. Heather Barnett, reflecting on psychological research and practice, notes that terms such as "mental illness", "mental disorders", "conditions" and "psychopathology" incorporate "medical and clinical language [that] contributes to an allure of the scientific and contributes to the positioning of clinical psychology as a powerful and authoritative producer of knowledge" (2004, p. 32). While Barnett's comments specifically refer to clinical psychology, her analysis can be extended beyond this profession: the use of medical and clinical language produces an "allure of the scientific" and is a means by which practitioners can communicate authority and wield symbolic capital within medicalised therapy services.

As the above discussion demonstrates, scientific and medical knowledges play key organising roles within mental health services. These forms of knowledge impose particular frameworks and methods onto therapy work. Central to these frameworks and methods is a positivist version of science, which assumes "that universal 'truths' can be discovered through scientific empirical research" (Barnett, 2004, p. 23). The scientific methods for discovering "truths" about "mental illness" and its "treatment" "mimic those adopted in the natural sciences" (Ussher, 2000, p. 209), including the homogeneous use of the hypothetico-deductive model, and an emphasis on objectivity, reliability, and research replicability (p. 209). Quantitative methods are typically favoured by this version of science (Barnett, 2004, p. 23). The application of these methods represent "good", rigorous, incontrovertible science. And, in turn, these "truths" and forms of "evidence" are used to instruct the practices of therapists within the mental health sector. Glenn Larner explains that "what is to count as knowledge in psychology and efficacious in therapy is established solely through controlled

scientific experiment or clinical trial methodology" (2001, p. 36). Science, in particular a positivist form of science, is positioned as an authorised and authoritative discourse and form of knowledge within the medicalised mental health sector. It instructs therapy practitioners in particular ways and defines what is credible, legitimate therapy work: that which utilises positivist scientific methods and is based on sound scientific evidence.

The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) (American Psychiatric Association, 1994), currently in its fourth edition, is a key instrument of mental health science and plays a major structuring role within both mental health services and the wider field of therapy work. Its continual refinement is a further expression of "the renewed vigour with which the 'new biologism' is being pursued" (Samson, 1995, p. 79). The *DSM* imposes much of the official language for conceptualising, talking about, and responding to the difficulties experienced by individuals who present at therapy services. The illness model of psychiatry – with its concern for the causes and treatment of "mental illness" – and the attendant positivist project to discover, through good science, universal truths about mental illnesses, "precipitated the desire to establish 'consensus definitions' of mental health problems" (Ussher, 2000, p. 210). The *DSM* represents the coalescence of consensus among psychiatric and psychological experts on definitions of mental health problems. It assembles and organises authoritative scientific knowledge about mental illnesses into a classificatory system of psychiatric diagnoses. Particular forms and features of mental illness are classified as "discrete, consistent, and homogeneous clinical entities, which further have an identifiable etiology, and *cause* the symptoms that women [and men and children] report" (Ussher, 2000, p. 210). By applying the manual, practitioners – acting as scientists – can observe, measure and define the specific pathology of their clients/patients, and, following this, determine appropriate treatment. The methods of positivist science and the premise that psychological distress or problems experienced by individuals can (and should) be understood through the application of a system of psychiatric diagnoses make up much of the knowledge that counts within mental health services. This knowledge, as this chapter will discuss in detail, exerts dominance within the wider field of therapy work, and constitutes the normative system within and against which postmodern therapy practitioners negotiate their practice.

The dominance and authority of psychiatry within mental health services is not a new phenomenon. However, with the rise of the new biologism over the last twenty years, and the expansion of mental health science through such instruments as the *DSM* and the practice of psychiatric diagnosis, biomedical and scientific knowledges have assumed even greater prominence within these services and in society generally (see Moncrieff, 2008, p. 235). Further, the ascent of these forms of knowledge is closely tied to and aided by the rise of neoliberalism: the "scientisation" of therapy work complements a neoliberal agenda. The neoliberal reforms that occurred in Aotearoa New Zealand in the late 1980s and the 1990s echoed similar reformist activities throughout the western world: fiscal restraint, privatisation, the retraction of state services, and the commodification and corporatisation of remaining services have become state agendas in many countries (Harvey, 2005). As they have pursued these agendas within public sector therapy and mental health services, many government agencies and policy makers have invoked and utilised mental health science, elevating its authority. Heather Barnett, commenting on how the *DSM* functions as an authoritative instrument within the mental health arena, notes that "DSM classifications are increasingly required to source government funding" (2004, p. 33). Diagnosis enables workers within publicly funded services to identify those individuals who are suffering from bona fide psychiatric "illnesses", and those who are not, ensuring that services can be gate-kept and that state funding is not spent unnecessarily. The authoritative taxonomy of mental illnesses serves a dual function – as a scientific tool enabling practitioners to identify pathology and categorise "mentally ill" individuals, and as an instrument of economic rationalisation.

Neoliberal agendas combine with the positivist science that dominates mental health in further ways, institutionalising specific approaches and practices within public therapy services. Rogers and Pilgrim (2005), in relation to mental health, observe that "(t)he rising popularity of 'evidence-based practice' (EBP) is linked to the imperatives of health policy makers to control service costs" (p. 158); what counts as evidence, under this model, in line with the assumptions of the science of mental health, is primarily discovered through positivist research methods. Neoliberal governments, with their interests in "measurable outcomes" and value-for-money (see chapter 5), encourage practitioners to utilise those therapy approaches that have been

scientifically "proven" to be efficacious.[19] As a consequence of government demands for evidence-based practices, cognitive behaviour therapy (CBT), which has become "synonymous with 'empirically validated treatments', 'evidence-based practice' and 'best practice'" (Barnett, 2004, p. 42), now dominates as "the" therapy approach within mental health services (p. 42). Barnett explains that, in part,

> CBT's rise in popularity has occurred as the [clinical psychology] profession has responded to a progressively restrictive political and economic environment internationally. The provision of short term and inexpensive psychological services is preferred when government agencies and third party payers dictate the conditions of health funding. (2004, p. 42)

Therapy approaches within publicly provided services are increasingly dictated by both the demand for "reputable" – i.e. scientifically validated – evidence, and therefore the promise of efficacy, and the requirement that they be as inexpensive as possible; conveniently, both these factors are features of CBT practices. Those therapies that lack a scientific evidence-base, and/or are not easily rationed and made cost-effective, lack legitimacy within neoliberalised therapy services.

This somewhat lengthy – albeit significantly condensed – background discussion to the issues raised within this chapter details the status of medicine and science within the specific arena of mental health services, demonstrating the dominance of these species of knowledge and the discourses that are linked to them. As chapter 3 detailed, postmodern-inspired critics and therapists see medical and scientific models and explanations of mental health as installing a particular model of power relations between therapist and client/patient. From this perspective, through the application and utilisation of psychiatric diagnoses, practitioners both display rarefied knowledge, taking up an expert role, and become arbiters of normality as opposed to abnormality – as clients/patients are informed about appropriate forms of behaviour and thinking. Clients/patients' self-knowledge, explanations and understandings of the issues affecting them are subordinated by the expert authority of the practitioner. In viewing the problems of clients/patients as "discrete, consistent, and homogeneous clinical entities" (Ussher, 2000, p. 210), the social and discursive contexts of individuals'

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[19] "Proving" the efficacy and validity of therapy approaches through the application of positivist, quantitative methods – the randomised control trial (RCT) representing "the 'gold standard' of EBP" (Rogers & Pilgrim, 2005, p. 158) – necessarily favours those therapies that are able to conform to the highly specific demands of such a research process.

lives are excluded, and the political meanings of their distress – such as issues of gender, class, sexuality and race – are ignored; the individual's flawed and faulty body, brain and person are deemed to be the cause of their problems and the object of treatment. These are precisely the power relations between therapist and client/patient that the postmodern therapy practitioners in this study sought to subvert. The increasingly medicalised and scientised terrain of therapy therefore complicated and obstructed their goals for their therapy practice.

The medical "takeover" of public therapy services in Aotearoa New Zealand: *"The* DSM *was in"*

The previous section detailed the increased authority and command that scientific and medical knowledge have come to enjoy within mental health services over the last twenty-five years, as consequences both of the new biologism and consequent expansion of mental health science, and of the imperatives of neoliberalism. This section examines this shift in the currency and status of forms of knowledge from the perspectives of postmodern therapy practitioners. Their descriptions ground the above discussion in a specific context, demonstrating how medical and scientific knowledges became increasingly powerful and commanding over the 1990s in public therapy institutions in Aoteaora New Zealand. From their vantage as self-identified postmodern therapy practitioners, they reveal their understandings of the meaning of these changes and the implications for their therapy work. Their descriptions reveal the workings and their own negotiations of particular forms of power relations within the field of therapy, especially within public services. These power relations involve the subordination of the practitioners' own forms of knowledge and capital – their knowledge of postmodern therapy ideas, social networks, training, credentials, and their professional language – while medical and scientific knowledge have increasingly been given official status. For these practitioners, the installation of medicalised and scientific approaches to therapy work within public services during the 1990s represented a hostile "takeover" and an assault on their professional identities.

Many of the therapists interviewed for this study who were doing therapy work throughout the late 1980s and the 1990s encountered the increasing authority of medical and, more specifically, psychiatric models and discourses within public

therapy services during this period. Their narratives described how medical and scientific discourses extended their reach within therapy services, and profoundly changed the nature of their therapy work. Kerry, for instance, was a social worker and counsellor who worked for a child and family therapy service provided by the local Area Health Board. In the early 1990s this service underwent a radical transformation. As we talked, Kerry explained how she had become very interested in narrative therapy ideas during this same time, so I asked her how these ideas were received within her work environment:

> Once again, a small number of people were very enthusiastic. And some people were very hostile, particularly the people who were psychologically trained by and large. Not all of them, but some of the psychiatrically and psychologically trained people. And this was as the move towards the greater use of the *DSM* was happening. And in actual fact that's, there was a coup really, and, so *DSM* was in. We had to diagnose all the children. And that's when I left.

Kerry detailed a professional and philosophical division within this workplace between a small group of practitioners interested in narrative therapy ideas, and those who were psychiatrically and psychologically trained (although she stresses that these demarcations were not absolute). With the introduction of the *DSM* and the requirement that children using the service be "diagnosed", the possibility for conversation about and consideration of differing therapy ideas among colleagues was significantly impeded: a "coup" had been staged in the interests of psychiatric and scientific constructs and frameworks for therapy.

The introduction of psychiatric diagnoses for children marked a change in the power relations that operated within Kerry's workplace; psychiatric knowledge and expertise now significantly directed her practice, which challenged the very tenets and ambitions of Kerry's narrative therapy ideas. Kerry explained:

> That was the final straw for me. And the power bloc had moved so that I could see that this was one battle we weren't going to win there, basically. And the whole thing was sweeping right through the DHB [*sic*] as well. Other organisations like us went totally that way – counselling became very much a part of the mental health rather than family therapy places, when previously they had been outside the mental health system.

Kerry lacked the requisite and legitimate capital to oppose or influence the institutionalisation of the *DSM*. The warfare metaphors utilised in Kerry's talk – "battle", "win", "coup" – coupled with the depiction of health sector managers and decision-makers as a "power bloc", conveyed an image of adversarial, all-powerful forces, "sweeping through" and radically changing the sector. The requirement that clients/patients be given psychiatric diagnoses transformed community and family therapy services into specialist "mental health" services, a move that led Kerry to leave her job: medicalised therapy work was not something she could reconcile with her postmodern, critical therapy interests.

The increasing authority of medical and scientific knowledges over the activities and objectives of therapy work within public services in the 1990s was similarly perceived by other therapy practitioners as a hostile and antagonistic "takeover": the shift in power relations within the public therapy sector challenged the values and ideals of postmodern therapy practitioners. Frances was a social worker and counsellor who worked for much of the 1990s and some of the 2000s for a therapy service provided by the regional health body.[20] Initially, this therapy service operated under the mantle of "primary health" and provided accessible counselling and group programmes, responding, according to Frances, to "the needs of the community". As the 1990s progressed, Frances explained, the health reforms meant the service came "under threat". As we sat in a café, she catalogued the impact that the health reforms and the reorganisation of public therapy services had on the service, using the muffin she was eating to demonstrate:

> Frances: You know, what's been happening is that – and I'll use my muffin for example [cuts up parts of her muffin to demonstrate] – is, um, if you take away primary health out of this, it's a big chunk isn't it?
> Kate: Mmm.
> Frances: And then we're in mental health, otherwise the service would have disappeared altogether, so that was a sensible sort of decision. And then over time it shifts and you get to a point where counselling has to come out of the name [of

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[20] The regional health body operated under various names and structures during Frances's time working for this therapy service. The various entities responsible for the provision of health and disability services within a specific region have included the following: AHB – Area Health Board (1983-1993); CHE – Crown Health Enterprise (1993-1997); RHA – Regional Health Authority (1993-1997); HHS – Hospital and Health Service (1997-2001); HFA – Health Funding Authority (1997-2001); DHB – District Health Board (2001-). (Gauld, 2001).

the service], and from this point diagnosis is really important. And in both those instances, um, you know, we were told that the changes were just what we needed to do in order to be able to keep doing what we were doing, but in fact that wasn't a very honest way of selling it. So from here, there has to be an Axis I diagnosis. … Um, but a little bit gets chopped off here [demonstrates with her muffin], chopped off there, and self-referrals are gone.

Kate: Oh okay.

Frances: They would have gone there if they hadn't gone before [gestures to a part of her muffin that has been discarded]. And, um, quite a lot's gone really. Now they're so dependent on, um, there's such a focus in mental health on Axis I diagnoses and treatment of disorders that I don't know what's happened to counselling in here [gestures to muffin] [laughs]. I don't know how much it still exists.

Frances's shrinking, carved up muffin was reduced to an unappetising scrap. Her narrative of the effects the health reforms had on her workplace – with the visual aid of the muffin – literally depicted a retraction and destruction of the social spaces of therapy, the activities of therapists, and the types of people able to access therapy services. The service shifted from being accessible and self-consciously positioned as responsive "to the needs of the community", to being a medical, "mental health" service, governed by the psychiatric construct "Axis I diagnosis",[21] and oriented towards the "treatment of disorders" – in keeping with both the scientisation of mental health discussed in the previous section and the accompanying neoliberal agendas. The process of transformation, from Frances's account, was presented as simply a matter of course – what was needed for therapists to keep doing what they were doing.

The agency's name change and re-organisation, however, were neither benign nor simply a matter of semantics. They signalled the ascent, legitimation and authority of medical science within the field of therapy. Clients'/patients' problems became psychiatric disorders through the compulsory application of *DSM-IV* diagnoses. Therapists were required to "treat" these disorders, an activity that Frances distinguished from counselling; in fact, counselling and activities outside of

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[21] The *DSM-IV* organises each psychiatric diagnosis into levels or axes. Axis 1 encompasses clinical disorders, including major mental disorders, as well as developmental and learning disorders.

medicalised treatment for psychiatric diagnoses were carved and sliced out and left with little role in her workplace. Frances pointed to a dramatic and sudden shift in the currency and legitimacy of particular forms of knowledge as she detailed the impact the health reforms had on professional therapy practices during the 1990s. Her knowledge and expertise – as a social worker with narrative therapy interests – were increasingly stifled and restrained as the scientific methods and approaches of psychiatry became the reigning knowledge form; with each cut to her service, Frances's therapy practices were curtailed. The space of her therapy work, structured by medical referrals, Axis I diagnoses, and the treatment of disorders, shrank – becoming an unappetising scrap – as did her own agency and autonomy as a practitioner.

Kerry and Frances's narratives described a concerted attack on public therapy services throughout the 1990s, which reorganised and redefined the power relations within these social spaces: "coups" were staged and the "power bloc" enacted changes with both force and duplicity, carving up therapy services. While their interests in narrative ideas, as Kerry pointed out, may have been shared by only a small number of colleagues, and no doubt provoked debate, before the 1993 health reforms, public therapy services offered a degree of space to these ideas and license to their practitioners. However, as the *DSM* "swept through" public therapy services this open space was severely retracted and practitioners' freedoms curtailed. The institutionalisation of the *DSM*, and its attendant psychiatric practices, were experienced by Kerry and Frances as an assault on their professional knowledge and expertise; so antithetical to Kerry's professional identity was the prospect of diagnosing psychiatric disorders in children that she resigned from her job. Tangible, verifiable and uniform scientific methods were given official status and accorded legitimacy, while individualised counselling, oriented by curious questions and an openness to the discovery of "unique outcomes" (White & Epston, 1990), played little part in the official activities of these mental health services. With the ascendancy of medical and scientific knowledge within public therapy institutions, and their incorporation into official discourse, the terrain of the field of therapy in Aotearoa New Zealand was sharply altered. Engagement with scientific and medical practices was required of therapists – complementing the cost-cutting agendas of the neoliberal

government – despite the reservations of postmodern therapy practitioners like Kerry and Frances.

Diagnosis and the illness model as official discourse: "business as usual"

For therapy practitioners working within specific mental health services, and within many other publicly provided therapy agencies, biomedical and psychiatric approaches to, and explanations for, the problems experienced by clients/patients have become part of the status quo operations of their workplaces. The rise of medicine and science that Kerry and Frances witnessed in the mid-1990s – as the *DSM* "swept through" health services – resulted in medicalised and scientised public therapy services. Medical and scientific approaches, as discussed in the opening to this chapter, are utilised by official institutions to fulfil the three functions of official discourse: performing a diagnostic and asserting what a person *is*; directing people in what they have to do, given what they *are*; and producing authorised accounts of what people have actually done (Bourdieu, 1989, p. 22). Psychiatric diagnosis, and its accompanying practices, greatly – and conveniently – aid the aims of official discourse within public therapy services in Aotearoa New Zealand. These practices organise and manage people in ways that enable the continued exercise of official bureaucracy and an "official point of view".

Frank illustrated how the compulsory practice of diagnosis within his therapy workplace forced him to comply with and impose an official point of view. Reflecting on his role as a counsellor at an alcohol and drug service in the 1990s, Frank described how he was required to formally assess clients/patients before offering them "treatment". The assessment was

> to find out how many of the seven criteria they meet for alcohol addiction, or opiate addiction, whatever it may be. And you also assess for all the psychiatric disorders as well. So, are there issues of social phobia? Depression? Whatever it may be.

In each of these interactions with his clients/patients, Frank was required to reiterate the idea that "mental illness" is a "thing" and to reinforce the presumption that diagnosis could faithfully discover and capture the nature of his clients' problems and

lead to and direct their treatment. He explained that, following assessment in these areas, practitioners

> determine what's actually the problem for this person. They may have alcohol dependence or whatever, depression, etc. And then they determine how this person should be treated and maybe come up with a plan, which could be to stop drinking, maybe to see a psychiatrist for a medical consultation, maybe medication for depression. Could they do that maybe with outpatient support? Or maybe they need to detox? Or maybe they need to go to a treatment centre? And then they're sent off there.

Through the official process of identity discovery and assignation – "depressed", "alcohol dependent", "socially phobic" – therapists determine "what people have to do, given what they are". Therapy practitioners at Frank's workplace appraised and determined the needs of clients/patients and, following the prescribed institutional pathways, directed them to appropriate services. As Frank engaged in the required processes of this institution, undertaking the practices of assessment and diagnosis, he produced authorised accounts of the outcomes of these practices and his own actions and directives. Therapists' notes, reports and other documents were shared with colleagues, fed into the health system's collection of data, and followed clients/patients as they moved through and out of services. The official discourse that governs Aotearoa New Zealand's public therapy institutions draws heavily on biomedical and psychiatric knowledges. Therapy practitioners working within these institutions are positioned as agents for this official point of view, which requires them to bestow identity; give directives, orders and prescriptions; and produce authorised accounts in biomedical and psychiatric terms.

Bourdieu explains that official discourse imposes the point of view of the institution: "This point of view is instituted as [the] legitimate point of view, that is, a point of view that everyone has to recognise at least within the boundaries of a definite society" (1989, p. 22). The legitimacy and validity of a medicalised and scientised official discourse is seen in the official dictates of Aotearoa New Zealand's mental health system: namely, that in order to gain access to clinical mental health services, "consumer(s) should have, or be suspected of having, a moderate to severe mental illness" (Midcentral District Health Board, n.d.; see also Ministry of Health, 1997). The psychiatric concept of "mental illness", determined through psychiatric methods

of assessment and diagnosis, is imbued with legitimacy and validity within the health system. Jo, a clinical psychologist working for a mental health service provided by the local DHB, detailed the workings of the official point of view in relation to clients/patients: "to not have a diagnosis is to not come here [to the service]". Clients/patients whose problems are undocumented and without psychiatric recognition, or fail to meet diagnostic criteria, are denied official recognition. The official, legitimate point of view therefore renders invisible and illegitimate such clients/patients. Without an identity as someone who is psychiatrically ill, the mental health system, and many other publicly provided therapy services, are inaccessible to potential clients/patients. Therapists become implicated in the task of bestowing and denying this identity.

The official point of view constrained and confined many of the therapists in this study, especially those working within officially governed therapy institutions: it clashed both with their professional knowledge bases and with their preferred approaches to therapy work. Pat, who worked as a clinical psychologist for a DHB mental health service, voiced numerous criticisms of the practice of psychiatric diagnosis, pointing out, for instance, that "the *DSM* is so inclusive that most people could diagnose themselves with at least one or two things". Yet, Pat explained, outright opposition to diagnosis is untenable:

> I could take a position in the system, "diagnoses are bad, I refuse to use them, I'm not going to use them", and I wouldn't survive in the system very long, and so I'd be somewhere else doing something else.

The mental health system required Pat's engagement with and reproduction of psychiatric diagnoses, despite his grounding in a knowledge system that critiques the very foundations of the scientific model; this model of operations had simply become part of the order of things.

The ubiquity of psychiatric practices within public therapy services and their sanction by officials provoked discomfort and turmoil for postmodern therapist practitioners, as their professional knowledge clashed with the official point of view. Sara, a social worker and counsellor working for a youth service operated by the local DHB, described the conflict she experienced over the issue of diagnosis in her work with young people: "in the course of my work I have to provide assessments. I have to

provide a diagnosis. Which is totally anti narrative [therapy] and totally anti postmodern approaches". Narrative therapy critiques the internalising, objectifying, expert-defined practices of traditional therapies. Recognising the complicity of therapies with dominant culture, narrative therapy proponent Michael White declares, "I think we should make it our business to ensure that we are not so" (White, 1995, p. 45). When Sara began training in narrative therapy and focusing her attention on how she could avoid being complicit with dominant culture in her therapy work, the act of diagnosing became an experience of conflict: "I'd sit down to write my diagnosis and I'd be like 'oh, I just don't know if I can do this. It's too much of a conflict of interest.'". The model of operations within public therapy services impedes and complicates the aspirations of postmodern therapy practitioners, drawing them into a "conflict of interest". Those therapists who worked within public services, but even those in private practice or working for NGO services, as the following chapters will explore, were forced to negotiate, through compromise, accommodation and acts of resistance, the official discourse that structures therapy practices in Aotearoa New Zealand

Kerry abandoned public sector therapy work in the early 1990s because she refused to diagnose children with mental illness. She explained this decision by saying, "I opted, in the end, to work privately because I could then work freely the way I wanted to work". Kerry assumed that private practice would allow therapists freedom from the constraints of officially governed institutions and the ability to do therapy work in accordance with their own preferences and ideals. However, the currency and authority of biomedical and psychiatric knowledge has even infiltrated the realm of private therapy practice. A portion of many private therapy practitioners' therapy work involved working with clients/patients whose sessions are funded through the Accident Compensation Corporation (ACC). The state-operated ACC allows a "sensitive claim" to be lodged when "a mental injury is caused by certain criminal acts", which comprise forms of sexual abuse and sexual assault (ACC, 2009). If a claim is accepted, ACC provides funding for claimants to engage with an approved therapist for therapy work that focuses on "rehabilitation" from the "mental injury" (ACC, n.d.). By providing ACC funded therapy work, Kerry, an experienced and qualified therapist, again confronted the medicalised "official discourse":

Initially there was no pressure in the ACC work to diagnose. And that has been one of the ongoing struggles for me, that the legislation has moved towards mental disorders. But it [the effects of sexual abuse] certainly is not a mental disorder.

Kerry, an experienced and qualified therapist, was fundamentally opposed to psychiatric explanations and descriptions of the effects of sexual abuse. However, the official point of view, enshrined and actioned through legislation, has moved increasingly in the direction of the psychiatric model.

Kerry went on to detail the "ongoing struggle" that she experienced as she interacted with and reported to ACC:

They [ACC] say that it doesn't have to be a diagnosis, you can, you know, describe it [the effects of the abuse] in the manner in which you were trained, but when I have done that in purely narrative [therapy] terms, every single time they send it back wanting a diagnosis.

Even in private practice, Kerry could not escape entanglement with official discourse. Despite the seeming "freedom" offered by private therapy practice in Aotearoa New Zealand, medical and scientific discourses exercise their command, obstructing postmodern, critical practitioners' philosophical and political approaches to both therapy work and the problems experienced by their clients/patients.[22] Kerry's experience highlights how narrative therapy lacks the requisite authority to be accepted as legitimate and valid by ACC; its terminology and non-diagnostic approach do not meet required standards. Kerry's knowledge and expertise, and her professional standing were invalidated by this official discourse. She was required to comply with the official point of view, or deny clients/patients ACC-funded therapy services and not get paid herself.

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[22] A postscript on ACC: In October 2009, subsequent to the interviews included in this study, ACC's Sensitive Claims procedures, requirements and provisions were amended to conform more rigidly with psychiatric practices. ACC now specifies that "mental injuries" "must meet the criteria outlined in 'The Diagnostic and Statistical Manual (DSM-IV™) of the American Psychiatric Association' in order to be eligible for ACC cover" (ACC, 2009). Counsellors and other practitioners who are not authorised to determine *DSM-IV* diagnoses can now no longer solely verify the injurious impact of incidents of sexual abuse or assault. Instead, claimants must undergo psychological assessment by appropriately qualified professionals in the process of making a claim.

In response to complaints and concerns raised by ACC counsellors and claimants about these changes, an amendment was made in August 2010: "people with a new ACC sensitive claim, or with a new claim already in the system but awaiting a decision, are able to access up to 16 hours with a counsellor, to ensure their safety and wellbeing" (ACC, 2012).

"Show us the evidence"

The hegemony of "evidence based practice" works to subordinate further the postmodern and critical therapy ideas of the practitioners in this study. Martyn Hammersley comments on the spread of the evidence-based practice movement across many disciplines over the 1990s and on the rhetorical power of its slogan: "After all, who would argue that practice should not be based on evidence?" (2001, para. 2). However, the seemingly commonsensical and uncontestable appeal for evidence-based therapy practice involves the predominant use of evidence that is discovered through positivist research methods. This "good science" has currency and authority among both the mental health sector and government funding bodies in Aotearoa New Zealand. Postmodern practitioners' therapy ideas and practices, and their professional experience lack validity, under current formulations of what counts as reputable evidence. Danny, a psychiatrist working within a community mental health service, was interested in and utilised narrative therapy approaches in his therapy work. However, he explained that one of the "stumbling blocks" for narrative therapy has been "that there hasn't been a sense of urgency about getting an evidence base, or the evidence base is seen as being a qualitative evidence base". He gave voice to the official questioning of narrative therapy within the mental health system: "it's a nice idea, but is there evidence to show that it makes a difference?" The importance of sanctioned, recognised evidence within the mental health system is indicated by his observation that "the Ministry of Health have poured lots of money into programmes that have evidence bases". Officially recognised evidence functions as a form of currency, both symbolically and in a very real economic sense in respect of state funding.

As Danny and I discussed the absence of a recognised evidence base for narrative therapy, he acknowledged the deliberateness of this strategy, explaining that it is in keeping with "Michael [White] and David's [Epston] idea of being anti-institutional or renegade." Narrative therapy, as discussed in chapter 3, has reacted against the positivist and medical methods of traditional psychological therapies and is self-consciously at odds with narrow, solely quantitative forms of evidence. As a "renegade" therapy, however, without reputable scientific evidence to justify its worth, the value and usefulness of narrative therapy are rendered invisible by the official discourse of the mental health sector. As a psychiatrist who was interested in

narrative therapy but working within the mental health sector, Danny recognised that scientific knowledge and discourse structure the sector and influence the activities and practices of therapists. The refusal and inability of many narrative therapy proponents and researchers to "play the science game" and conduct "sound" quantitative – rather than qualitative – research invalidates their therapy approach within the official mental health environment. Without reputable scientific evidence to base their therapy preferences on, postmodern, critical therapists are positioned as illegitimate within the official discourse of their work environments.

Numerous scholars have drawn links between the proliferation of the rhetoric of "evidence-based practice" and neoliberal, managerialist agendas for the public sector (Davies, 2003; Hammersley, 2001; Trinder, 2000). Under managerialist modes of operation, as detailed in the previous chapter, therapy practitioners' knowledge and expertise wield limited power over the organisation and management of services. Managers and policy-makers, instead, tend to make management decisions and increasingly direct the activities of therapists. The evidence-based practice model similarly usurps the professional knowledge and experience of therapists. Hammersley explains how research evidence is privileged over professional experience when evidence-based practice dominates a professional arena:

> The idea that research can make a major contribution to improving practice stems from the assumption that it is systematic and rigorous, and provides explicit evidence which can be assessed objectively. This is held to contrast with evidence from professional experience, which is portrayed as unsystematic – reflecting the particular cases with which a practitioner has happened to come into contact – and as lacking in rigour – in that it is not built up in an explicit, methodical way but rather through an at least partially unreflective process of sedimentation. (2001, para. 5)

Within many contemporary disciplines and institutions, evidence discovered through adherence to the principles of objectivity and verifiability, and to the expectation that research be systematic and rigorous, is deemed superior to the observations and experiences of professionals themselves. Professionals lack the authority and reliability of the findings of a reputable scientific research project.

Alex, an educational psychologist, demonstrated the potency of scientific accounts of evidence and the illegitimacy of professional experience within the field of therapy work in Aotearoa New Zealand. He told me how he had written to a key manager within his service "around the issues to do with evidence and outcomes", raising the idea of professional "intuition" as a source of valid evidence:

> He did at least entertain a few flurries of emails and then just said "no" [laughs], "you're wrong. This is the way it is". And he was very disparaging about the whole idea of intuition. I wasn't actually suggesting intuition as the main guide for our work, but actually … it means that, as a practitioner for over seventeen years, you would have been in many, many different situations, incorporated patterns of interactions, ways of thinking, whatever, and you've developed a felt sense for that and you're able to somehow communicate that. And this is more of the art of what we do in these complex social situations.

Alex argued that the "felt sense" born from professional experiences and observations over time is an important component of therapy work and a source of knowledge and guidance. Yet the official point of view disparages and discredits this knowledge source. As with narrative therapy, Alex's experiential knowledge could not be quantified or scientifically verified so was deemed suspect and excluded from officially recognised evidence bases.

Medical dominance and the hierarchy of therapy professions

The discussion above depicts the promotion and assertion of particular forces within the cultural and professional spaces of therapy in Aotearoa New Zealand – namely, an expansion of medical and scientific knowledges and their function as official discourse. Therapists included in this study witnessed the expansion of these knowledges – and the exclusion and denial of their own forms of knowledge – as publicly provided therapy services became increasingly governed by psychiatric practices and the doctrine of evidence-based practice. The tradition of medical dominance, and its accompanying occupational hierarchy, bolster the hegemony of medical and scientific knowledges within therapy services. In turn, as therapy services have become more medicalised and scientised, many therapists have found themselves subject to this occupational hierarchy. This section looks closely at how power relations among numerous therapy professions reinforce and reproduce medicine and science as dominant, officially authorised discourses. It examines the

implications of these forms of power relations for therapists, paying particular attention to the agency and autonomy of therapists and their abilities to practise their preferred therapy approaches.

This section demonstrates how command of, and proximity to, medical and scientific knowledges organises the therapy workforce, demarcating colleagues from each other and determining the status and power of different occupational roles. Those practitioners who are aligned with medicine and science, and who possess the requisite qualifications and credentials, are granted authority and the right to "speak", whereas, to quote Bourdieu again, "speakers lacking the legitimate competence are *de facto* excluded from social domains in which competence is required, or condemned to silence" (as cited in Prosise, Miller and Mills, 1996, p. 124). Throughout my interviews with therapy practitioners, it became apparent that the ability to "speak" among therapy colleagues within public services – to put forward a point of view, to participate in discussions and, importantly, to be listened to and recognised as legitimate – was linked to people's professional therapy roles. Postmodern and critical therapy approaches, as the previous section suggests and as later sections will demonstrate, lack the legitimacy and recognition that is accorded to medicine and science by officialdom and within public therapy services: these therapies are, as Danny observed, positioned as "renegade" and "anti-institutional". Despite this, as will be discussed in the following chapters, the therapy practitioners gathered in this study utilised varied methods to resist or subvert the official discourse and requirements in place within public therapy services and to practise their preferred forms of therapy. Importantly, however, the extent and nature of their acts of resistance and subversion was influenced by their professional role and their status within a medicalised occupational hierarchy.

Within the arena of health, as Bryan Turner explains, "medical dominance is a necessary feature of the professional power of the medical practitioner in relation to other occupations" (1995, p. 138). Turner goes on to define medical dominance as "a set of strategies requiring control over the work situation, the institutional features of occupational autonomy within the wider medical division of labour, and finally occupational sovereignty over related occupational groups" (p. 138). For therapy practitioners working within the general health sector, which is predominantly

focused on physical health and illness, medical dominance over their own inferior positions was often palpable. When I interviewed Ruth, a clinical psychologist, she was working in a public hospital – the medical setting *par excellence* – offering therapy services alongside the medical treatments received by patients. Ruth explained that, within this hospital setting, she was required actively to market psychology:

> So it's about actually doing quite a lot of liaison with different professionals, introducing ourselves and presenting a friendly face of psychology basically, and almost de-emphasising the mental health aspects of psychology and emphasising the user-friendly, kind of human, chatty side, the more informal side of psychology perhaps in a setting like this. … There is no acknowledgement of mental health needs or the needs of psychologists in this kind of setting, so we need to survive in a medical environment.

Ruth depicted a health setting in which people's "mental health needs" and the profession of psychology were given no regard: physical bodies, and their medical treatment, were the legitimate focus of medical practitioners' attention. Ruth's actions within this environment indicated conscious efforts on her part to avoid any perceived threat posed by her work and knowledge as a psychologist to the sovereignty of the medical profession. She sought to educate medical professionals who knew little about psychology and/or needed to be convinced of the benignity and "human-ness" of psychologists, and of her acceptance of her own subordinate and ancillary status.

Ruth's comments conveyed the potential for suspicions and preconceptions among her medical colleagues in regard to her psychology work. She explained some of these preconceptions: "Like perhaps they might have a perception of someone who's focusing on acute mental health problems or who's, you know, perhaps got strong political views or particular views that might be unhelpful to the medical profession." Ruth's medical colleagues enjoyed sovereignty over the ailing, physical bodies of their patients within this medical setting, while her therapy work occupied a marginal role within strict boundaries. Within the occupational hierarchy of this hospital environment, Ruth's clinical psychology credentials carried less sway and authority, and she was forced to negotiate a workplace that was either oblivious or hostile to her knowledge and expertise.

Medical dominance is particularly pronounced within the clinical setting of a public hospital, ensuring medical control over patients' treatment and the activities of non-medical allied professionals. The mental health sector, while differing in many ways from the wider health sector, also reproduces power relations on the basis of medical dominance. Within mental health services, psychiatrists tend to occupy the pre-eminent position in regard to therapeutic decision-making. In the main, they possess the highest-ranking medical qualification within the sector and have been bestowed with the title of Doctor. Within multi-disciplinary teams – the main model for the provision of treatment and therapy services within the sector – they are often, as one participant described them, "the top dog". By virtue of their medical status, psychiatrists exercise dominance via the strategies outlined by Turner (1995). Frank, commenting on team meetings at the alcohol and drug service for which he worked as a counsellor in the mid-1990s, described how "the psychiatrist has the last word on everything". While governments, policy-makers and managers exert degrees of control and influence over the work situations within public therapy services, in the day-to-day activities of service provision and decision-making about clients/patients, psychiatrists are usually in charge and wield the most authoritative voice. The psychiatrist role is distinguished from other medical occupations through a unique combination of specialist medical and therapy skills: rigorous training in medicine and the discipline of psychiatry, a focus on a therapeutic doctor-patient relationship, the ability to conduct physical as well as psychiatric examinations, and authority to prescribe psychotropic pharmaceuticals. Psychiatrists are distinguished from other therapy practitioners as a result of their medical knowledge, and from other medical practitioners because of their knowledge of psychopathology: their role within public therapy services is specialised and exclusive.

Within the mental health sector and other public therapy services, psychiatrists work alongside other medical and allied professionals, including nurses, clinical psychologists and social workers. During my conversation with Jo, she highlighted the sovereignty often exercised by psychiatrists over other professionals' therapy work with clients/patients. Jo, a clinical psychologist working for a community mental health service, described an instance where she and the psychiatrist in charge of her team disagreed over whether a particular client/patient should receive therapy services:

Jo: The psychiatrist on our team just seems to be arbitrary in terms of how he divides up people's problems.

Kate: And he is, in the hierarchy, he's at the top?

Jo: Oh yeah, oh yeah. So he can, he could over-rule me, like he could say, "no, she shouldn't be here", he could over-rule me. But if you make a strong enough case, that has enough clinical justification, and it's not considered a dangerous decision or an unethical decision, you can get it through, but you're constantly questioned around it, you know.

Within her team, the psychiatrist's sovereignty was evidenced by the fact that, at any point, "he could over-rule me". In order to assert her professional opinion, Jo utilised the terms and frameworks of the psychiatrist, providing appropriate "clinical justification" and adhering to the official forms of knowledge: she needed to "play the game" if her point of view was be seen as valid. Even when she was able to defend her position and have it accepted, Jo's position and actions were subject to constant scrutiny and appraisal from the psychiatrist. Jo's critique of the "arbitrariness" of the psychiatrist's decisions in regard to clients/patients demonstrated a clash of professional knowledge. However, the sovereignty and authority of the psychiatrist over the various professionals within the team curtailed Jo's agency and required her compliance with the psychiatrist's frame of reference. Medical dominance distinguished the psychiatrist within medicalised public therapy services from other professionals and enabled the exercise of power over these professionals.

While clinical psychologists are not medical practitioners in a traditional sense, the biomedical and psychiatric interests of their profession, and its concern for scientific methods and practices, accord clinical psychologists high status roles within the field of therapy. The association of clinical psychologists with scientific rigour and authority is captured in their self-description as "scientist-practitioners". Ian John (1998) argues that the scientist-practitioner discourse serves

as a means by which an epistemic status claim furthering the interests of psychologists as an occupational group, or guild, is staked out and defended. In the process it also enables a particular group of psychologists to position themselves as the elect voice of psychological authority. (p. 25)

John contends that clinical psychologists distinguish themselves from other practitioners through the scientist-practitioner discourse. The cultural authority and

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prowess of science as a form of knowledge and an official discourse serves as a badge of distinction for clinical psychologists, imbuing their profession with legitimacy and high-ranking status.

The legitimacy and eminence of clinical psychologists is widely recognised within the therapy field. While telling me how she came to the decision to study clinical psychology, Charlotte explained that counsellors "in this country don't seem to have the mandate that a psychologist has, you know? And I suppose that's what attracted me to doing clinical". Pat, another clinical psychologist, echoed Charlotte's sentiments. Pat was initially uncertain about what training path to take in order to become a therapist. He relayed a conversation he had with the head of a university counselling department that influenced his decision-making: "He said to me, 'I only employ clinical psychologists. That's the best profession' [both laugh]. So I thought, 'oh well, I should do that'. So that's how I became a psychologist". Charlotte and Pat described a perception of clinical psychology as "the best" among the therapy professions and as having a mandate and authority within this field of work: the alleged superiority of the profession and its status as reputable and authoritative influenced their own career paths. The mandate that is given to clinical psychologists and the profession's status as the best is reflected in the recruitment practices of the mental health sector. Clinical psychologists occupy the bulk of specialised therapy roles within mental health services. Counselling practitioners who do therapy work within these services tend to do so as a result of their qualifications as nurses or social workers; there are few jobs for people with only counselling credentials.[23] The mandate that is granted to therapists within public services, and the extent of their endorsement as eminent professionals, relates to their proximity to scientific and medical knowledge; the possession of these forms of cultural capital is like, to use Bourdieu's game analogy, holding "aces in the game of cards" (1989, p. 17).

The hierarchy of therapy professions that was invoked and described by participants throughout my research process sees psychiatrists exercising sovereignty over other therapy professionals as a feature of medical dominance. Clinical psychologists, by virtue of their scientific credentials and close proximity to medicine, while still

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[23] Counsellors are currently largely excluded from District Health Board services, on account of the profession not being recognised under the Health Practitioners Competence Assurance Act.

subject to psychiatric control, have prominence as "expert" therapists, superior to other therapy practitioners. For therapy practitioners further down this occupational hierarchy, distance from medical and scientific knowledges and credentials results in, for many, subordination and limited agency and autonomy within public therapy services. Turner identifies "subordination" as a particular mode of domination exercised in medical settings in respect to allied professionals: "Subordination describes a situation in which the character and activities of an occupation are delegated by doctors with the result that there is little scope for independence, autonomy and self-regulation" (1995, p. 138). While, as this thesis will explore in the following chapters, one-to-one therapy sessions are difficult to govern or wholly control, and therapists find ways to subvert prescriptions for their practice and instead practise their preferred therapy approaches, therapists who occupy low-ranking professions are, in the main, subject to more restrictions than their higher-ranking colleagues. Social workers and nurses who engage in therapy work within public therapy services tend to be permitted less license for independence or autonomy in their work with clients/patients. Frances, a social worker-counsellor who worked for a community mental health service over the 1990s and early 2000s, demonstrated the distinctions between different occupations within her workplace in terms of the levels of agency experienced by practitioners. She commented on efforts made by people working within this service to defy its operations: "And then there was Susannah, through the wall from me, who was just subversive [both laugh]. Well, she's a medical officer so she's further up the hierarchy, so the things that she did were more tolerated for that reason." Frances perceived her workplace as tolerant of the subversive, independent actions of practitioners with medical credentials because of the status and legitimacy accorded to these credentials. Non-medical practitioners, who also lack the scientific legitimacy of clinical psychologists, by her account enjoyed far less tolerance when they deviated from or challenged prescribed activities: those therapy professionals with subordinate credentials and knowledge were expected to remain subordinate.

Frances's perception of the value and authority of particular therapy qualifications within public therapy services, and of her own subordinate status, was echoed by other "low-ranking" therapy practitioners interviewed for this study who worked in officially governed institutions. During my interview with Cal, a social worker-

counsellor, he told a story about his clash with a trainee psychiatrist while working for a child and family therapy service provided by the local DHB. The clash involved the trainee psychiatrist complaining about Cal's use of narrative therapy ideas and practices in his work with a child and family. Cal explained the trainee psychiatrist's actions and the conflict between these two therapy professionals as consequences of the hierarchy of therapy professions:

> I think she [the trainee psychiatrist] believed in that hierarchy of professional knowledge and that she was above me: even though she was an intern there, learning how to be a psychiatrist, she was already a doctor, and I was a qualified social worker, that didn't come into it, right? [laughs]. So I started to get a sense of the hierarchy of professional knowledge that is taken to be the reality.

The currency of Cal's professional credentials, in his experience, counted for little alongside the doctor status of the trainee psychiatrist; medical knowledge, expertise and qualifications eclipsed his social work training and experience. The conflict between Cal and the trainee psychiatrist – which, in fact, led to Cal leaving this job – was characterised by Cal as inherently connected to his "place" as a social worker within a medically dominated mental health system.

Cal went on to explain in more detail his view of the mental health system's understanding of the rightful place of social workers:

> I had a supervisor too, bless her, who said to me 'Cal, you realise when you go there [to this organisation] your role will be handmaiden?' And I thought 'that's great', you know, she's deliberately saying too that I will be seen as pretty much a token female, you know I won't have status as male there because I haven't got any sort of qualification that would even give me a male kind of identity.

Cal's professional supervisor seemed concerned that he should be aware of "his place" upon joining this therapy service, stressing that as a social worker within this system he would be a "handmaiden" – a metaphor that suggests subservience, a lowly position, and menial tasks. Cal also analysed the supervisor's metaphor as feminising, suggesting that as a social worker he was emasculated, while those with more legitimate, medical qualifications, even as females, were imbued with symbolic masculinity – potency, power, authority.

The supervisor's comment, and Cal's analysis of it, invoked the gendered nature of both medical hierarchies and the relationship between medicine and allied professions. Rogers and Pilgrim (2005), discussing the subordinated role of women within caring professions, explain how "women on average occupy lower-status positions within professions" and that "those occupational groups which are numerically dominated by women (like nursing) are more likely to be subordinate to male-dominated professions (like medicine)" (p. 135). While the literal demographics of these professions are subject to change, the gender associations remain: Cal, in his profession as a social worker, was associated with women as a consequence of the low status of this profession within a medicalised hierarchy of occupations. Social work, as an allied, "caring" profession under the command of the traditionally male dominated domain of medicine, further connected him with women – hence his role as "handmaiden". Despite his "real" gender as male, Cal experienced female-like subordination within the work setting. As Cal summed up the story of the conflict between himself and his colleague, and the lesson of this experience, he explained, "I realised that I should have been a meek handmaiden and I shouldn't have dared to do anything kind of spontaneous or outside the usual medical kind of practice." Cal's comments suggest both the belief that he should have "known his place" if he had wanted to survive within this system – and therefore have refrained from experimenting in his therapy work – and that practices that differ from "the usual medical kind of practice" are generally not well received within medicalised mental health services, especially when they are introduced by a social worker. His account of the incident with the trainee psychiatrist and of his supervisor's educational lesson on his role as a social worker within a specialist mental health team demonstrated his cognisance of his subordinate position in the team; within this hierarchy of therapy occupations, he experienced little scope "for independence, autonomy and self-regulation" (Turner, 1995, p. 138). Cal left this job, frustrated by the conflict that ensued in response to his narrative therapy practices and his lack of agency.

Conclusion

This chapter has focused explicitly on the forces that influence, instruct and dominate the practices of therapists within public therapy services in Aotearoa New Zealand, and, increasingly, those also working in community and private practices. The previous chapter detailed the effects of neoliberal and managerialist discourses and

the activities of the state on therapy services, demonstrating how these services have become "neoliberalised". In tandem, contemporary therapy services have also progressively become more "medicalised" and "scientised" in their approaches to the problems experienced by clients/patients and in their expectations of therapists. Medical and scientific knowledges exercise dominance within the contemporary therapy field in Aoteaora New Zealand. The terrain of the therapy field, particularly within the public sector but also even within private, independent practices, requires therapists' engagement with the medico-scientific practice of diagnosis and with medicalised explanations for clients/patients' distress. As they apply and engage with psychiatric diagnoses, therapists are required to reproduce, and act as agents for, an official point of view, despite their own misgivings. Their own therapeutic knowledge – their capital, accrued through training, qualifications, experience, reputation, research, participation in interest groups, and collegial memberships – is of dubious value without a sound scientific evidence base, while scientifically endorsed therapies enjoy legitimacy. Their capital is also ordered and organised by an occupational hierarchy that sees those professionals with the highest ranking medical and scientific credentials granted greater autonomy and authority, garnering for them the right to speak over and instruct others. Within Aotearoa New Zealand's contemporary therapy field, postmodern therapy ideas and practices lack currency and are likely to be met with scepticism, if not hostility, by both officialdom and many therapy colleagues. It is unsurprising that at least three of the therapists discussed in this chapter – Kerry, Frances and Cal – resigned from therapy jobs within public therapy institutions in protest at the regime requirements and their own restricted agency and subordinate status.

It is from within this context, in which neoliberal, medical and scientific discourses dominate and are enshrined, that the therapists in this study attempted to mobilise postmodern therapy ideas and approaches. They operated within a conflicted and contradictory social space, alert to the paradox of their position: their therapy knowledge and expertise stemmed from the critique of medical and scientific techniques in therapy, and were founded on an alternative vision for therapy work, and yet medicine and science were accorded hegemonic status within the contemporary therapy field. In order to pursue their interests and practice therapy in ways that cohered with their own ethics and ideals, these therapists had to negotiate

institutional forces and practices that, to varying degrees, were obstructive to their aspirations. The next part of this thesis analyses their strategies of negotiation, including some of forms and methods of resistance and subversion that they utilised, as well as their compromises and accommodations.

PART 4

7. Introduction to Part 4

This part of my thesis examines and analyses how the therapists interviewed in this study saw themselves as negotiating their workplaces and professional roles, given the social and political forces that they perceived as influencing their working lives. As detailed in the previous two chapters, publicly funded therapy services[24] have increasingly been subject to neoliberal/managerialist and medico-scientific discourses. Over the last two decades, these discourses, endorsed and promoted by powerful social institutions, have accrued authority and legitimacy, becoming naturalised features of the order and talk of public therapy services. The discursive frameworks utilised by the therapists in this study – including postmodern, feminist, and social justice discourses – backed by less powerful forces, tended to be subordinate rivals to those dominant discourses: these less powerful discourses and species of knowledge were often "trumped" within "the game" (Bourdieu & Wacquant, 1992) at play in the field of therapy by discourses of "evidence based practice" and "organisational efficiency". As discussed, the spaces, talk and objectives of therapy work were defined in particular ways by neoliberal, managerialist and medico-scientific discourses. And, as the previous chapters suggest, these definitions frequently clashed with those preferred and asserted by the therapists in this study. For many of these therapists, the neoliberal, medicalised and "scientised" therapy workplace was experienced as restrictive and obstructive of their ambitions.

Complicating my thesis narrative

The previous chapters set up a relationship of conflict and rivalry between competing discourses and social forces. In chapter 4, I detailed how postmodern therapy

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[24] I use the term "publicly funded therapy services" to encompass services provided directly by public health, welfare and education sector organisations, as well as services provided by NGOs or private practitioners through contractual relationships with public sector organisations.

practitioners, seeking to undermine the pathologising, individualising and expert-led traditions of therapy, participated in and were encouraged by a similarly oriented social movement. Their vision of therapy was concerned with collaboration and "co-authorship" (Epston, Freeman & Lobovits, 1997) between clients/patients and therapists, exposing and, where possible, undermining the power relations of therapy, and deconstructing dominant discourses. Members of this social movement within the field of therapy connected and bonded through shared teachers and mentors, similar training backgrounds and interests, and participation in peer support and interest groups. The ideas and practices espoused and enacted by this movement represent a distinct challenge to the canon and traditions of therapy and frequently defy the knowledge forms that are positioned as pre-eminent and authorised within the therapy field.

Yet I followed that chapter with two potentially totalising chapters, which could likely suggest that the activities and objectives of postmodern therapists were thwarted and stifled and that they were sapped of agency both in their work with clients and in the wider systems of their workplaces. Neoliberal discourse took on official status in Aotearoa New Zealand in the late 1980s and early 1990s and was "rolled out" within the public sector and beyond, taking shape in managerialist business practices. Scientific and medical discourses have also been integral to the conceptualisation, organisation and delivery of public therapy services. I argue that these discourses play profound roles in the field of therapy in Aotearoa New Zealand and have greatly influenced the language, activities and objectives of publicly provided therapy services. In turn, many therapists in this study described the ascendancy of these discourses as oppressive and limiting, creating working environments where their own forms of knowledge and expertise were marginalised or excluded. The trajectory of my narrative could suggest that working life in Aotearoa New Zealand's publicly provided services was wholly antagonistic to the philosophical orientations of these postmodern therapists and repressive of their therapy practices. The force of neoliberal and medico-scientific discourses could be presumed to be so powerful and total that rival discourses were simply unworkable and absent from working life.

Contrary to how the thematic structure of the preceding chapters could be interpreted, however, I am not interested in a simple, binary narrative where the rebellious

postmodern, critical therapy movement is squashed by the omnipotent forces of neoliberal and medico-scientific discourses; the narrative is much more complicated than this and involves struggle and contestation over the meaning of therapy and the nature of practice. Hegemony is never a finished, static or one-way process. Indeed, as Michel Foucault reminds us, "where there is power, there is resistance" (1990, p. 95). Foucault explains that power relationships depend

> on a multiplicity of points of resistance … These points of resistance are present everywhere in the power network. Hence there is no single locus of great Refusal, no soul of revolt, source of all rebellions, or pure law of the revolutionary. Instead there is a plurality of resistances, each of them a special case. (1990, pp. 95-96)

While the postmodern therapy movement represents a public ideological challenge to both traditional therapy practices and the discourses of neoliberalism and medico-science that are so persuasive and powerful within the therapy field, this challenge, when viewed from the local, peopled level of everyday working life, is mixed, diverse, and necessarily partial. Power and resistance have an inextricable and constantly shifting relationship and take shape at multiple specific points. Indeed, "resistance is never in a position of exteriority in relation to power" (Foucault, 1990, p. 95); there is no "outside" to power relations, and resistance, like power, inevitably involves contradiction, tension and ambiguity. Individual resistance, as Thomas and Davies (2005) explain, is "a constant process of adaptation, subversion and reinscription of dominant discourses" (p. 687). The following two chapters seek out and analyse processes and strategies of resistance, negotiation and accommodation that were utilised by individual therapists in their neoliberal, "scientised" workplaces. I examine these processes and strategies as specific, contextual, and necessarily variable "special cases".

Bourdieu's game

Foucault's descriptions of power and resistance inform my analysis of how the therapists in this study negotiate both the culture and practices of their workplaces and the contestation between rival discourses and forms of knowledge. In concert, the following chapters also draw on Pierre Bourdieu's theory and metaphor of the field as a "game". The idea of the therapy field functioning as a game, where players, invested in its terms and stakes, make moves according to "the volume and structure of … [their] capital" (Bourdieu & Wacquant, 1992, p. 99), coheres in many ways with

Foucault's approach to power and resistance. Like Foucault, Bourdieu conceives of power networks as always open to resistance and the field as a constant site of struggle:

> players can play to increase or conserve their capital, their number of tokens, in conformity with the tacit rules of the game and the prerequisites of the reproduction of the game and its stakes; but they can also get in it to transform, partially or completely, the immanent rules of the game. (1992, p. 99)

Bourdieu explains that players' efforts to transform the rules of the game involve competition between forms of capital; for instance, players can work to discredit the species of capital on which their opponents' authority rests and to valorise the capital they preferentially possess, changing the value of species of capital within the game (1992, p. 99). The concept of the field as a game, structured by the possession, display and exchange of species of capital, refuses the idea that individuals can evade or be outside the power relations of the networks of social relations in which they participate: the efforts of those who are dominated within the field to resist and to transform the game still reify its existence and involve attempts "to usurp, exclude, and establish monopoly over the mechanisms of the field's reproduction and the type of power effective in it" (Bourdieu & Wacquant, 1992, ibid, p. 106). Throughout the previous two chapters, I repeatedly referred to the symbolic power and hegemonic status of particular forms of capital within the therapy field – in particular, scientific, medical and business credentials, and command of the accompanying discourses. In chapters 8 and 9, I will examine how postmodern therapists endeavoured to "play the game" within the contemporary therapy field in Aotearoa New Zealand.

Resisting neoliberalism

Foucault's specific, micro-political, anti-universal approach to power relations, and Bourdieu's conception of fields as complex sites of struggle that are "always relational, dynamic social microcosms" (Everett, 2002, p. 60), call into question grand narratives of power and domination. Their ideas necessarily challenge and complicate any sweeping claims made about neoliberalism, and the associated discourses of "new public management" and managerialism. Neoliberalism, and the managerialist discourses that have flourished with its application in state and public sector organisations, have become favourite subjects for researchers of all areas of contemporary social and political life. The influence of neoliberalism over the past

forty years has seen it become, to quote David Harvey, "hegemonic as a mode of discourse. It has pervasive effects on ways of thought to the point where it has become incorporated into the common-sense way many of us interpret, live in and understand the world" (2005, p. 3). Thomas and Davies discuss how new public management focuses strongly on "the desire to introduce new disciplinary technologies designed to inculcate new attitudes, values and priorities and self-understandings among … [public service] professionals" (2005, p. 685); new public management has been explained by the authors as an "identity project" because of its mission to transform and redefine the public service workforce (p. 685). Neoliberal and managerialist discourses, through their own articulations and in the analyses of some critics, may be presumed so powerful and widespread "that they are almost inescapable" (Spicer & Böhm, 2007, p. 1668).

While neoliberalism has been enormously successful "in colonising economic and cultural life in innumerable contexts" (Bondi, 2005, p. 499), in its translation from a philosophical theory to lived practices and effects, it becomes something "more complex, diverse, contested and open to interpretation than is often recognized" (Campbell & Pederson, 2001, p. 3, as cited in England & Ward, 2007, p. 7). Neoliberal discourses, despite their hegemonic status and profound influence, have not been "rolled out" and enacted in any simple or total sense. Thomas and Davies' research on managerial identities in the UK public service reminds us that individuals "are not passive recipients of discourses" (2005, p. 700). And neoliberal discourses are not the only discourses that vie "for attention in the process of identity make-up" (Thomas & Davies, 2005, p. 690). Numerous critics have challenged over-arching claims about the power of neoliberal discourses, and instead demonstrate individuals' agency and the "ways that people resist, manoeuvre and play with discursive practices" (Halford & Leonard, 2006, p. 657). Rather than reproducing generic claims about neoliberal discourses, such critics urge colleagues to examine the complexity of the relationships between these discourses and individuals by situating their discussions within specific organisational settings and the particular contexts of people's lives (Thomas & Davies, 2005; Halford & Leonard, 2006). It is at this micro-political level that the multiple and varied effects of neoliberal discourses can be examined, and points of resistance and struggle revealed.

Boundary riding

In the next two chapters I will examine the micropolitics of the postmodern therapy movement, grounding my analysis in the reported experiences of my study participants. Situated in distinct institutional contexts, and occupying variously similar and diverse subject positions, these therapists utilised particular discursive strategies as they straddled the mixed and at times fraught interests of their workplaces. As they negotiated and resisted the frequently conflicting forces that structured their working lives and therapy practices, they engaged in constant processes of "adaptation, subversion and reinscription of dominant discourses" (Thomas & Davies, 2005, p. 687). As the following chapters will demonstrate, working life for the therapists in this study required, to varying degrees of both comfort and discomfort, a doubleness, an ability to negotiate and translate seemingly conflicting social discourses. During my interview with Harry, a nurse/counsellor, he encapsulated this necessary doubleness in his description of himself within his public mental health work setting: he described himself as operating "as sort of a boundary rider". He, like other therapists, was required to traverse the in-between of very different forms of knowledge. The following chapters explore this in-between-ness and the concomitant strategies of boundary-riding.

8. Boundary Riders, Group 1: Battlers, Burn-Outs and Blow-Outs

Introduction

As I analysed the interview texts of therapists who participated in this research project, I observed that they fell into roughly two main categories, around which I have structured the following two chapters. This chapter examines the talk and narratives of approximately half of the participating therapists. These "group one" therapists are united by experiences of struggle, tension and disillusionment as they endeavoured to negotiate the cultures of their public sector workplaces. I have created a classificatory system to label and name these participants and to structure into stories their accounts of their experiences within publicly funded services. These group one participants include the "battlers", whose texts positioned them as therapists struggling to ride the boundary between sanctioned knowledge and therapy practices and their own ideals; despite disillusionment and, for some, self-doubt, they remained within public systems, using numerous strategies to negotiate the cultures of their workplaces. Other participants are labelled as "burn outs": those who eventually chose to leave the public sector as their strategies of negotiation became unworkable or the personal toll became too great. The final category is the "blow outs", therapists whose maverick tactics or head-to-head conflict with high-ranking colleagues forced them to leave their public sector workplaces.

This chapter analyses the discursive strategies utilised by postmodern therapists to "play the game" within the neoliberalised, scientised therapy field in Aotearoa New Zealand, focusing on their efforts to resist the hegemony of the field and practise their preferred therapy approaches. It pays attention to the efficacy and consequences of these strategies, as they combined with the specificities of the therapists' work settings. The chapter is organised in two parts. Part A is an exploration of the therapists' engagement with the official discourses of their working environments and their assertions of professional selfhood. These processes frequently involved the reproduction of the languages and ideals of liberal humanism, and even aspects of neoliberalism itself. Numerous therapists used these languages and ideals in strategic ways to promote their preferred ways of working, to display professional

knowledge/power, and to justify their actions within their workplaces. Part B examines how, in response to a recognition of the limits of the efficacy of employing these official discourses, these therapists also utilised oppositional and subversive practices, in keeping with the "under siege" narrative detailed in the previous two chapters. I bring to light a "hidden transcript" of the therapy field in Aotearoa New Zealand, exposing some of the subversive resistance strategies developed by therapists. In the talk of these therapists there is not a revocation of the liberal humanist discourse, so much as a reaction against its instantiation within the new, neoliberal institutional environment: in fact, much of these participants' talk is indebted to a liberal humanist tradition, which they see as corrupted by a culture of surveillance, financial austerity, and decreasing professional autonomy.

Part A: Professional voices

"Official politics" and the professional self

In *Governing the Soul*, Nikolas Rose (1990) gives an exhaustive account of the production of the modern concept of "self". He progressively details the relationships among war, industry, family, and the proliferation of psychotherapies over the twentieth century, tying these to the rise of autonomy, entrepreneurialism, self-management, and self-direction as idealised qualities of selfhood (p. 114). These qualities, Rose argues, are promoted and presumed across modern western social institutions, acting as techniques of normalisation and governmentality and informing our "commonsense" understandings of human selfhood.[25] Likewise, liberal humanist tenets of individual freedom, character development, and a capacity to critique (Davies, 2005, p. 10) have encouraged western individuals to operate as autonomous and rational agents, to make "free" choices, and to question and critique civil society. These features of the modern, humanist self, as detailed by Rose and Davies, are influential to the workings of neoliberal discourse. As Liz Bondi (2005) explains, "[n]eoliberal governmentality invokes a concept of the human subject as an autonomous, individualised, self-directing, decision-making agent" (p. 497). These attributes, she points out, are "fostered in different ways by psychotherapies and processes of professionalisation" (p. 497). While in one instance neoliberalism speaks the language of financial austerity, efficiency and measurable outcomes, and takes

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[25] See chapter 3 for a discussion of how the "self" figures in therapy.

shape in managerialism, at the same time, the neoliberal professional is constructed as a resourceful, participating, autonomous agent.

The concept of the autonomous, decision-making professional was invoked by the therapists discussed in this chapter and was evident in their workplace practices of resistance and negotiation. As mentioned in chapter 6, Alex's interview presented a conflict between the medical, managerialist knowledge that structured his workplace and his own professional therapy knowledge over what counts as evidence within a publicly operated therapy service. Alex retold how he had

> written directly to our big boss around issues to do with evidence and outcomes, and initially, it felt rather patronising, but he did at least entertain a few flurries of emails, and then just said "no" [laughs]. "You're wrong. This is the way it is".

In this instance, Alex attempted, through open discussion and debate, to resist and challenge the definition of the kind of evidence that was accepted as the base for therapy practice within his workplace. He detailed other instances where he voiced opposition and posed resistance to the norms of his workplace through overt, public practices: submitting lengthy comments on proposed standards within his workplace and putting himself forward to debate the nature of evidence in a forum of mostly conservative psychology colleagues.

Alex demonstrated the strategy of "official politics" (Spicer and Böhm, 2007, p. 1674), as he directly challenged and disputed the instructions and forms of knowledge governing therapists' practices within his workplace. Spicer and Böhm (2007), drawing on the work of James C. Scott, define this strategy as comprising "all open, declared forms of resistance" (p. 1674). Involving relatively open debate and conflict, official politics is often "the realm of elites (e.g. lawyers, politicians, revolutionaries, political bosses), of written records (e.g. resolution, declaration, news stories, petitions, lawsuits), and of public action" (p. 1674). As he engaged in official politics – through emails, formal comments, and public debate – Alex assumed a position as an elite actor, and presumed that his participation in conversation and debate about workplace decisions was both acceptable and a potentially effective resistance strategy: he clearly articulated his critique of workplace systems, putting forth an alternative point of view with the aim of changing or influencing others, and, in turn, changing the rules of the game. The concept and discourse of professional selfhood,

where autonomous, self-directed professionals are decision-making agents, makes engagement in official politics seem like a natural, predictable strategy for therapists like Alex.

However, Alex identified official politics as offering limited success as a resistance strategy. As indicated by his words in the excerpt above, he felt patronised in his engagement with his "big boss", who blankly refused Alex's claims and eventually shut down their conversation. Similarly, Frances demonstrated official politics to be an unworkable resistance strategy for many therapists in public sector services, and to be risky for those who attempted to use it. Referring to her time working in a public mental health service, Frances described herself as having

> a reputation for being the one who stuck my neck out and asked questions in clinical meetings and in staff meetings. You know, the sort of things that people talk about in twos and threes over coffee, that they're unhappy about, but nobody speaks up in meetings. And I was the one who would ask those questions in a meeting, I think trading on how long I'd been there and my relationship with the unit manager. And I think I was set back a bit, so it cost me a lot. I was getting bitten, um, I got bitten a fair bit.

For Frances' colleagues, who voiced dissatisfaction over coffee but kept quiet during clinical and staff meetings, official politics was seemingly not a viable resistance strategy. As discussed in the previous chapters, the dominance of medical and managerialist knowledge within public sector therapy services, and the accompanying medical hierarchy, restricts the abilities of those with alternative knowledge forms to "speak" and be accorded legitimacy. Despite this, Frances took an active and vocal role in the public spaces of this workplace, raising critical questions and participating in discussion. Yet she did not experience the freedom, autonomy and decision-making capacities promised by the discourse of neoliberal professionalism: "sticking her neck out" and critiquing the workings of the organisation were actions that "cost" her. Frances was unspecific about what "getting bitten" in her workplace meant, and whether this took the form of official reprimands or being made to feel generally uncomfortable. However, she followed this comment with a lengthy account of the difficulties she encountered with workload issues and tense employment contract renegotiations, and described feeling unsupported and undervalued by those in charge of her workplace. Her narrative of working life at this organisation emphasised

repression and discomfort, with few successful avenues for participation in decision-making or public expressions of dissent.

The humanist tradition of the free, autonomous individual, possessing a capacity to critique and an ongoing interest in character development, was implicit in Alex and Frances' engagement in official politics as a resistance strategy. Both presumed their professional roles accorded them agency and a right to participate in debate and discussion with managerial colleagues. Yet in practice within public sector therapy services, engagement with official politics was limited as a resistance strategy. As Frances suggested, there could also be uncomfortable consequences for those who used this strategy. Alex and Frances' attempts at using official politics to resist the regimes and regulations of their workplaces revealed a clash between the neoliberal discourse of autonomous, decision-making professionals and the realities of their neoliberal, managerialist workplaces: their experiences suggested that the humanist tenets of autonomous selfhood functioned more as rhetoric than reality within the public spaces of these environments.

Liz Bondi explains that neoliberalism has "proved itself to be a flexible beast, capable of being marshalled in relation to both economic and social policies, and capable of hybridising with both authoritarian and social democratic ideas" (2005, p. 499). While "freedom" and "choice" are catchphrases that suggest liberal and democratic ideals, the goals of efficiency and financial austerity create workplaces where calculative technologies, measurable outcomes, and other forms of surveillance have a profound influence on activities – as discussed in chapter 5. Bronwyn Davies (2005) argues that within these neoliberal systems, the energies of supposedly free, autonomous, decision-making individuals often end up focused on individual survival: "Survival is constructed not as moral survival but as economic survival" (p. 9).

Such combative, untrusting systems – which use surveillance to encourage self-monitoring and self-preservation – limit space for the ideals they supposedly embody:

> Elements of the liberal humanist self that were integral to the maintenance of the social fabric (a commitment to liberal values – the development of character, predictability, a capacity to critique) are now less important than the skills for individual survival (the capacity to earn money, entailing flexibility, responsiveness, responsibility for self against the other). (Davies, 2005, p. 9, 10)

Davies' analysis of neoliberal systems demonstrates the clash between different facets of neoliberal discourse: despite the rhetoric, in practice liberal humanist values have been dislodged from many contemporary work systems. Her characterisation of neoliberal work cultures can be extended to illuminate the limited success of official politics as a resistance strategy within Alex and Frances' state operated workplaces. As the reluctance of Frances' colleagues to "speak up" attests, and Alex and Frances' own efforts demonstrate, their workplaces did not eagerly encompass or particularly welcome the enactment of liberal values: Davies' argument suggests that neoliberal work cultures, and the people within them, have shifted in the direction of economic concerns, with less attention to moral or social issues. Davies' analysis also demonstrates the flexibility of neoliberalism, where humanist selfhood and the ideals of autonomy and freedom are hybridised into a form of agency that is focused on individualised responsibility and economic survival. As humanist selfhood is transformed into its neoliberal version, engagement in official politics becomes less viable for vulnerable workers subject to surveillance and operating within work cultures that are structured around economic imperatives. Alex and Frances' narratives demonstrate this tension for therapists in public sector therapy services, where official politics and the capacity to critique appear to be at odds with the culture of their workplaces.

Professionalism as a resistance resource

Overt acts of resistance

While official politics was an often limited resistance strategy for the therapists discussed in this chapter, professional selfhood still proved to be an important resource for resistance practices. These therapists utilised discourses of professionalism, through which they asserted and performed a professional identity, to refuse or subvert the dominant regimes of their workplaces. Discourses of professionalism, including the concept of the autonomous, decision-making professional, enabled therapists to exercise agency within the therapy field and to justify acts of defiance. The therapists discussed in this chapter demonstrated the multiple and contested meanings of professionalism (Noordegraa, 2007, p. 2). As they used professionalism to resist the managerialist and medical norms of their workplaces, they simultaneously adapted and reinscribed dominant discourses.

Over the last decades of the twentieth century, there was a proliferation of claims to professional status. The numerous branches of expertise that can be included in the therapy profession have undergone increasing professionalisation: psychologies, psychotherapy, nursing, social work and counselling have all developed or enhanced systems of self- and/or statutory-regulation;[26] their training programmes have become increasingly academic; and specific and exclusive roles as therapy practitioners exist within the paid workforce (Bondi, 2005, p. 509). With increased professionalisation comes an increased claim by practitioners to symbolic power and authority: as Bondi (2005) explains, "professional status confers autonomy on practitioners who are deemed to have internalised and to embody the knowledge and conduct required for professional practice" (p. 501). While professional status accords cultural and economic capital to its bearers, it is also seen by many as enabling the extension of the neoliberal project. The multiple and contradictory character of neoliberalism is demonstrated by practitioners' achievement of professional autonomy at the same time that they submit to the disciplinary mechanisms of their professions. Therapy professions, as previous chapters have made clear, have become increasingly concerned with the expansion of accountability and reporting, and managerialism has become central to the neoliberal definition of "professionalism" (Davies, 2005; Doolin, 2002; Gray and McDonald, 2006; Halford and Leonard, 2006; Larner and Craig, 2005). Discourses of professionalism are multiple and slippery, and while neoliberalism operates as a powerful and colonising force, professionalism can still be harnessed by therapists to oppose this force and to enact their preferred therapy practices.

Despite the limitations of official politics as a resistance strategy, the therapists discussed in this chapter did still engage in overt acts of resistance. Therapists retold instances where they had refused to comply with the managerial and medical cultures of their workplaces and displayed their alternative practices to colleagues. In these instances, practitioners were buoyed by their professional identity as autonomous

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[26] While counselling is governed by a professional body, to which membership is granted when counsellors have demonstrated the application of particular knowledge and skills, as of 2012, it is not a registered profession. However, social workers, nurses, psychologists and psychotherapists are all able, or required, to be registered health practitioners. The New Zealand Association of Counsellors is considering registration under the Health Practitioners Competence Assurance Act 2003, but for the time being counsellors do not experience the bureaucracy and potential constraints of registration, nor the privileges and protections it offers (for example, DHBs do not generally employ counsellors for therapy roles).

decision-makers, in concert with their accumulated therapy knowledge/capital and their own claims to professionalism. Harry's narrative therapy training and orientation, combined with a sense of professional autonomy and discretion, informed his refusal to use some of the psychiatric disorders included in the *DSM-IV*:

> The DSM-IV also has an axis two category, and the axis two category has to do with personality disorders, and you're probably familiar with anti-social personality disorder, narcissistic personality disorder, borderline personality disorder? Well I hate those particular descriptions and don't use them, and that's brought me to some slight, um, I'm not quite sure what the word is, some slight controversy.

Harry refused to use Axis II diagnoses to categorise or discuss the problems experienced by clients/patients. This stand marked him as different and somewhat controversial among his colleagues within a public mental health service, revealing to some extent his critical perspective on the use of diagnosis. While outright refusal to engage with the concept of diagnosis was not possible within the medicalised mental health setting where Harry did therapy work (see chapter 6), he exercised autonomy over how he used diagnosis and resisted fully adhering to the psychiatric model.

Similarly, Jo, a clinical psychologist, exercised overt resistance in relation to the use of psychiatric diagnoses at her mental health service workplace. She explained how the requirement that she enter a diagnosis for all clients into a national computer system "drives me crazy":

> Jo: So I rebel against it and don't do it.
>
> Kate: You don't do it?
>
> Jo: Well yeah, but I'm being increasingly challenged about that. And there are other people that say that because only psychiatrists do diagnosis, if you want to be true on the computer system, on somebody's record that will be there for life, get your psychiatrist to do the diagnosis. But even that doesn't solve the problem of, um… [pause] being told that to not get a diagnosis means you can't come here [for therapeutic services].

Jo rebelled against the instruction within this workplace that psychiatric diagnoses be assigned to all clients and entered into a national database, which recorded clients' diagnoses "for life". In doing so, she drew on both an institutional understanding of professionalism and her own personal construction of herself as a professional

psychologist. The definition of the clinical psychologist role can function as a resource for resisting the dominance of psychiatry in the therapy field. Jo described how others critical of the practice of recording diagnoses used the boundaries between professions as a means to oppose this practice: only psychiatrists are officially endorsed by their profession to assign diagnosis; the extension of diagnosing to those without psychiatry's authority therefore risks inaccuracy and undermines the responsibilities that should be held by psychiatrists. This defence against the requirement that non-psychiatrists diagnose clients/patients represents both resistance to and reinscription of the medicalisation of "mental health": those non-psychiatrists personally opposed to diagnosing have an argument to support them, but it is an argument that shores up psychiatric power and authority and does not undermine the practice of diagnosis *per se* – but only asks that it be as "true" as possible.

Jo voiced misgivings about this resistance strategy, explaining that it did not solve the problem that she perceived – namely, diagnosis being a requirement for accessing therapeutic services. During our interview, Jo retold two experiences where she fought to be able to provide therapy services to young women who did not easily fit the psychiatric model for diagnosis and treatment because of their circumstances of being young and homeless. For Jo, the goals of therapy work are about "connection":

> Helping that person start to feel like they have a connection, and strengthening the other connections that they have, to deal with whatever issues that they have to live with, yeah. Which is probably, you know, the homeless girl, that was definitely what I was advocating for, you know, it's like "fuck it, she needs something to hold onto or she's going to hang herself, so fuck you, like come on", you know? [laughs]. And everyone else was too busy focusing on entry criteria to be concerned, so that's probably what I was trying to do, yeah, to advocate for her.

Jo constructed and articulated a personal professional identity as a clinical psychologist that was based on the provision of timely, accessible services to people in need and that prioritised connection over bureaucracy and medical practices. This professional identity became a resource and strategy for resisting the requirement that she enter diagnoses into the computer system. This was an instance of a therapist drawing on her accrued therapeutic capital and the humanist and postmodern discourses that are integral to the construction of a professional identity. Combined

with the presumption of professional autonomy and a capacity for decision-making, she used these resources to pose resistance to the norms of her workplace.

Harry and Jo's examples of overt resistance practices occurred within public sector therapy services that significantly constrained the abilities of postmodern therapy practitioners to practise therapy as they would like to. As described in chapters 5 and 6, neoliberalism and the medical model dominate the structures and systems of public services. Harry and Jo's acts of resistance are significant for their openness and for their relative success: Harry experienced some controversy but was seemingly able to persist in his refusal to use Axis II diagnoses, while Jo continued to rebel against the instruction that she enter diagnoses into a database, despite being increasingly challenged over this stance. In each instance, the therapist asserted and demonstrated an alternative approach to therapy work, challenging the reach of psychiatric knowledge and practices. For other postmodern therapy practitioners in this study, acts of resistance may not have been as overt as the actions of Harry and Jo, and may have taken place surreptitiously or not been discovered by colleagues and managers. However, the concept of professionalism still informed and was invoked to justify these actions, revealing contestation over the nature and meaning of therapy work within public sector services.

Ethics

The concept and discourse of "ethics" plays a central role among all the officially recognised therapy professions. With the rise of professionalisation in recent decades, ethics have been discussed, defined and codified, and then subjected to ongoing reviews and revisions. Through the operation of codes of ethics for therapy professions,[27] governing professional bodies stipulate principles, values and guidelines by which respective therapists are required to govern themselves. Ethical codes are also integral to the process by which authorised ethics committees investigate complaints against therapists. The ethical codes in operation within specific therapy professions share many common features. Therapists – as nurses, psychologists, psychotherapists, social workers or counsellors – are required, to

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[27] Codes of ethics operate within the Nursing Council of New Zealand, New Zealand Nurses Organisation, New Zealand Association of Counsellors, Aotearoa New Zealand Association of Social Workers, New Zealand Psychological Society, New Zealand College of Clinical Psychologists, New Zealand Association of Psychotherapists, and the New Zealand Psychologists Board.

varying degrees depending on the professional body, to have regard "for the provisions of, and the spirit and intent of, the Treaty of Waitangi" (Code of Ethics Review Group, 2002, p. 3). They must also respect the dignity of others, recognise people's autonomy and rights to self-determination, have personal integrity, provide appropriate caring, and promote social justice and the wellbeing of society (Aotearoa New Zealand Association of Social Workers, 2010; Code of Ethics Review Group, 2002; New Zealand Association of Counsellors, 2002; New Zealand Association of Psychotherapists, 2011; New Zealand Nurses Organisation, 2010). These ethical codes combine both liberal humanist and social justice ideals, and neoliberal rationality: as Bondi explains, referring to the ethical codes governing counselling professions in the United Kingdom, practitioners are incorporated "into a strict disciplinary framework, which, alongside its collective level of operation, individualises responsibility for maintaining discipline" (2005, p. 510). Therapists are required to adhere to ethical codes, with transgressions by individual therapists subject to formal complaint procedures and investigations by their professional body. While the professional status accorded to therapy practitioners requires self-discipline and adherence to regulatory guidelines, as discussed earlier, it simultaneously bestows autonomy on these practitioners to act within the interests of the profession.

Alex and Frank both demonstrated how professional ethics could be used as a resource that enables agency and resistance for postmodern therapy practitioners working within neoliberalised and medicalised workplaces. Within the therapy field, ethics, as a symbol of professionalism and specialist knowledge, functions as a form of cultural/therapeutic capital and a means by which therapists "confer… a power over the field" (Bourdieu & Wacquant, 1992, p. 101) and engage in a struggle over the configuration of forces that shape the field. Ethics offers a rationale for resistance and a potential defence for therapists if challenged. Alex revealed to me that he had not "done my files in the way that I've been asked to do them", which he said would be discovered by management when his record-keeping came to be audited. He explained that while he kept what he considered appropriate records of his work with clients, the information was not "in the form that they've requested it. Because they want to audit the files, they want a system that's nice and easy for some auditor to come in and find it". Alex perceived managerialism as dictating the professional practices of therapists within his public sector workplace, and resisted this.

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I then asked Alex whether, despite being subject to auditing and other forms of surveillance and instruction, he would still try to resist the constraints of managerialism on his therapy work. He said:

> Yes, I will continue to do that because if what we hold at the centre of what we do is ethical practice, you know, I can't do something that is not consistent with trying to do what I understand to be best for the young person I'm working with at the particular time.

Despite the hegemony of neoliberal and medico-scientific discourses and capital within the contemporary therapy field in Aotearoa New Zealand, these are still subject to challenge and contestation. Alex used professional ethics to explain and justify his refusal to adapt his therapy practices to suit what he saw as the goal of easy auditing. By invoking and demonstrating his professional ethics, Alex gave his act of resistance legitimacy and the authority of an exclusive, specialist profession. He issued a reminder of his profession's definition of what psychologists *do* as professionals: hold "ethical practice" at the centre of all activities. While Alex's defence for his refusal to comply with instructions for recordkeeping had not yet been tested, it bolstered and supported his acts of resistance.

Like Alex, Frank explained and justified his subversion of his workplace's system by using a discourse of professionalism, with the concept of therapist ethics at its centre. Frank's professional status imbued him with a sense of authority and autonomy that enabled him to defy the rules of his workplace, even though his actions required subterfuge and secrecy. During his time working for a public sector therapy service, Frank wrestled with the requirement that all clients received a maximum of only six therapy sessions. He explained his problem with this short therapy timeframe for all clients and how, consequently, he found a solution:

> If you were doing some work with people who have had maybe quite major sort of emotional trauma, I mean it's almost criminal to half way through say "oh sorry, your numbers are up, I can't see you anymore". I mean that would be professionally and even humanly very unethical and detrimental, although the system may kind of require that. So, you know, people were reviewed every three months so you might choose to keep quiet, or you may present someone in these reviews in such a way that it's likely that they would get some sort of extension.

Frank positioned himself as a professional, ethical practitioner interacting with a system that he portrayed, on this occasion, as "almost criminal" and at odds with being "human". In complying with the ethical code of his profession, Frank was required to prioritise his clients/patients' interests and welfare, advocate social justice and "act to ensure that everyone has access to the existing resources, services and opportunities that they need" (Aotearoa New Zealand Association of Social Workers, 2010). While his references to "ethics" and being "human" in this instance were generalised, Frank determined what was and was not ethical by virtue of his professional membership and specialised training, and drew upon the backing of an ethical code. These credentials supported him to pose and justify this act of resistance. In Frank and Alex, we see efforts to resist and transform – or perhaps, more correctly, to rehabilitate – the immanent rules of the game within the therapy field. Their texts and actions discredited the economic and managerial forms of capital upon which the force of their workplace "opponents" rested. Instead, they valorised the species of capital they preferentially possessed: therapeutic, professional capital (Bourdieu and Wacquant, 1992, p. 100).

Credentials and standing

As in other institutions, the distribution of capital within therapy professions creates hierarchical relations between members. Even with the incursion of neoliberalism and medico-science into the therapy field in Aotearoa New Zealand, command of authorised capital – or knowledge/power – provides postmodern therapy practitioners with opportunities to increase their stakes in the contestation over the nature and meaning of therapy work and to pose resistance. Those therapists with considerable experience, senior positions and distinguished clinical qualifications or credentials described these as assets within conflicted work cultures. For example, Frank explained how reputation and his command of therapeutic and cultural capital granted him some license and leeway within his public sector workplace:

> I mean the clinical coordinator, because my office was opposite hers, and in some
> ways she knew that I didn't do certain things that I was required to do. But on the
> other hand, I think because I was very good at my job, I mean I had good
> outcomes therapeutically with people. And because of my formal training I was
> very knowledgeable in many areas, so I had clinically quite considerable

standing. And I had started as a social worker and then after two years I became

senior social worker, and I had sort of a clinical leading role as well.

Professional status and prowess, in the form of clinical knowledge, networked

relationships, successful therapy outcomes and seniority, enabled Frank to resist and

refuse some of the requirements of his workplace, as his clinical coordinator turned a

blind eye to his activities. When the extent of his resistance was discovered, however,

as will be discussed later, the license granted to Frank evaporated. But, within certain

boundaries, the possession of significant markers of cultural capital sanctioned some

challenges to the norms imposed within therapy workplaces. Again,

professionalisation provided resources and space, to some degree, for postmodern

therapy practitioners to resist the neoliberal and medico-scientific cultures of their

workplaces.

Summary of Part A

Discourses of professionalism, as discussed earlier, are multiple and slippery. The

humanist and, more recently, neoliberal concept of autonomous, decision-making

selfhood has been explained by critics as a project focused on individualising

responsibility and directing professionals' energy towards self-monitoring, self-

discipline, and, consequently, self-governance. Yet the rhetoric and humanist roots of

autonomous selfhood are still powerful, and see postmodern therapists presume a

right to contest the meanings and nature of therapy in contemporary Aotearoa New

Zealand public therapy services. The disciplinary boundaries of therapy professions

both regulate therapists and provide a means to contest the managerialist systems that

organise many contemporary public sector therapy services. In their command of

professional ethics, postmodern therapy practitioners were able to assert authority and

justify subversive actions. As bearers of credentials and titles within a hierarchical

institution they were also granted some leeway and license in their activities.

Professionalism proved a powerful discourse for resourcing and justifying the acts of

resistance discussed so far, many of which involved overt refusal in some form.

However, my discussion of official politics revealed this to be a somewhat limited

resistance strategy for postmodern therapists in public sector therapy services. For

instance, Frances' questions and criticisms of management led to her being "bitten".

Harry encountered controversy, and Jo was increasingly challenged, in response to

their resistance to diagnose clients/patients in the orthodox manner. And Alex and Frank's invocation of ethics related to surreptitious and not-yet discovered acts of resistance. Overt, public acts of resistance and opposition to the managerial and medical regimes imposed within therapy workplaces were apparent within these therapists' narratives. However, these acts were frequently laborious and/or risky for the therapists and not often successful: therapists frequently needed to fight and lobby for their professional viewpoints, sticking their necks out in the process. Within these often oppressive and tightly regulated systems, resistance much more often took shape in underground, secret and subversive forms, as the next section will analyse.

Part B: Hidden transcripts – the appearance of conformity

Chapters 5 and 6 described the therapy field in Aotearoa New Zealand as an increasingly difficult and uncomfortable environment for therapists wanting to practise postmodern and politically engaged modes of therapy, especially for those working in public sector services. Participants in this research demonstrated how managerial and medico-scientific knowledge and credentials were used to wield authority and legitimacy within the therapy field, leaving many therapists excluded and alienated from decision-making about the nature and workings of their workplaces. This chapter considers and analyses the strategies and discursive resources employed by one group of participants to resist the regimes of their workplaces and to carve out space to practice their preferred therapy approaches. The first section of the chapter has examined the intersection of professional selfhood with the concept of official politics, and the wider potential for discourses of professionalism to enable therapists to pose resistance. This section looks more closely at what James Scott terms the "hidden transcript" that subordinate groups create, where "a critique of power [is] spoken behind the back of the dominant" (Scott, 1990, p. xxi). I examine the less public efforts of therapists to negotiate the power relations of their workplaces, and reveal strategies that offer the appearance of conformity while simultaneously undermining these power relations. These therapists appear to be aligned with, or even to revere, the hegemonic discourses of their workplaces, and in the process enact modes of resistance, critiquing the dominant from behind its back. My discussion of the discursive resources and strategies utilised by therapists again reveals their simultaneous accommodation and subversion of dominant discourses and the necessary complexity of resistance.

"Wearing a false moustache"

In their discussion of employee struggles against the hegemony of management, Spicer and Böhm (2007) explain that the "location of resistance in the workplace is mediated by the availability of space to engage in acts of resistance in the workplace" (p. 1678). When workplaces provide spaces, resistance may take shape in formal mechanisms and official politics. When little space is provided, as is the experience of many of the therapists discussed in this chapter, resistance "might also take the form of informal spaces of everyday life created by incomplete surveillance and ingenious methods of avoiding surveillance. These would allow a zone where it is possible to challenge discourses of management" (p. 1678). During my interviews, the therapists detailed the efforts they made to construct such a zone within their therapy workplaces, with the goal of evading surveillance and the discourses of management and doing therapy work that aligned with their professional ideals. To construct this zone, therapists actively performed conformity in the public spaces of their work and managed the impressions they created among managers and medical colleagues.

Frank and Frances revealed how they knowingly constructed performances of conformity with the dominant medical discourse of their public health sector workplaces as a means to resist the dictates and instructions of management. They explained how they utilised double-talk and translation to pursue their own interests while appearing to embrace those of management. Frances retold the origins of this resistance strategy:

> Frances: I once made the mistake of presenting a case in a clinical meeting in narrative [therapy] terms. The psychiatrist was incredibly scathing.
> Kate: Really?
> Frances: Yes [laughs]. So I learned the skill of translating it [the case report] into CBT [cognitive behaviour therapy]. … A little is lost in the translation but a least you get through a clinical meeting unscathed.

Frank similarly navigated and resisted the confines of the official instructions for his therapy work. He observed that many of his clients/patients at a public sector therapy service did not fit the prescribed format for therapy. When I asked him what this meant for his therapy practice, he responded by saying "well, I just sort of decided to operate on two levels really. So I worked with clients in a very narrative [therapy] way but I'd produce material in a very medical way". In both instances, these

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therapists learned to hide their actual therapy practices with clients/patients behind a performance designed to appease their clinical managers. They evaded the surveillance that operated within clinical meetings and avoided scrutiny of their narrative therapy work by strategically utilising dominant medical discourses, including the medically sanctioned cognitive behaviour therapy (CBT); this evasion enabled them to get through clinical meetings "unscathed". They constructed the appearance that they possessed and subscribed to the reigning symbolic capital within their workplaces. As they negotiated and attempted to resist, Frances and Frank made "use of disguises, deception, and indirection while maintaining an outward impression, in power-laden situations, of willing, even enthusiastic consent" (Scott, 1990, p. 17).

Scott identifies the tension that is integral to this kind of resistance strategy: "In ideological terms the public transcript will typically, by its accommodationist tone, provide convincing evidence for the hegemony of dominant values, for the hegemony of dominant discourse" (1990, p. 4). The public, official discourse of Frances and Frank's workplaces appeared content and unchallenged as these therapists spoke and endorsed its language and logic; discontent and alternative discourses were largely absent from the public transcript. Yet therapists' manipulations enabled them to exercise greater autonomy within the private and everyday spaces of their therapy rooms and to protect the meaning and nature of their therapy work with clients from scrutiny and criticism. However, Frances also suggested that by reproducing medical discourse, therapists might simultaneously be able to incorporate some aspects of their actual therapy philosophy into their public records and discussions: their seeming adherence to the medical model perhaps tempered management responses to their less conventional practices. She explained how elements of her narrative therapy practice were discernible in her reports on her work with clients: "There were a couple of us who used clients' language rather than pathologising descriptions, sprinkled with enough terminology for it to be acceptable. It's like wearing a false moustache [both laugh]". As she "wore a false moustache" – which conjures images of espionage, subterfuge and ruses – and strategically reproduced just enough of the dominant discourse, Frances seemed to win some space in the struggle and was able to resist some of the pathologising habits of medicalised therapy by including her clients/patients' descriptions of their experiences in her official reports. As a

resistance strategy, the performance of conformity by postmodern therapy practitioners was necessarily partial, as these therapists negotiated political regimes that were at times hostile to alternative knowledge forms.

The "false moustache" resistance strategy, where therapists performed compliance and conformity with the dictates and instructions of their workplaces, involved the strategic use of silence and secrecy. As therapists translated their narrative therapy work into the language of CBT and managed their performances during clinical meetings, they kept silent about aspects of their therapy practice and kept their critique of the established order secret. These therapists were active and strategic in their use of silence, which helped them to navigate and resist the regulations imposed on their therapy practice. Throughout my interviews, therapists repeatedly pointed out the privacy they were afforded in their actual work with clients/patients. As Frances explained, "what I did behind closed doors was a secret". The possibility of attaining a degree of professional autonomy – albeit unofficial and surreptitious – behind closed doors was echoed by Charlotte. Much to her frustration, during Charlotte's clinical psychology training she was required to practise CBT in a prescribed, formal manner. Her practice was monitored in various ways by her teachers and supervisors. However, when she became employed as a therapist, she discovered methods to evade prescriptions for her practice:

> You can get away with it a bit more because you [laughs] don't have to like write case studies. You don't actually have to kind of say what you're doing [laughs], which sounds awfully kind of covert and undercover, but it's true.

As the previous two chapters demonstrate, therapy work in Aotearoa New Zealand has been subject to increased surveillance through auditing and the imposition of medical practices and "measurable outcomes". Yet therapists' face-to-face encounters with clients/patients are generally private and free from immediate scrutiny. By actively employing the tactic and discourse of silence in their interactions with clinical and bureaucratic management, therapists like Frances and Charlotte were able to avoid surveillance and construct a zone outside the full reach of management.

Brown and Coupland's (2005) discussion highlights the complex and multiple meanings of silence within organisational settings. Frances and Charlotte's strategic silences were "active performance[s]" (p. 1051): they constructed "*knowing*

compliance through reference to impression-management activities", which suggested they were "agentic" (p. 1056, original emphasis). Frances held and protected her own secret, which enabled her to subvert the instructions of management, while Charlotte "got away with" refusing to do CBT with her clients/patients in the prescribed way. In each instance, being silent functioned as a deliberate resistance tactic that utilised impression-management, providing a means for these therapists to secure some space to exercise autonomy in their therapy work. Like the participants in Brown and Coupland's research, these therapists were "reflexively able to create space for resistance even in the apparently accommodative performance of themselves as knowingly compliant employees" (2005, p. 1063). Their clinical managers experienced no obvious challenge to the dominant discourses of the workplaces, but challenges were manifest in the covert, underground activities of postmodern, politically engaged therapists like Frances and Charlotte. Strategic silence provided a means for therapists to meet their own needs and interests within their workplaces.

At the same time that Brown and Coupland theorize silence as an active strategy of impression management, they highlight how it may also function "as a power effect" (2005, p. 1049). While the therapists discussed in this chapter constructed themselves as active agents who utilised silence as a means of resisting the regulations of their workplaces, several also perceived silence as an experience of oppression and marginalisation, particularly when it became an established, long-term practice. Reflecting on her many years working at a public mental health service, Frances declared that one of the greater costs for her "was developing the habit of being quiet. Allowing myself to be silenced". Frances referred to her attempts at utilising official politics, which led to her being "bitten":

> So I did learn to be silent. I thought of it as picking my battles, but I don't think it
> was quite as functional as that. I was a bit silenced at the end, and it wasn't good
> for me. I shouldn't have worked there quite so long really.

She went on to describe the severe "burn-out" she ultimately experienced as she tried to "hold onto the things that I'm passionate about" while working in a service that was shifting more and more towards managerialism and medicalised therapy. Frances' self-narrative in our interview positioned her as an underground rebel, sporting a "false moustache" and being strategically silent in order to claim some autonomy as a therapist. Yet she also positioned herself as a "burn-out", suffering

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from the toll wrought by a hostile workplace that "silenced" her and from the exhausting labour involved in resisting and finding ways to hold onto what she was passionate about as a therapist. Her text showed the slipperiness of the meanings of silence, as she described how the strategy of "picking my battles" became less "functional" and more about *being* silenced by an oppressive system, which was implicated in her burn-out.

Jo reinforced the dual meanings of silence for the group one therapists discussed in this chapter: it functions as both an active resistance strategy and a potential "principle of their own subjection" (Brown & Coupland, 2005, p. 1059) and oppression. After observing that Aotearoa New Zealand's public mental health services "are moving more and more towards an American model of managed care", evident in a focus on medically defined outcomes and definitions of "progress", Jo declared:

> If you start to think about all that stuff it's actually quite crazy making. Or you feel like if you stay involved with the family or a young person then it's something the system might not approve of. And you feel in the closet, which is why I use that term, that you're doing something that feels a bit devious.

While "deviousness" does suggest therapist agency in the struggle over the nature and meaning of the therapy field, it is also the perspective of a judging onlooker; practising silence and evasion in her workplace seemed to make Jo feel like a wrongdoer. This was reinforced by her use of the metaphor of being "in the closet", which evokes an oppressive identity politics where a lack of safety and fear of persecution work to stifle and inhibit full identity expression, leaving those "in the closet" in necessary but self-imposed hiding.

Like Frances, Jo illustrated the personal toll of trying to resist a "crazy making" system that required her to be "in the closet":

> I think for me it's been quite a struggle, but I'm really passionate about working with kids, especially, and I think that's how I hold on. But at times I've wanted to quit, I've wanted to get out and I've wanted to just grow flowers [Kate laughs], seriously.

Like Frances, Jo "held on" to her passion for therapy work with clients as a means of trying to cope with an oppressive and exhausting system. Silence provided a shield

for both of their activities, and enabled some autonomy within private work with clients/patients, but could also be an experience of subjugation. The shifting, multiple meanings of silence for the therapists discussed in this chapter demonstrate the necessarily contradictory and contested natures of both resistance and hegemony. Silence and the other subversive activities involved in "wearing a false moustache", as everyday acts of resistance, "represent the ways in which relatively powerless persons accommodate to power while simultaneously protecting their interests and identities" (Ewick and Silbey, 2003, p. 3). The appearance of conformity enabled these therapists to protect their interests and their therapist identities, but it also involved accommodating to power, bringing with it a personal toll and leaving the public transcript largely intact. In turn, the hegemonic system within the therapy field appeared to thrive.

Playing the game and working the system

"Wearing false moustaches" and staying strategically silent enabled postmodern therapy practitioners to appear to conform to the neoliberal and medical regimes of their workplaces while subverting these regimes and finding space for professional autonomy and agency. The therapists discussed in this chapter detailed other resistance strategies that similarly entailed the reproduction of dominant discourses and the appearance of conformity. These strategies involved the calculated use of the "Master's tools", rather than the overt rejection of these tools. With so little space for overt resistance and engagement in official politics, many therapists found they needed to "play the game" strategically within their workplaces, rather than to refuse or attempt to evade the game. The examples that follow demonstrate Bill Doolin's assertion that "[d]isciplinary power is not exclusively constraining. It also empowers, in the sense that it opens up and legitimates a discursive space for action" (2002, p. 381). Having the ability and authority to use the Master's tools, or the dominant forms of knowledge and capital, and to play the game within the workspaces of the therapy field can win therapists some space for action.

Caputo and Yount (1993) expand this idea in their discussion of the critique of institutions by agents from within. They declare that, "if a narrow claim to 'expertise' allows one to operate machineries of domination, that person is also positioned to leak the secrets of the machine, even to calibrate its parts toward opposite functions" (p.

8). Despite their reports of repression and constraint within neoliberalised, medicalised therapy workplaces, the professional knowledge and status of therapists still allowed them to claim expertise. As agents of institutions, equipped with recognised expertise, they were unavoidably involved in the operation of machineries of domination, focused as these institutions are on the regulation and normalisation of populations. However, Caputo and Yount (1993) suggest that the capacity to critique the power relations of institutions presents the option to agents of knowingly using the machineries toward opposite functions. By playing the game – reiterating dominant discourses and engaging with the terms that govern official discussion – therapists strategically vied for space and authority to practise therapy as they preferred to, or to at least temper the instructions for their therapy work. Their criticisms of the sanctioned knowledges and practices of their workplaces enabled a critical and knowing engagement with these knowledges and practices, through which these therapists worked to further their own therapeutic goals.

During our interview, Alex critiqued the lengthy consent form that his organisation required him to administer with all the families he worked with. He explained the complexity and sensitivity of his work, especially in regard to building contact and engagement with the family members of a young person who is referred to him. He gave the example of the process of relationship-building with a mother, which would have been much more difficult "if I'd gone into my first meeting with her and said 'right, we've got to cover these 14 things [on the consent form]'". Instead, because the family was Māori, Alex was able to justify working with the mother in a less formulaic way and to spend concerted time focusing on the question of "how do I engage this family?":

> One of the great things about this country is that it at least pretends, and at least this organisation pretends, that it wants to be bicultural. So whenever I get really stuck and in a hole I can wave, you know, the Māori, Tangata Whenua[28] flag and say "ohh, hang on a minute". And our Māori colleagues are a little bit

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[28] Tangata whenua is a Māori term of the indigenous peoples of New Zealand and literally means "people of the land", from *tangata*, "people" and *whenua* "land" ("Tangata Whenua", 2011, para. 1).

beleaguered here but, you know, they would back me and would say "kanohi ki te kanohi",[29] and, you know, I'm able to pull that one.

Alex adhered to and reiterated the official "rules" of the game within his work setting – that services acknowledged and responded to Māori cultural norms and values – as a means of mitigating the prescription for how he administered the consent process with Māori clients/patients. He identified and exploited the clash of rules and discourses within the service.

The government of Aotearoa New Zealand is committed to "upholding the principles of the Treaty of Waitangi" (Te Puni Kokiri, 2001, p. 7).[30] This commitment is documented in the policies and strategic plans of organisations and departments across the public sector, including health, education, social development, local authorities, and community organisations. While Alex expressed cynicism about the claims to "biculturalism" made by the public sector organisation, suggesting it was pretence, he also strategically utilised this dominant discourse when he was stuck or "in a hole" in regard to his client work and the demands of the system. The principle of "kanohi ki te kanohi" is reiterated in the policies and guides for providing effective and appropriate services to Māori in many public sector services and organisations.[31] "Kanohi ki te kanohi" requires direct, face-to-face contact and communication between service providers and the people receiving services, and is integral to whakawhanaungatanga – that is, "building a relationship based on connectedness that allow[s] for a richer sharing of information" (Jones, Ingham, Davies, & Cram, 2010, p. 3). Being bicultural in Aotearoa New Zealand requires public services to demonstrate that they recognize and incorporate the cultural practices and values of Māori. When faced with a complex family situation and the requirement that a

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[29] "Translated - 'Eye to eye'. To meet face to face to discuss issues. This is seen as important so physical reactions like body language and facial expressions are easily read" (Office for the Community & Voluntary Sector, Department of Internal Affairs, n.d.).

[30] For information on the "principles of the Treaty of Waitangi" see http://www.tpk.govt.nz/en/in-print/our-publications/publications/he-tirohanga-o-kawa-ki-te-tiriti-o-waitangi/

[31] See, for instance, the Environmental Risk Management Authority (http://archive.ermanz.govt.nz/resources/publications/pdfs/teputara9.pdf), the Ministry of Education (http://www.minedu.govt.nz/NZEducation/EducationPolicies/MaoriEducation/AboutMaoriEducation/WhoWeAre/EngagementWithMaori/HuiTaumataMatauranga/BetterRelationshipsForBetterLearning/Principles_of_success.aspx), the Hawke's Bay District Health Board (http://www.hawkesbay.health.nz/page/pageid/2145869726/Maori_Health), Suicide Prevention Information New Zealand's Māori Suicide Prevention Resource (Ihimaera & MacDonald, 2009), and the Department of Internal Affairs (http://www.communityoutcomes.govt.nz/web/coutcomes.nsf/unid/TCAO-7GT2FE?openDocument).

lengthy consent process be promptly administered, Alex waved the "Māori, Tangata Whenua flag". Despite his suggestion that the biculturalism of his workplace was only "pretend" and lacked sincerity, he recognised that its symbolism was powerful and could be harnessed to stall and contest the management and bureaucratic imperatives imposed on therapy work. By "playing the game" and appealing to the dominant discourse of biculturalism, Alex was able to prioritise face-to-face relationship-building with members of the whānau[32] over the strict requirement that the consent form be filled in immediately, and could win some space for professional autonomy in his therapy work with this mother. He used a dominant discourse to trump the power and authority of other dominant discourses within the therapy field.

Several therapists who were working in publicly operated mental health services found ways to mitigate and resist the requirement that they engage with psychiatric diagnosis in their work with clients/patients through the strategic use of such diagnosis. Wherever possible, Frances and Harry both used the *DSM-IV* "V-Codes" to diagnose clients/patients. Frances described the "V-Codes" as "preferable, less pathologising descriptions". The "V-Codes" are included near the end of the *DSM-IV*, in a section titled "Other Conditions That May Be a Focus of Clinical Attention" (American Psychiatric Association, 1994, p. 675); they occupy less than ten pages in the 800-page tome. Harry explained that the "V-Codes" include

> things like "parent-child relational issue", or actually "parent child relational problem", "partner relational problem", and then there are other ones, there's maybe a dozen more respectful descriptions.
> Kate: Yeah, it sounds a lot softer.
> Harry: And I would use those where I can. And it's possible to write, well "no diagnosis given". And there's also a V Code called "phase of life problem". So
> it's possible to draw upon the *DSM-IV* to defuse its own toxicity at some level.

Harry harnessed both his critique of psychiatric diagnosis and his professional expertise to find a way to limit the force of diagnosis, while still adhering to the *DSM-IV*. He complied with the requirement that he diagnose clients/patients, but wherever possible used the least pathologising descriptions for their problems. The "V-Codes"

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[32] Whānau is a Māori-language word for extended family, now increasingly entering New Zealand English, particularly in official publications. In Māori society, the whānau is also a political unit, below the level of hapū and iwi ("Whānau", 2011, para. 1, 2).

allowed him to speak of specific and contextual "problems", rather than psychiatric "disorders", and were less obstructive to narrative therapy-style conversations with clients/patients: to speak of problems and people's relationships to them is more in keeping with narrative therapy than the language of disorder and dysfunction. Harry's critique of the "toxicity" of the *DSM-IV* enabled him to strategise to defuse and undermine it, from within the confines of a medicalised work environment: he calibrated the parts of this machinery of domination toward an opposite function. Like Alex, he "works the system" and knowingly reproduced its discourses to meet his own ends.

"Beating the system": a story of a maverick

This chapter has considered various strategies and discursive resources utilised by therapists to resist the hegemonic regimes of their workplaces and the prescriptions for their therapy practice. As they wielded professionalism to engage with official politics and justify acts of defiance, or constructed an appearance of conformity to secure some space for autonomy and to "work the system", these therapists attempted to negotiate and where possible limit the hegemony of medico-science and neoliberalism within the therapy field. Despite the dominance of these discourses, therapists found ways and occasions to contest and undermine them. Their resistances and rebellions were neither sweeping nor without compromise or tension; the impracticability of official forms of resistance and the necessity for hidden, subversive methods demonstrated the limited nature of therapists' acts of resistance. Most of the therapists discussed in this chapter reluctantly abided by the rules and regulations of their workplaces, or at least worked hard to appear to, but pushed at the edges of these rules whenever it was possible and safe to do so.

This section looks at the narrative of one therapist in particular – Frank – who stood out in the research because of his risk-taking and the scale of his resistance to the rules of his public therapy workplace. Frank's narrative involved many of the resistance strategies discussed so far: impression management and the appearance of conformity, the strategic invocation of professionalism, and using the "Master's tools" to obtain space for autonomous action. Yet he was distinguished by the extent of his efforts to "beat the system". His narrative was significant and is discussed here because it is an interesting case study of the breadth and success of resistance in the

therapy field in Aotearoa New Zealand, but also of the consequent toll for therapists. His efforts also exemplify the vulnerability of "the system" and highlight how the logic of neoliberal/managerialist and medicalised therapy regimes can be exploited and within them gaps can be found for resistance. In particular, Frank manipulated the auditing and accountability systems of his workplace and exploited his manager's lack of grounded knowledge and engagement with the activities of staff. Both of these strategies enabled Frank to develop his own sub-system of autonomous professional practice.

My discussion of Frank's resistance strategies reiterates the claims made in the introduction to this section: that neoliberal discourses, despite their hegemonic status and profound influence, have not been "rolled out" and enacted in organisations in any straightforward and absolute or total sense. At a micro-political level of analysis, discourses and power relations at play within organisations are always multiple and contestable – even the master discourse of neoliberalism. Knights and McCabe's (2000) research is useful for my analysis of Frank's narrative. They examined the effects of a recently introduced "Total Quality Management" model on the activities of employees at a major retail banking corporation. This neoliberal-inspired management model focused on employee subjectivity, with attention to "employee self-discipline and the internalisation of production and performance norms" (p. 421). As such, Knights and McCabe report claims that it "all but eliminates [employee] resistance" (p. 421). However, their research illustrates Foucault's assertion of the interdependency of power and resistance (1990, p. 95). They found that:

> New opportunities for alternatively interpreting management directives are always arising on the office floor. While management seeks to devise universal coherent strategies, … gaps and gaffs, and deviations and disjunctions frequently occur. Employees can readily exploit the resulting tensions, inconsistencies and contradictions. (p. 431)

However bold and totalising neoliberal discourses may be, their implementation within specific organisational settings is necessarily variable and in some instances contradictory. As Frank's narrative demonstrates, at the level of the office floor – or the therapy room – contradictions and disjunctions provide employees with opportunities for resistance.

In our interview, Frank constructed himself as a maverick: he described himself to me, saying "I've always been a bit of a rebel and always been interested in finding out how to beat systems". Some years earlier, Frank had been working as a therapist for a publicly operated counselling and mental health service, which was being managed along neoliberal/managerialist and medical lines. His description of the system operating within this workplace demonstrated both his maverick, rebel subject position and how his critique informed the actions he took to calibrate the parts of the "machine" of the system toward his own interests:

> The system is a bit like a straitjacket. I mean you have so little room and how to work is so prescribed that it becomes really difficult, and, you know, what you're doing is actually not of great help to the people who come to see you. And, so you start looking for ways, you know, "can I find my own way in this?" Which I eventually got very good at.

Frank critiqued the efficacy of the system of his workplace, asserting his professional identity as a therapist as he questioned the helpfulness of the prescriptions for therapy work with clients/patients. Like the descriptions included in chapters 5 and 6, he depicted the system as a stifling, constraining force that impeded therapists from working effectively. Frank's narrative foregrounded these critiques and linked them to the beginnings of a project focused on finding his own way within the system and securing space for autonomous professional practice.

Frank's narrative of "beating the system" and "finding his own way" depicted the dominant, official system of a public sector therapy organisation and his own rival sub-system. He described an official system, which focused on bureaucratic accountability and rationed therapy time, and the evolution of his own sub-system in reaction to this official system:

> Frank: There's a system that's largely based on meeting the formal requirements of the organisation and accountability. Although, I mean on a therapeutic level there's not a great deal of accountability or great depth; people don't even have an understanding of this because of the limitations on time and everything. …
> So I mean, what you eventually do, which is what I did, is that you work entirely in your own way. So I ended up seeing people for far longer than I was officially allowed to.
> Kate: How did you get around that?

Frank: Oh, I got around everything really [Kate laughs]. … You end up working in an entirely different way within the system.

Frank described a highly developed sub-system that allowed him to work "entirely in his own way", while the official system appeared to prevail; his narrative brought to light a hidden transcript from within Aotearoa New Zealand's therapy field.

The strong focus on measurable outputs – that is, the numbers of clients/patients who were assessed by the agency – created tension for Frank: "As a worker, you were constantly caught up in that game, the numbers game versus trying to help people". The "numbers game" was ironically integral to Frank's ability to devise a sub-system from within the official system of his workplace:

I mean there were so many audits and accountability systems. But then, because it was so focused on numbers, one month I thought I'd like to test these systems. You have to write a list of people seen, so I wrote down a person I hadn't seen at all, a name, just to see what would happen. And nothing happened [Kate laughs]. And then I wrote down a couple more names, and nothing ever happened. And so, in some ways there was this focus on numbers but nobody actually checked if anything matched up or not.

Frank's tactic of regularly providing false client/patient details for his organisation's database and accountability reports allowed him to work with his actual clients/patients for longer than the six sessions they were officially allocated. He subversively seized more time for his therapy work with individuals, which enabled him to exercise autonomy and professional judgement over the timeframe of their work together.

As detailed in chapter 5, the extension of the market model into public sector services saw "value for (state) money" established as a governing management principle. Surveillance and performance monitoring became routine practices, with particular emphasis on "calculative technologies" (McKinnon, 2000, p. 298); evidence of the worth and value of services were increasingly required in visible and quantitative forms. These practices were evident in Frank's workplace, where accountability was measured by client/patient output statistics and monitored through audits. Ironically, despite the emphasis on surveillance and quality management under neoliberalism, Frank was able to detect and exploit the "incomplete surveillance" (Spicer & Böhm,

2007, p. 1678) at his workplace. In doing so, he secured himself a zone where he could challenge discourses of management (Spicer & Böhm, 2007, p. 1678). The focus of the "numbers game" on only measurable data, rather than specific client/patient names, enabled Frank to provide false names without detection. Frank exploited the oversight and inefficiency of the system that attempted to govern his therapy practice; within this specific organisational setting, managerialism was both manipulable and inconsistent. His resistance also called into question the seeming precision and transparency of quantitative data, exposing the limitations of the neoliberal approach.

Frank found and took advantage of other inconsistencies and disjunctions in the managerial regime at his workplace. As discussed in chapter 5, a feature of neoliberalism/managerialism has been the elevation of business and corporate management knowledge and professionals. With the health reforms in Aotearoa New Zealand in the 1990s, "health" managers were replaced with "business" managers; practitioner knowledge was no longer a requirement for the management of public sector services. Chapter 5 detailed criticisms and the frustrations of therapists who worked in organisations where neoliberal forms of capital were legitimised over therapeutic capital. Yet for Frank, this management arrangement also provided opportunities for resistance and the operation of his sub-system. He described his workplace as "quite an oppressive environment, particularly with this [one] manager". In response to oppression:

> People became more creative in defying it in a way, and it was kind of almost like a game. And because he was the manager, I mean he actually had no clue of what really happens most of the time. And as a group of people, you also became proficient in sidetracking him, and when something else was put in place that maybe closed one gap then very quickly you find some other gap to still continue in the way you're operating.

Frank "played the game" within this system, with the intention of winning space and autonomy, by manipulating his manager. His description suggested a gap between management and practitioners, as he claimed the manager "had no clue of what really happens most of the time". He and his colleagues exploited this arrangement in order to operate their unofficial sub-system. Again, Frank's resistance undermined the supposed precision and reliability of neoliberal management and surveillance. The

manager's lack of knowledge of practitioner activities was a weakness that Frank could harness to pursue his own professional goals.

Frank operated his sub-system within the official system of this workplace for a couple of years. He did so with the knowledge that his tactics were time-limited and would eventually be discovered and halted:

> Frank: I mean in the end it all fell to bits, which I knew…
>
> Kate: You knew that was going to happen?
>
> Frank: Well, whatever you do sooner or later something will happen. And I also knew the system would be quite unforgiving.

Frank's deception and subversive, rule-breaking activities were eventually discovered and the sub-system did fall to bits. After this, he continued working but his activities were more closely scrutinised and controlled by management, and his working conditions became increasingly uncomfortable: "all these other things happened, which made life kind of awkward in a way, and I suppose were meant to teach me a lesson really". The workplace eventually became intolerable for Frank and he resigned from his role. He continued to do therapy work, but from outside the immediate public sector, working for an NGO service. Frank posed the most extreme and systematic acts of resistance of all the participants in this study, and was very successful at securing the means and space to do therapy in accordance with his professional standards. Yet his actions were not sustainable and carried significant risks in terms of his livelihood and professional role. Being a maverick and beating the neoliberal, medicalised therapy system were possible, but were also at odds with long-term survival within this system.

Conclusion: the toll and effects of resisting

The postmodern therapy practitioners discussed in this thesis are "boundary riders". Of necessity, they ride and negotiate the boundaries between their own philosophical positions, professional identities and aspirations, and the rules and norms of managerialist, medicalised public sector workplaces. This chapter examined the strategies and tactics used by one group of therapists to contest these rules and norms and to win space where they could exercise professional autonomy and do therapy work as they would like to. The discourse of professionalism and the liberal humanist and neoliberal concepts of self were used by therapists to play and contest "the game"

in their workplaces. At times, therapists refused instructions from management, voiced criticisms, and made use of the license granted to them by their professional status. Where possible, they agitated within the systems of their workplaces, voicing opposition and posing challenges. As they presumed a right to engage in official politics or invoked their therapeutic capital to discredit the regimes in their workplaces, they also reinscribed and reasserted dominant discourses, including neoliberal discourse: their resistances simultaneously undermined and reproduced dominant power relations. These public and professional contests – as in any hegemonic system – were necessarily complex, mixed and "never in a position of exteriority in relation to power" (Foucault, 1990, p. 95).

Part A of this chapter focused on therapists' assertions of their professional identities and capital, and their engagement with official politics as means of challenging the systems of their workplaces. As discussed, official politics had limited success for these therapists and posed potential risks. While overt acts of resistance did take place, my research shows that resistance by therapists to the rules and norms of workplaces largely happened surreptitiously and away from official view. Part B brought to light and examined the hidden transcript of the therapy field in Aotearoa New Zealand. Unofficially, and unbeknownst to management – and often colleagues – many therapists found ways and spaces to determine for themselves how they would practise therapy and engage with clients/patients, and for how long. They did so by constructing appearances of conformity with, and acquiescence to, the regulations and prescriptions of their workplaces, evading surveillance and sanction. As with the methods discussed in the first part of this chapter, these methods of resisting and subverting the governing system of their workplaces were similarly complex. While privately these therapists ignored and subverted the reigning discourses and norms of their workplaces, publicly they accommodated and reproduced them. They exploited the clash between different dominant discourses to further their own ends and interests, but left the public discourses of their workplaces intact. Under cover, and through the use of dominant discourses, therapists contested the meanings and nature of the therapy field and won space for autonomous practice, yet this largely remained absent from the official discourses and workings of their workplaces. The official discourses were maintained and reproduced, and appeared successful.

The tensions involved in "boundary-riding" and trying to negotiate the demands and instructions of neoliberalised, medicalised public sector therapy organisations also inflicted a toll on the therapists discussed in this chapter – hence my names for them, as battlers, burn-outs, and blow-outs. The in-between-ness experienced by these therapists, where they both attempted to resist and were forced to engage and appear to comply with workplace demands and instructions, was uncomfortable and, for many, unsustainable in the long term. As discussed, the strategy of using silence was an active performance by therapists that was integral to securing space for autonomous practice. However, several therapists spoke of the personal toll of *being silenced* within their workplaces, and connected this to burn-out, fatigue and disillusionment in their work. While these therapists seemed to enjoy sharing their triumphs and telling me about their methods for evading or beating often hostile work systems, isolation, weariness and uncertainty about both the value of their efforts and their future employment were common themes. For instance, I asked Alex what and who supported and sustained him in his work:

> Hmm, I kind of wonder that myself really, to be honest [both laugh]. Um [sigh/groan], I don't know. I mean I have my up and down days, and if I was actually honest I think I've been pretty close to leaving a number of times. So, you know, it still puzzles me.

While these therapists did find and exploit gaps, gaffs and disjunctions in the management of their workplaces, they were still largely constrained in their practice and unable to exert significant influence on organisational decision making. Frank was most successful at freeing himself from constraint, but for only a limited time and with harsh consequences.

Unsurprisingly, most of the therapists discussed in this chapter ended up leaving publicly operated services (a strategy that will be discussed in the following chapter): many were recounting past experiences to me during their interviews, and others have left their workplaces since being interviewed. Those who had left frequently described themselves as having "burned-out", reaching a point of physical and emotional fatigue that would not allow them to continue, or feeling the weight of profound disillusionment. For the likes of Frank, successful resistance was always going to be temporary, resulting in an eventual "blow-out", where he was effectively squeezed out of his position. The others, like Alex, the "battlers" who remained in the

public sector and were talking to me of current experiences, exhibited weariness and uncertainty that often made me feel sad. Boundary-riding for these group one therapists was personally difficult and professionally precarious.

9. Boundary Riders, Group 2: Infiltrators, Outsiders and Accepters

Introduction

As discussed previously, my analysis of the "boundary-riding" strategies and perspectives of the postmodern, critical therapists in this study organises them into two distinct groups. The therapists discussed in the previous chapter (group one) were united, to varying degrees, by experiences of personal and professional struggle. Publicly asserting professional autonomy and engaging in official politics were often disappointing and unsuccessful for these therapists. Of the tactics they employed to resist or subvert the norms of their public sector workplaces, many involved subterfuge or had thus far been undetected; while their acts and expressions of resistance demonstrated the incompleteness of the hegemonic discourses that attempt to structure the therapy field, and called these discourses into question, within the official, public realm these discourses seemed to remain intact. Within their neoliberal and medicalised workplaces, boundary-riding frequently involved isolation, disillusionment and fatigue, with several therapists either "burning-" or "blowing-out".

This chapter focuses on the second group of therapists (group two) – the infiltrators, outsiders and accepters – whose narratives were distinguished by the lack of personal struggle or pain involved in their boundary-riding. It focuses on the avowed strategies used by these therapists to negotiate between their own interests as therapists and the forces that limit and define the therapy field in particular ways. Some of the strategies used were similar to those employed by the therapists in the previous chapter: the group two therapists engaged in "official politics" (Spicer and Böhm, 2007, p. 1674) and they "worked the system", exploiting gaps and disjunctures. Others differed markedly: some of the group two therapists were intent on infiltrating the systems of their workplaces or sector and doing "inside work", while a significant number (including many of the group one therapists from the previous chapter) chose to leave the public sector. Their positions within the medicalised hierarchy of therapy professions influenced their use of these strategies and the success and comfort they experienced; their roles within the specific contexts of their workplaces impacted on

their experiences of "playing the game" within the therapy field in Aotearoa New Zealand. This chapter analyses these boundary-riding strategies, closely examining therapists' efforts to practise critical, postmodern-inspired therapy within the institutions of the therapy field. I pay particular attention to the "success" – personally, professionally and politically – of these strategies within the therapists' work contexts.

Following from this, the chapter closes by shifting focus briefly to the personal philosophies and deliberate self-positions taken by therapists in order to personally manage the tensions and contradictions of their work. The therapists examined in this chapter utilised and spoke discourses that privilege a tolerance for contradiction: they positioned themselves as practitioners with postmodern sensibilities and/or lived appreciation for biculturalism and the necessity of compromise, or as followers of Buddhism. These discursive frameworks both influenced and justified their experiences as critical, postmodern therapists negotiating neoliberal, medicalised work cultures.

The group two therapists avoided "burn-out" or "blow-out" and were able to practise their therapy work in ways that they experienced as sustainable and fulfilling. This chapter canvasses their boundary-riding strategies and discusses their self-conscious deployment of professional status and symbolic capital in effecting these; it concludes with a reflective discussion of their employment of discourses of tolerance for contradiction in the context of this work.

Strategies for negotiating and resisting

Official politics and medical/scientific capital

The previous chapter examined Alex and Frances' presumptions of professional autonomy and their attempts at utilising official politics as a resistance strategy and a means of engaging in debate over the nature and workings of their workplaces. These attempts, and Alex and Frances' expressions of professional opinion, garnered little success. I argued that despite rhetoric claiming the opposite, neoliberal, managerialist therapy workplaces are actually opposed to therapists' expressions of autonomy, freedom, and the capacity for critique and decision-making. However, other therapists in this study had more success with official politics and perceived this to be a viable

means for introducing alternative therapy ideas and practices to their professional colleagues; rather than wearing false moustaches and communing secretly with like-minded colleagues, these therapists were public and open about their interests. As the following discussion will demonstrate, the possession of particular species of social and cultural capital – namely, those that relate to science and medicine, and that wield symbolic power within the game at play in the therapy field – was integral to the openness with which these therapists shared their therapy interests and their abilities to exercise professional autonomy and opinion.

Danny was a psychiatrist working in the public mental health sector who had strong interests in critical, postmodern therapy practices. He told me about his experience of using narrative therapy ideas with a particular client/patient over a reasonably long period. Over the course of their work together, significant positive change took place in the client/patient's situation and the effects of what had been labelled as a specific psychiatric disorder lessened greatly. Consequently, Danny decided that it would "be good to present this [their work together] in a psychiatric context". According to Danny, the tradition of presenting interesting or significant "cases" to colleagues within the discipline of psychiatry involved a standard practice: "If you did bring a patient along you'd kind of wheel them in and then you wheel them out, and then you'd have the real conversation once they'd been wheeled out". When he discussed the idea of sharing this "case" with the psychiatry fraternity with his narrative therapy mentor, she promptly rejected this standard practice, declaring "well you can't do that. You have to do it differently". She challenged Danny to do a presentation that was consistent with the aims of narrative therapy. Danny's engagement with official politics – presenting an alternative perspective and challenging conventional psychiatric practices – was twofold: publicly introducing narrative therapy as an interesting and seemingly successful therapeutic approach and subverting the standard practices used for presenting casework to psychiatry colleagues.

The idea of engaging in official politics and presenting narrative therapy work in a psychiatric context was contingent upon Danny's full membership of the psychiatry profession. He explained his trepidation about doing an unconventional presentation:

> I knew that the ideas weren't necessarily going to be well received, because in my training, I mean in the exam process, I was able to get through it reasonably well

by not emphasising my exotic interests. In the exam process you play the game, if you want to pass. If you want to get stalled and struggle with it then you can put your hand up about all the different exotic things that you're keen on and all the rebellious things that you might do. But if you want to get through, you play the game. And in the end I felt quite at peace with that because it was a means to an end really.

During the psychiatry exam process, Danny – like many of the therapists discussed in the previous chapter – kept his "exotic interests" secret and gave an appearance of conformity and conduct appropriate for a future psychiatrist (narrative therapy constituted one of his "exotic interests"). He policed himself and "played the game", recognising his subordinate position as a trainee-psychiatrist and publicly reproducing the norms and conventions of psychiatry.

However, by the time Danny contemplated presenting his narrative therapy work – and exposing his "exotic interests" – to his psychiatry colleagues, he had gained full membership of this professional group. He developed a narrative therapy-inspired presentation and delivered it at a regular meeting of psychiatry colleagues. Danny's presentation involved an inversion of standard practice. It was created in collaboration with his client/patient, who was positioned as an expert and authority on his own experiences:

> … all of these psychiatrists, some of whom would have had control over him at various times, but also some of whom he had tremendous respect for, asked him about his experiences of this stuff and what it meant to him, and so he was able to be the expert in this situation. He was creating new meaning around what had happened, in a typically narrative kind of way but very different for that setting.

Danny explained that the presentation consciously worked against the psychiatric tradition where "the patient would be sort of an object of observation, and you'd learn certain things". He endeavoured to orchestrate the presentation so that that client/patient was a subject, whose understandings of his experiences were of value to a psychiatric audience. Danny publicly introduced an alternative form of therapy practice to his psychiatry colleagues, disrupting and resisting the traditions of his discipline.

Danny's engagement in official politics, and public discussion about the nature of psychiatry work and practice, was integrally tied to the status he had achieved as a psychiatrist. In becoming a psychiatrist, Danny was granted entry into a specialised medical guild, where "medical dominance" accords practitioners control over the work situation, occupational autonomy within the wider division of labour, and occupational sovereignty over related occupational groups (Turner, 1995, p. 138). Bourdieu explains the transformation that took place in Danny's status, arguing that the academic and professional qualification "institutes cultural capital by collective magic" (Bourdieu, 1986, p. 51): with the achievement and conferral of qualifications comes an immediate increase in cultural capital. Within the medicalised therapy field, Danny's psychiatry qualification "confer[ed] power over the field" (Bourdieu & Wacquant, 1992, p. 101), and functioned as a "trump card" within the game at play in the field (p. 98). It granted him authority to share his "exotic interests" with colleagues and to engage in collegial conversation over the nature of psychiatry, however unconventional his ideas may have been. Danny challenged the norms and practices of psychiatry by publicly displaying his narrative therapy work to the psychiatry fraternity and by transforming the "standard practice" of case presentations. Yet he was only able to do this after achieving the requisite cultural capital that grants the right to exercise professional autonomy and to "speak" within the field.

When I asked how his colleagues received the presentation, Danny said: "Oh they were totally into it. And I think it was helped by the fact that I had relationship with quite a few of them and they'd been supervisors and so there was mutual respect and whatnot". Danny's comments highlight the role that social capital played in his successful use of official politics to challenge the norms and standard practices of psychiatry. According to Bourdieu,

> social capital is the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition – or in other words, to membership in a group – which provides each of its members with the backing of the collectivity-owned capital, a 'credential' which entitles them to credit, in the various senses of the word. (Bourdieu, 1986, p. 51)

Alongside, and in concert with, his psychiatry qualification, the relationships Danny had formed with psychiatry colleagues provided him with membership of an elite group. He had graduated from being a student, supervised and mentored by representatives of the psychiatry fraternity, to being a full member himself of this professional and social group. The recognition and acquaintance between Danny and members of his audience functioned as a "credential" that entitled him to credit: "mutual respect and whatnot" helped him as he presented alternative therapy ideas to his psychiatry colleagues. Unlike Alex in the previous chapter, Danny's presumption that he was able to publicly exercise professional autonomy and use official politics to engage in debate and conversation about the nature of therapeutic work with clients/patients was realised and welcomed by his professional colleagues. His cultural and social capital enabled him to participate in the "realm of elites" (Spicer and Böhm, 2007, p. 1673), who are most able to use official politics as a resistance strategy.

As discussed in the previous chapter, "[d]isciplinary power is not exclusively constraining. It also empowers, in the sense that it opens up and legitimates a discursive space for action" (Doolin, 2002, p. 381). Danny's narrative illustrates Doolin's assertion: Danny's recognition and acceptance of disciplinary power provided him with legitimate discursive space to introduce alternative therapy practices and perspectives to the discipline of psychiatry. Ruth also described the benefits of strategically accepting and reproducing disciplinary power. Ruth was a psychologist working in a public medical health setting. She was trained in critical and feminist therapy theories and methods, but described the new knowledge and training she had willingly pursued while working in her current workplace:

> My sense is of never having been a robust practitioner of mainstream psychology. I'm coming more to that as I've progressed really through my working life, learning different models and things. Like just now I'm learning about quantitative research and how to do a randomised control study [Kate laughs] and statistics, which were just so irrelevant when I was studying, because I was doing feminist qualitative critiques and things like that. So in some ways I'm only coming into it now [Kate laughs].

My laughter punctuated Ruth's story: I was amused by the thought of this critical psychologist teaching herself how to do a randomised control study. I assumed that

we both shared a critical view of the dominance of this scientific method in relation to the therapy field and what is known and seen as valid within the field, so to hear Ruth talking about these new interests seemed incongruous and surprising to me.

I questioned Ruth about her movement towards these methods of research:

> Kate: Is that necessary knowledge? Is that what you're finding? Or you want to learn those things?
>
> Ruth: Yeah, it is quite necessary in this environment, being the ultimate kind of medical quantitative environment [laughs]. If you want to do any research in this type of environment, and have it understood and listened to by colleagues, then you've got to know how to speak the same language. And as a psychologist I'm finding that my confidence has increased just because I'm approaching those areas that were previously taboo in some ways and can now relate to colleagues that perhaps came through more mainstream [clinical psychology] training programmes.

As discussed in chapter 6, the therapy field in Aotearoa New Zealand has become increasingly medicalised and "scientised": the "feminist qualitative critiques" that Ruth learned during her training represent subordinate and inferior knowledge and cultural capital in relation to authorised scientific methods. Ruth learned that, in order to engage in official politics and to "speak" and participate in professional debate in her medical workplace, she needed to strategically use the dominant discourses. Professional selfhood and autonomy is sanctioned and can be realised by possessing and utilising symbolic capital: namely medical and scientific knowledge and methods. Being seen and regarded as a "robust practitioner" promised Ruth access to the "realm of elites" and the ability to use official politics to present alternative perspectives to her largely medical colleagues (Spicer and Böhm, 2007, p. 1673). Ruth actively worked to include her critical and feminist therapy perspectives in official discourses by using the authorised scientific methods. These methods also gave Ruth access to social capital, as she was able to form relationships with a wider range of clinical psychology colleagues and achieve greater membership of this professional group.

The resistance posed by Danny and Ruth – as they engaged with official politics and introduced alternative therapy perspectives to colleagues – was persuasive because of the reverence they displayed for the norms and values of their disciplines and their

possession of the forms of capital that have the most currency within the medicalised therapy field. In their elite professional roles, they consciously worked with the power relations that structure the therapy field, strategically taking up the posture of a "robust practitioner" and utilising dominant discourses. However, in doing so they were able to offer forward alternative ideas to their colleagues and work towards altering the cultures of their workplaces.

Infiltrating the mainstream: "I'm not interested in being a heckling voice"

Ruth's pursuit of the most powerful species of capital within the therapy field was consistent with a broader discursive strategy used by some of the therapists examined in this chapter. Both Ruth and Jac's narratives emphasised a discourse of infiltration, which positioned them as therapists seeking to join and participate in the mainstream of the therapy field. Rather than fighting "the system" in their work cultures, they sought to strategically join it and to do, as Ruth described, some "inside work". This tactic differs significantly from those used by the group one therapists. As the following discussion demonstrates, Ruth and Jac deliberately accommodated and accepted many of the norms and structures of the institutions they worked in and engaged with, as they aspired to be included and recognised within these institutions. They specifically resisted the dominant medical interpretations of problems experienced by their clients/patients and instead put forward critical and alternative ideas and perspectives. Their efforts to involve and include themselves within the mainstream of their work cultures again illustrates the "ambiguity and double-edged nature of resistance" (Trethewey, 1997, p. 284).

As mentioned earlier, Ruth was a clinical psychologist with strong interests in feminist and critical psychology approaches to therapy work. She worked in a medical setting where there was little knowledge or awareness among medical staff of the mental health needs of clients/patients, and psychologists were regarded with some suspicion. She described needing to actively work against the preconceptions of medical staff:

> Ruth: We also need to really work to promote ourselves as allied health professionals, or adjunctive to a person's medical treatment. So, I mean, I was interested in talking to you because I see your focus is on perhaps critical

psychology. That's my assumption, is critiquing the norms of psychology.
Whereas, conversely I'm actually working hard to market psychology in this type
of setting …

Kate: Right, yeah. That's fascinating [laughs].

Ruth: … whilst at the same time being very aware of critical perspectives on
psychology and women's health and that sort of thing.

Ruth was correct in her assumption about my research: I was interested in therapists
who were critiquing the norms of psychology and I had presumed that her critical
psychology background would make her a rebel and agitator in her medical
workplace. Instead, she was working hard to promote and market psychology in order
to work alongside medical professionals, advocating psychological services as an
adjunct to medical treatment. She described marketing as "presenting a friendly face
of psychology" and "being personable and creating relationships with medical
professionals and the women who attend this service, being someone who moves
around the hallways, who's relatively friendly and approachable". Ruth identified
how, within the epitome of a medical setting, she negotiated the field. Her
negotiations involved seeking inclusion and acceptance within the field, rather than
courting controversy or openly disrupting the norms of psychology.

Ruth actively promoted her psychologist role within her hospital workplace by being
personable, friendly and approachable, and developing warm relationships with
colleagues. These were her initial means of promoting her discipline, and how she
worked at infiltrating the culture of her workplace. Rather than critiquing the norms
of medicine and psychology or engaging in the organisationally defined relationships,
she initially focused on the pleasures of relationships between colleagues. Maria
Dixon (2007) draws on the work of Foucault to discuss the role of pleasure in inter-
personal relationships. Foucault's pleasure principle, Dixon explains, assumes

> that the more pleasurable and transformative the relational tie, the more power
> actually flows between relational partners. Consequently, friendships or
> relationships that provide partners a sense of well-being, pleasure, and personal
> self-actualization could manifest a power that, as it grows in pleasure, could
> supersede the power of transactional, organizationally structured relationships
> (such as manager-subordinate) to shape organizational behavior (p. 290).

Dixon foregrounds the power that emerges and flows when people form pleasurable relational ties. This power is often overlooked when researchers restrict their focus to the influence of transactional, organisationally structured relationships on organisational behaviour. Friendly, pleasant and pleasurable relationships – even though, in Ruth's case, these were entwined with organisationally structured relationships – in themselves can be a determinant of how people experience and enact power (p. 291). Ruth's focus on friendly interpersonal relationships with work colleagues can be seen as instrumental to her negotiation of power relations within her hospital workplace: it enabled a flow of power that supported her as she worked in the hospital and aided her organisationally structured relationships with colleagues and her goal of infiltration.

Ruth utilised the power experienced from the establishment of warm and friendly relationships with colleagues to advance her own feminist political agenda within a highly medicalized workplace. It was a resource that helped her to join and then influence the workings of the dominant medical system that structured the activities and relationships at the hospital. By being personable, developing strong relational ties with medical colleagues, and promoting psychology as friendly and non-threatening to medical dominance, Ruth was able to action her agenda in regard to the treatment of gynaecological problems: "it's about increasing awareness of the role of the links between physical symptoms, intra-psychic factors, relationship factors and environmental stressors". She sought to expand health practitioners' understandings of women's gynaecological problems, encouraging them to view these problems as more than simply physical symptoms requiring physical remedy. Ruth had success in achieving this goal: "the staff general awareness of the link between physical symptoms and psychological factors is increasing as people become more aware of it here. We do quite a bit of staff education, mini seminars, that type of thing". Infiltrating the culture of her workplace, through the development of interpersonal ties and then the promotion of psychological services and approaches, allowed Ruth to establish some "discursive space for action" (Doolin, 2002, p. 381). In this space she was able to problematise medical ideas about women's gynaecological problems and effect change in how medical practitioners perceive these problems. Significantly, and in contrast to the group one therapists, she described her workplace as "an exciting environment" because it offered her a chance "to do some quite useful feminist

political work" – both at an institutional level and in her interactions with clients/patients. Ruth negotiated the forces of her workplace by infiltrating its medical culture. She won space for action and influence and for practising critical, feminist therapy.

Like Ruth, Jac also utilised a discourse of infiltration as she negotiated the dominant discourses of the therapy field and her own interests in feminist and poststructuralist therapy ideas. Jac was both a counsellor and a nurse, with a strong interest in sexual health. For Jac, infiltration involved utilising her already accrued cultural and social capital as a nurse in order to influence the treatment of sexual health issues in the public sector. Jac explained her relationships with health professionals:

> I do interact with health professionals and I really enjoy that. I think that I know that world so well that I can carry my ideas into that world in a way that I know how they'll be received. I can speak in a way that cultivates a receptivity to those ideas, and that's what I really enjoy, and that's where my work will be taking me. I'm really interested in bridging these ideas [feminist and poststructuralist approaches to sexual health issues] back into areas of health. Because, you know, doctors and nurses, those are the people who have the most impact on the people who are living with what concerns me.

Jac recognised the power exercised by medical practitioners in their professional relationships with people with sexual health problems. In turn, she recognised the value of both her familiarity with the medical world and her ability to use and speak medical discourse. These made her confident that she could "speak in a way that cultivates a receptivity" among medical professionals to feminist and poststructuralist ideas. Her knowledge of medical discourse and culture allowed infiltration, and for her to pursue change and influence from "inside" the system.

Jac explained more fully her use of infiltration as a strategy for resisting the norms of both medicalised therapy and medical approaches to sexual health, and for bringing about change in the overlapping medical and therapy fields. Infiltration involved the knowing reproduction of the power relations that govern the therapy field, particularly in relation to the forms of capital that have the greatest currency. This strategy was born from Jac's recognition of her difference from the mainstream of the therapy field:

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I do feel that I'm on the margins and the way that I can strengthen my voice on the margins, what I have done is to get qualifications because I think that allows me to have a voice that's considered to be creditable, even though it's a different voice.

Like Ruth and Danny, Jac recognised that qualifications, as well as proximity to medicine and science, authorise therapy practitioners to exercise professional autonomy and provide the possibility for putting forward alternative perspectives to colleagues. Recognised qualifications bestow legitimacy on practitioners and allow them to be perceived as "creditable". Jac strategically and calculatedly invoked her medical knowledge and credentials and pursued further qualifications in order to strengthen her voice from "the margins"; she recognised that her feminist and postmodern therapy ideas lacked currency and legitimacy within medical and dominant therapy discourses, so consciously sought protection and backing from qualifications.

Jac clarified the nature of the voice she sought to "strengthen":

I'm interested in being a voice from the margins but I'm not interested in being a heckling voice, you know. I'm interested in being a voice that makes a difference. And I think to make a difference, well… [pause]. I think heckling voices on the margins do make a difference, but that isn't the position I want to be in. I want to be able to infiltrate the mainstream and make a difference there, to be alongside medical colleagues, nursing colleagues, therapy colleagues saying "have you considered this set of ideas?"

Jac distinguished between a "heckling voice on the margins" and a voice that infiltrates "the mainstream" and is able "to make a difference there". While heckling voices on the margins can make a difference, Jac viewed working from inside the mainstream as the most effective and desirable means of bringing about change within the therapy and medical fields. Infiltrating the mainstream gives opportunities for collegial conversation and the sharing of ideas, while "heckling" from outside the mainstream connotes protest, antagonism and a potentially unreceptive audience. Jac was actively seeking and courting a receptive audience to her ideas, and saw joining and participating in the mainstream as a requirement for effectively trying to change mainstream treatment approaches to people's sexual health problems.

Like Ruth's, Jac's strategy for resisting and challenging the pathologising, individualising and de-politicising habits of therapy, especially within medical settings, involved strategically accommodating the norms of those settings: accommodation allowed space and license to present alternative ideas to colleagues. The professional hierarchies of the therapy field, and the power designated to particular discourses and species of capital – over others – remained in place and largely secure. These therapists consciously accepted and demonstrated respect for medical dominance within the systems they engaged in, with Ruth actively seeking pleasurable collegial relationships. They "played the game" within the public health sector, accruing symbolic capital and fashioning themselves to fit these systems, benefitting also from the association of their respective professions – nursing and clinical psychology – with medicine and science. The use of infiltration as a strategy for negotiating and resisting aspects of the power relations that structure the therapy field illustrates Dick and Hyde's (2006) claim (quoting Collinson)

> that consent and resistance are inextricably and simultaneously linked, often in contradictory ways within particular organizational cultures, discourses and practices. Resistance frequently contains elements of consent and consent often incorporates aspects of resistance (p. 555).

Resistances are necessarily engaged and entwined with the structures of power that they resist. Jac and Ruth strategically utilised dominant forms of capital and discourses: they followed the rules of their professions in order to earn success and power, invoked the "languages" of medicalised workplaces, participated in professional collegiality, and demonstrated conformity and reverence for professional hierarchies. They did so in order to challenge other dominant discourses within the therapy field. For them, doing "inside work" to infiltrate and change "the mainstream" meant both resisting and accommodating the power relations that work to structure the therapy field in Aotearoa New Zealand.

Leaving the public sector

Richard Sennett's book *The Culture of New Capitalism* (2006) examines the cultural influence of the "new economy", which has emerged out of institutional changes within the "cutting edge of the economy" (p. 12) over recent decades. The norms and practices of the new economy call for a flexible workforce, able to manage short-term relationships, while migrating between tasks, jobs and places. The ideal employee is

"constantly learning new skills, changing his or her 'knowledge basis'" (p. 44). The bureaucracies of the new economy operate under a "highly centralized, diminished authority model". With diminished authority and the rapid turnover of management that accompanies this model, "there is then no one in power who has shown commitment to the organization, who has experience of its problems, who can serve as a witness of the labours of those below" (p. 60). The workings of this new economy, Sennett argues, have been heralded as the exemplar for the larger economy, including government agencies and public sector services: chapter 5 demonstrated the influence of this model, as neoliberal and managerialist discourses have assumed dominance within the therapy field in Aotearoa New Zealand and "entrepreneurialism" has been encouraged among workers. The professional knowledge and skills of therapists have been usurped by managerial power and imperatives, and practitioners have been forced to adapt to unstable, frequently changing and "restructured" work environments. Within these environments, those in authority often lack understanding of the work done by therapists and may be motivated by a very different agenda.

Sennett contends that most people do not resemble the self that is idealised in the new economy: "they need a sustaining life narrative, they take pride in being good at something specific, and they value the experiences they've lived through. The cultural ideal required in new institutions thus damages many of the people who inhabit them" (p. 5). Chapters 5 and 6 documented the manifestation of neoliberal and medical/scientific dominance within the work settings of the therapists included in this study. These chapters detailed the limited space and agency granted to therapists motivated by critical and postmodern therapy ideas. Following from this, chapter 8 closely examined the boundary-riding strategies utilised by one group of therapists working within public sector therapy services to negotiate and resist the norms of their work environments and the instructions for their therapy practice. I concluded that these strategies were difficult for the therapists to sustain: isolation and the efforts required to both "wear false moustaches" and "work the system" left therapists fatigued and disillusioned, with some suffering from "burn out" or being reprimanded for their subversive activities. A closeted, underground working life, where it is difficult to find an appreciative and supportive audience for both the successes and challenges of therapy work with clients/patients, obstructs therapists from

experiencing a sustaining life narrative and taking pride in being good at their work: there is little institutional support for the development of pride under these circumstances. The difficulties they experienced in trying to "fit in" to their public sector workplaces – which required engagement with and seeming adherence to neoliberal and medical discourses – caused damage to these group one therapists.

In response to this damage, many of the therapists discussed in chapter 8 chose to leave public sector therapy services. This trend among my research participants is consistent with Van Heugten and Daniels' research (2001), which linked the rise of neoliberal reform of the public sector in Aotearoa New Zealand over the late 1980s and the 1990s to the movement of social workers into private practice. "Burn out" and disillusionment as consequences of the restructuring of public services led many social workers and other public welfare workers into private practice (p. 745). For the therapists in this study who experienced struggle and difficulty in their public sector workplaces, working privately or for non-governmental and voluntary sector welfare organisations became increasingly appealing. Moving to employment outside of the public sector was a strategy therapists used to resist the impact of medical and neoliberal discourses on their therapy work and to secure space, freedom and support to practise critical, postmodern therapy.

Private practice therapy work differed greatly from Jo's previous workplace, which had delivered clinical psychological services within the public mental health system:

> It's very different [in private practice] because I'm away from the concept of assessment, there's no requirement to do that. And what the client comes to me about is totally what we look at. Like there's no other thing that I'm having to manage. Like I'm not having to manage how I communicate all that assessment stuff to them. It's so liberating, and I'm sure that has an impact on how the clients feel too. … And in private work I don't have to work with a psychiatrist at all, so yee ha!

As discussed in chapter 6, the official discourse of public sector therapy services relies on and reproduces psychiatric discourse: biomedical constructions of the problems experienced by people engaged with these services dominate, and psychiatric assessment and diagnosis are fundamental to the therapy provided. In private practice, Jo was removed from official bureaucracy and able to avoid the full

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force of this official discourse, which meant she was not compelled to conduct clinical assessments of her clients/patients. She was able to focus her therapy work on "what the client comes to me about", rather than being sidetracked by the needs and instructions of the institution. Private practice freed her from having to manage the impact and repercussions of the institution's interests on her therapeutic work with clients/patients. Likewise, she was free from the clinical oversight of a psychiatrist and able to exercise her own professional judgement, much to her delight. As a practitioner, the freedoms offered by private practice were "liberating", allowing her greater space to exercise her own autonomy and skills as a therapist.

In my discussion of the medicalised, scientised therapy field in Aotearoa New Zealand in chapter 6, I described Cal's experiences of the medical professional hierarchy within a public sector mental health service. Cal had clashed with a trainee psychiatrist over his use of narrative therapy ideas in his therapy work. Cal explained that the conflict emphasised to him his "place" as a social worker within a medically dominated mental health system – as a "handmaiden" who "shouldn't have dared to do anything kind of spontaneous or outside the usual medical kind of practice". As a consequence of the conflict, Cal left this workplace and joined a community-operated counselling service. He described his first experiences in this new workplace:

> I remember getting to the agency and just feeling like I'd gone to a geographical piece of this city, an actual physical territory, where I could walk around and know that there would be other people who would be interested in the same approaches. And it was a huge relief to get to this agency, where there was a community of interest there and a community of support there. It didn't, it just couldn't exist at [my previous public sector workplace] at that time.

Cal's new workplace contrasted markedly from his experiences of the public mental health sector: he described a territory where he was both freed from the constraints of a medical professional hierarchy and able to enjoy a community of similarly oriented colleagues. His comments suggest that there was space and freedom for therapists to realise the promise of their professional status and to exercise autonomy and judgement in their therapy work. The official discourse of public sector therapy services did not dominate or govern working life within this community organisation, enabling therapists to discuss and practise critical and postmodern therapy approaches. Cal's experience of connection and community within this workplace

contrasts with the secrecy and isolation often experienced by the therapists discussed in the previous chapter: there was little need for false moustaches and subversive tactics within this territory.

Jo and Cal's descriptions of private and community sector therapy work suggest a positive alternative for critical and postmodern-influenced therapists to the opportunities available within public sector services. They experienced liberation, relief and – for Cal – community, and were able to do their therapy work largely free from medical authority and surveillance. Leaving the public sector represents a strategy for resisting the hegemony of neoliberalism and biomedical discourse, for finding space where the forms of therapeutic capital held by these therapists are recognised and legitimised. Yet this resistance strategy is not without compromise or tension; at the same time as securing space for agency and evading medical dominance, the move to private practice and community sector services also enacts and extends neoliberal ideology. The principle of privatization is essential to neoliberal ideology. Neoliberal reform in Aotearoa New Zealand involved – and continues to involve – a deliberate project of reducing the provision of welfare (and other) services by the state, with privatization and the outsourcing of public services favoured and encouraged. As therapists move into the private sector or join agencies that provide services on behalf or in lieu of the state, they accept the state's abdication of responsibility for the welfare of its citizens and take part in the construction of welfare services along neoliberal lines.

Ilcan (2009) analyses what it means to provide welfare services along neoliberal lines, explaining that the rise of the neoliberal governmental approach in Western states during the late twentieth and early twenty-first centuries has involved "a shift of emphasis from social responsibilities to private responsibilities" (p. 208). She describes this neoliberal style of thinking about and acting on problems as "privatizing responsibility" (ibid). As therapists shift into private practice work, funded often by government third-party payment schemes[33] or by clients/patients

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[33] Therapists may receive third-party payment for services from the Family Courts and from the state-run Accident Compensation Corporation. The Family Courts purchase counselling services from approved therapists "to aid couples to resolve difficulties and prevent expensive court proceedings" (Van Heugten and Daniels, 2001, p. 747). The ACC employs approved counsellors for sexual abuse counselling, physical injury counselling and work-related mental trauma counselling (Accident Compensation Corporation, 2011). In other instances, government agencies may establish additional

themselves, or join community-run welfare agencies, they participate in the privatizing of responsibility. Individual clients/patients, therapists, and community agencies all take up roles as agents of responsibility, while the state withdraws. When therapy is privatized, clients/patients are compelled to select and arrange for their own care, and often pay for it themselves or top-up third-party payments. Therapists operate their own small businesses, assuming responsibility for all aspects of the therapy transaction, as well as for their own professional development and sustainability. Both the client/patient and the private practice therapist are forced to demonstrate "entrepreneurship, autonomy, efficiency, and individualism" (ibid, p. 212).

These neoliberal values emphasise self-responsibility: clients/patients take on the responsibility for their own care and self-management, and therapists play multiple roles – as "responsibility experts" in their work with clients/patients, as businesspeople in addition to being therapists, and as providers of social welfare services in lieu of the state. Ilcan emphasises that privatization and the outsourcing of welfare services are

> not merely the reworking of the state but the means of governing new ways of thinking and acting, which stress a neoliberal governing rationality, that is, a rationality that emphasizes the opportunities of the market and business perspectives to solve current problems. (p. 212-213)

As clients/patients and therapists increasingly demonstrate their entrepreneurship and engage in therapy as a business relationship, they extend and entrench the market model as the solution for social problems.

With privatization and the outsourcing of services, in combination with a government emphasis on financial austerity and the reduction of state services, specific individuals and organizations have taken on duties that were previously the responsibility of the state. Since the economic reforms of the late 1980s and 1990s, the not-for-profit

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third-party schemes for the provision of therapy services; for example earthquake related counselling services after the Christchurch earthquakes in 2010 and 2011.

Disability allowances from Work and Income New Zealand are sometimes paid to people on low-incomes or receiving welfare benefits for the provision of counselling.

In addition to government schemes, privately operated employment assistance programmes also contract therapists to provide services to their member organisations.

voluntary or community sector in Aotearoa New Zealand has played a prominent role in the provision of health and welfare services. Community sector therapy organizations – like private practice therapists – following Ilcan's (2009) analysis, function as agents of responsibility: they support clients/patients to "act more responsibly" (p. 221-222), in the absence of a welfare state, at the same time as being compelled themselves to continually demonstrate entrepreneurship, autonomy and efficiency, particularly when they are accountable for public funding. Ilcan points out that the increased responsibilities of the voluntary/community sector have changed its character:

> Voluntary organizations and volunteers in many parts of the world are becoming increasingly responsible for managing the more vulnerable members of society instead of being a dynamic campaigner that demands change for the disadvantaged and the marginal. This situation has substantially reduced the capacity for the voluntary sector to make changes at the social policy level, especially under current conditions where research, advocacy, and sponsorship are fading in many western liberal societies (p. 228).

As the voluntary/community sector subsidises the state's withdrawal of responsibility for the welfare of citizens and/or is contracted by government to provide welfare and health services, resources and funding are increasingly geared towards service provision. Political advocacy, campaigns for reform and social policy initiatives become less of the "business" of busy, largely under-resourced community providers, and may be impeded when government contracts are a key source of funding. The dispersal of the work and social responsibilities of the state into the community and private sectors complicates and obscures lines of accountability and responsibility. Community organisations and private practitioners are implicated in the agendas and workings of the state, but are also isolated and outside of it: accountability to their "consumers" – both clients/patients and the parties who fund them – rests with the individual organisation or practitioner. Under this model, community organisations and private practitioners have fewer pathways or opportunities to advocate or work for social change at a macro level in society.

Private practice and community sector therapy work offered therapists in this study freedom from medical scrutiny and hierarchy, and space and support to practise their preferred therapy approaches, and they enjoyed being able to exercise professional

autonomy. Yet, as the above discussion demonstrates, therapy work within these locations involves therapists in the privatisation of responsibility and makes them actors in the campaign to extend the market-model into the activities and issues of social life: their professional autonomy is double-edged. For many of the therapists in this study, the user-pays principle of privatization was an obstacle to private practice therapy work and highlighted their discomfort with entrepreneurship and the market-model for social services. Charlotte pointed out that "in private practice, you tend to only get people who can pay for it, which is another constraint". With the state's retraction of welfare services and the rise of privatized therapy, clients/patients often need to fund therapy themselves. The limited availability of third-party funding means that therapy is often only possible for those who are able to make the financial investment. Jac explained her preference for therapy work within institutions that impose no charges on clients, comparing it to her experience of private work and demonstrating the impact of user-pays on clientele:

> I meet a very interesting cross section of people, you know, it's very interesting and enlivening for my work. When I have done private sector work I have found it's a much more homogeneous group of people that I work with, which is very pleasant, but I just find it more enlivening working with a wider cross section of people. … I think philosophically I find it much easier working in an agency that provides free therapy than I do charging individual people to talk about the suffering that they're living with.

In Jac's experience, workplaces where therapy services are free of charge allow diverse groups of people access to therapy. Jac's preference for public sector therapy work related to her desire for the "enlivening" work that comes as a result of this diversity, but also stemmed from a critique of privatization. She countered the self-responsibility, user-pays discourse of neoliberalism, expressing discomfort with the idea of charging clients/patients "to talk about the suffering that they're living with" – her summation invites incredulity for private therapy as a line of business. For many therapists in this study, entrepreneurialism and the competitive business ethos did not fit easily with their professional identities as postmodern, critical therapists, and made private practice a problematic refuge from the struggles experienced within the public sector: leaving public sector workplaces did not entirely free therapists from the constraints and tensions that neoliberalism has brought to the therapy field.

Like other therapists, Kerry found the user-pays culture of private practice difficult to adjust to after leaving the public sector. She explained how she attempted to navigate user-pays in her private therapy practice:

> So it took me a long time to grapple with the idea of people paying me.
> I found that very difficult to start with, um. So I sort of found some ways of making peace, I compromised with it really around having a sliding scale. So at times being paid more by agencies to do supervision and subsidising people I might be seeing like for ten dollars. Or like with the disability allowance, making sure it was within what they [clients/patients] were actually being paid, so it was extra money coming in for counselling rather than eating into the money people had to live on. And I've never charged a top up for ACC work for that reason either. So that's the sort of compromises that I made really.

Kerry's compromises enabled her to moderate the impact of the user-pays model on her therapy work with clients/patients. Her concern for ensuring that her clients/patients did not use money needed to live on to pay for counselling meant she operated a sliding scale, where she lowered her charges for people for whom counselling would otherwise be unaffordable, and did not charge money on top of a WINZ disability allowance or ACC funding for sexual abuse counselling.[34] By using these strategies, Kerry undermined the entrepreneurial discourse of privatization and the competitive, wealth-generating ethos of capitalist business. She combined social justice discourse with her private practice business enterprise. However, she also individually subsidised the shortcomings of the state, sacrificing her own income to ensure that therapy services were accessible for those who needed them, when there are few options in the stripped back, medicalised public sector. Van Heugten and Daniels made the observation in 2001 that "although the hourly rates paid under third party schemes seem attractive to some wage earners, these may be a cheap option for the provision of welfare services" (p. 748). They point out that private practice therapists do not have employers who pay for "accommodation and other overheads, sick leave, holiday pay, or maternity leave. The largely female private practice workforce absorbs fluctuations in demand, expanding and contracting as required" (p. 748). Their comments highlight both the value for money that privatized therapy offers the state and the precariousness of this realm of employment for therapists. In

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[34] See footnote 32 for a description of the WINZ disability allowance and ACC funded counselling.

refusing to top-up third-party payments – which may not adequately cover the full costs of counselling services – Kerry eased her own ethical concerns but at her personal expense. She assumed individual responsibility for the provision of affordable welfare services to clients/patients, a responsibility that once belonged to the state.

As mentioned above, privatisation and the outsourcing of services have meant the dispersal and individualisation of responsibility for the social welfare of citizens. The privatisation of responsibility means that individual practitioners and community organisations tend to operate in greater isolation than practitioners within the public sector and are more removed from the workings of the welfare system. For Alex, this made both private practice and community sector work unappealing, despite his many frustrations with his public sector workplace. He explained his view of the limitations of non-public sector work in relation to his work with young people in educational settings:

> The only place to practise easily in the public system, across school, home, other agencies and other types of contacts is in this job. Which is really sad but it's really hard to do this kind of work being positioned in any other place. … I mean I think I could work privately but again the contract that you have is very different. Well, I don't think I have that much of a say now [in my job], but the way in which you are linked in to systems is very, very different, in fact [in private work] you're quite removed. And it's interesting when a school will employ a counselling agency, counsellor comes in, does group work, child disengages, that's it really. You know, they're not involved with parents at all, not really involved in the school systems at all, not able to challenge the principal at all.

In his role as an employee and representative of a public sector welfare service, Alex was given authority that extended across multiple institutions, including the family of the young person, the school, the systems surrounding the school, and other agencies. He observed that privatized responsibility for the welfare of specific young people in schools lessened the reach of practitioners: their agency and authority were limited, making it difficult for them to engage with the systems and the contexts that affect their clients'/patients' lives. This lack of engagement implied that such practitioners were primarily only able to focus the responsibility for change on the individual

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young person. As a practitioner influenced by postmodern therapy ideas, Alex took a contextual, systems view of the problems experienced by young people in schools. By being in the public sector – however restrictive his workplace was in other ways – he was authorised to engage with relevant systems when working with young people. He viewed the isolation and limited reach of private practice and community agencies – where they are unable to act beyond a child disengaging with counselling – as impediments to working effectively, making non-public sector work unappealing to him.

As this discussion demonstrates, leaving the public sector is a double-edged strategy for resisting the hegemonic forces of the therapy field in Aotearoa New Zealand. Individual therapists were able to enter and participate in work environments that were much more comfortable than those many of them had experienced in the public sector. For therapists like Jo and Cal, and others who had struggled in the public sector, private practice and community organisations provided relief from and an alternative to the prescriptions, regulations and management agendas of the public sector. They enjoyed greater professional freedoms and autonomy, without medical surveillance. Away from the full force of the medical model of mental health, there was also greater potential to experience collegial support and community within agencies and for therapists to find encouragement in their work with clients/patients. The freedoms and autonomy experienced by therapists outside the public sector enabled them to practise critical and postmodern-inspired therapy with fewer restrictions, but were also consistent with neoliberal rationality: therapists and the community sector become more entrepreneurial and self-governing, while the state retreats from responsibility for the social welfare of its citizens. Private practice therapists and community sector organisations take up this responsibility, economically subsidising the state and enabling its retreat and the spread of the free-market model for social services. The privatization of responsibility makes private practice therapists and community organisations – as well as clients/patients themselves – agents for self-responsibility, individualizing therapy work and isolating it from the official realms of the state. While isolation from the state, and its systems and authority, granted therapists more space to determine for themselves the nature of their therapy work, it also makes it difficult to engage with the wider systems affecting clients'/patients' lives or to advocate for social change.

Conclusion

This chapter has considered the strategies used by critical, postmodern therapists to resist the dominant forces at play within the therapy field in Aotearoa New Zealand and to win space for action. The therapists in this chapter are distinct from those in the previous chapter because their strategies were largely viable and sustainable, and they were largely satisfied in their working lives: they were not battling and did not "burn out" or "blow out". Like the group one therapists, some group two therapists engaged in official politics, openly and publicly presenting critical therapy ideas and alternative approaches to colleagues and wider audiences within the field. In doing so, they consciously used and exploited their command of symbolic capital and their status within the medicalised, "scientised" therapy field. Similarly, those therapists who used infiltration of the mainstream of the therapy field as a resistance strategy made deliberate and calculated use of the dominant species of capital in order to engage in the flow of power. They also demonstrated how focusing on the pleasures of collegial relationships could generate power. The activities that accompanied infiltration – as opposed to "heckling" – won therapists access to legitimate discursive space for action and enabled them to influence the operations of their work environments. Numerous group one therapists – who frequently lacked symbolic capital or status within the medical hierarchy – refused to be further damaged by the cultural ideal of the "new economy" and left the public sector. They resisted the most regulatory and restrictive forces of the therapy field by exiting and instead joined community health or welfare organisations or embarked on their own private practices, where they were less encumbered by medical discourse or organisational restructuring.

In using these particular resistance strategies, therapists both challenged the dominant norms and values of the therapy field, finding ways to practise critical and postmodern-influenced therapy, and experienced contentment and pleasure in their work. Engaging in official politics and infiltrating the mainstream of their work systems – making strategic use of accrued symbolic capital – enabled therapists to present and share alternative approaches to therapy work with authority and persuasiveness. In doing so, they successfully engaged in altering the terrain of the therapy field, but avoided conflict, discomfort or threats to their livelihoods. For others, who lacked the resources and authority to use official politics or to infiltrate,

leaving the public sector provided them with far greater space to do critical, postmodern-influenced therapy work and enjoy the pleasures and satisfaction of collegial relationships away from the medical hierarchy and managerial scrutiny. These acts of resistance and negotiation are important examples of how therapists can negotiate the conflicts and constraints of the therapy field and maintain their livelihoods and physical and mental health.

Yet, as my discussion demonstrated repeatedly, these strategies were also double-edged and not without compromise and tension. Successfully using official politics and infiltration to pose resistance also involved reproducing and demonstrating reverence for dominant discourses and forms of capital within the therapy field. These tactics relied on and affirmed the medical professional hierarchy, which grants greater license and autonomy to practitioners with medical and scientific qualifications and credentials. The systems and methods of power that structured these therapists' workplaces remained strong and intact, even while they found ways to introduce some alternative and critical perspectives. Leaving the public sector allowed greater freedoms to therapists, but also made them actors in the neoliberal project of privatisation of health and welfare services. In their efforts to ameliorate the problems of the private practice and contracting-out models, therapists and community organisations took on the state's responsibilities, including the subsidising of therapy costs. The gaps and tensions in these resistance strategies demonstrated both the strength and complexity of the forces at play within the therapy field in Aotearoa New Zealand and the inevitably intertwined relationship between power and resistance: therapists drew on, used, and engaged with disciplinary power in order to pose resistance. The critical, postmodern therapy movement within Aotearoa New Zealand's therapy field takes shape in ways that are necessarily partial and without clear force or consistency.

Addendum: Reflecting on tolerance for contradiction

The final section of this chapter discusses a crucial feature of this group of therapists. It focuses on their professed ability to accept and tolerate the partial nature of resistance and the compromises they made in order to work with relative peace. The bulk of this chapter has examined the positions taken by therapists as they resisted and negotiated the structural imperatives of their work cultures: I have looked at the

strategies used to participate and intervene in the therapy field. This final section focuses on participants' self-reports of their states of mind, rather than on their external positions within the structures of their workplaces. It is an important component of the chapter as a whole because it examines how these therapists presented themselves personally in relation to the tensions and conflicts of their work: it considers their personal philosophies and stances as aids to avoiding "burn out" or "blow out" and having sustainable, enjoyable working lives. It is also significant that their philosophies demonstrated a matching of personal and professional orientations. However, this discussion has been separated from the main text of the chapter because the focus throughout has been on the play of institutional forces, not on subjective states of mind. Nonetheless, the material in this section seems to me necessary to include here because it represents an integral factor in these group two therapists' ability both to pose resistance in the ways that they do and to do this sustainably.

As I have emphasised and discussed throughout this study, my theoretical orientation to my research is informed by postmodern/poststructuralist thinking. This means that as I examine the resistance strategies used by critical and postmodern therapists to navigate and negotiate the neoliberal, medicalised therapy field, I necessarily find and foreground tensions, inconsistencies and contradictions: I demonstrate the inevitable partialness and complexity of resistance, and question totalising or binary conceptions of human activity. Many of the therapists discussed in this chapter self-consciously took up similar positions in relation to their professional lives. They acknowledged and embraced incompleteness and the inevitability of contradictions as they talked about themselves, freeing themselves from pressure to achieve completeness or coherence in their acts of resistance. Many drew on the same theoretical orientation as I do. Their knowledge of and training in postmodern, critical therapy approaches also functioned as a resource for their own approach to their working lives, informing their wider systems of values and beliefs. Therapists drew on other discourses that likewise supported them to take up deliberate positions of tolerance for contradiction and ambiguity. These included a national discourse of biculturalism and the spiritual beliefs and orientation of Buddhism. At the same time, this tolerance for contradiction was most common among therapists with standing in the medical hierarchies of their workplaces or whose public sector workplaces were less hostile to them, and among

those who had left the public sector: enjoying professional esteem and regard among colleagues, or relative freedom from oppressive forces within the therapy field, presumably makes tolerating contradiction an easier project. This section examines key examples of therapists describing and discussing their tolerance for contradiction and ambiguity; it concludes with a critique of these positions, questioning their efficacy and discussing their potential reinscription of neoliberal values.

Michel Foucault's view on resistance has been referenced and discussed throughout this thesis. He emphasises the inextricable relationship between power and resistance, explaining that "where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power" (1990, p. 95). Power relationships depend

> on a multiplicity of points of resistance: these play the role of adversary, target, support, or handle in power relations. These points of resistance are present everywhere in the power network. Hence there is no single locus of great Refusal, no soul of revolt, source of all rebellions, or pure law of the revolutionary. Instead there is a plurality of resistances, each of them a special case. … Are there no great radical ruptures, massive binary divisions, then? Occasionally, yes. But more often one is dealing with mobile and transitory points of resistance, producing cleavages in a society that shift about, fracturing unities and effecting regroupings, furrowing across individuals themselves, cutting them up and remolding them, marking off irreducible regions in them, in their bodies and minds (ibid, pp. 95-96).

The entanglement of power and resistance, from a Foucauldian perspective, means there is no "outside" to power relations; resistance is always engaged with power relations and is seldom absolute or consistent. Resistances occur at points and in moments in the power network, but fluctuate, serving multiple roles. They are mobile and transitory, and can both challenge and support power relations – often simultaneously. Foucault's view on resistance coheres with the broader postmodern view that human reality "is messy and ambiguous" and that "moral decisions are ambivalent" (Bauman, 1993, as cited in Chan and Garrick, 2002, p. 692). For those with a postmodern sensibility, modernist assumptions of objectivity, truth and coherence hold little sway, and grand ideas about resistance and the "pure law of the revolutionary" are not possible.

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Numerous therapists demonstrated this postmodern sensibility during my conversations with them. For instance, Ruth explained how postmodern/poststructuralist theories supported her within her hospital workplace:

> One of the Foucauldian analyses of power that I find very validating actually is the idea that to be a political agent of change you don't need to be a revolutionary, you don't need to overthrow big systems. You can actually be an effective agent of change in quite small, subtle ways. And I think that's one of my primary motivations at an individual level to do psychology.

Ruth was alert to and content with pursuing small, subtle acts of resistance as she worked as a psychologist. Foucault's theories of power and resistance freed her from feeling compelled to seek or be part of a "single locus of great Refusal", and enabled her to do psychology work with individuals in a relatively peaceful way, knowing that she could still be a political agent of change. For Ruth, being a "revolutionary", or being discontent with small and subtle moments of resistance, were incompatible with surviving the system of her workplace:

> In the end you realise that if you're going to survive here as a relatively mentally healthy person you actually need to realise that it's a lot bigger than you and a lot bigger than a few individuals. In the end, I mean I suppose this is quite an interesting political observation, but you end up focusing on your own sphere of influence to the extent that you can. I'd say that's how I survive in it.

While poststructuralist ideas greatly influenced Ruth's approach to working as a psychologist with clients/patients, they also proved integral to negotiating her own position within the system of her workplace. Foucault's focus on resistance at the level of micropolitics, where cleavages and fractures can occur in the midst of regimes of power, supported Ruth to focus on her own "sphere of influence". Poststructuralist discourse enabled her to refuse the binary of resistance/accommodation and to tolerate the inevitable compromises and contradictions of her working life – allowing her to survive the system as a "relatively mentally healthy person".

As discussed in chapter 3, postmodern, critical therapy practitioner-theorists have taken up the philosophical ideas of deconstruction, postmodernism and feminist poststructuralism and developed practices for doing therapy work: they have found ways to enact these philosophies within the therapy field. For example, Johnella Bird

extends poststructuralist criticism of binary oppositions into the realm of therapy. From Bird's poststructuralist perspective, binaries represent experiences as static, and therefore trap people within them. She encourages therapists to use processes that "move past the polarities" (2000, p. 21): "In moving away from polarities (forgiveness or not) we create opportunities to generate language for the in-between. The language of the in-between generates an experience of movement" (p. 23). Bird's text *The Heart's Narrative* (2000) teaches therapists how to generate the language of the in-between in their work with clients/patients, and to thereby dismantle the binary oppositions that limit their lives. The subtitle to this text – *Therapy and Navigating Life's Contradictions* – foregrounds the inevitability of contradictions and "messiness" in people's lives. Bird stresses that "when we (therapists) are faced with contradictions, we must resist siding with one position over another" (p. 170). Her work encourages therapists to resist and move away from polarities and firm positions, and to embrace and practise in-between-ness in their therapy work.

Numerous therapists discussed in this chapter invoked the concept of in-between-ness, as an alternative to binary oppositions, when talking about how they positioned themselves within their work situations. In several interviews, therapists made reference to "both/and", a catchphrase that represents an alternative to polarised ways of thinking and speaking. When Cal was interviewed he was working as a therapist in a primary health setting, alongside medical colleagues. He talked excitedly about connections and collaboration among his colleagues, describing growing harmony and complementarity at his workplace among medical, psychological and other therapy approaches – including his own postmodern orientation:

> Gradually they're [medical colleagues] realising that psychology is not the only option, that there appear to be other alternative clinical approaches that aren't medical, that aren't psychological, that are not just available but actually sometimes preferred. There's a kind of a "both/and" thing: you can have medical approaches that are profoundly and magnificently healing, especially for physical things, but when you get into the realm of emotion, spiritual experience, there just isn't enough language in medicine, there isn't enough medical science to help medicine or medics to kind of get into conversations like that.

At the same time that Cal felt respect from medical colleagues for his therapy approach, he also expressed his regard for psychiatry: "I need people who know about

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medications and how to kind of fit a medical prescription to a person, and psychiatrists, they're it, they're the people who know that best. So 'both/and', that's how I keep answering these questions". Implicit in Cal's use of the term "both/and" was his rejection of a binary opposition between a medical model and postmodern, critical therapies: he embraced both his medical colleagues' approaches and postmodern therapy.

Cal contrasted his appreciation for "both/and" with his earlier life as a therapist when he had worked in DHB operated mental health services: "It was a bit evangelical for me for a while there. I wanted to trumpet kind of the 'good news' [about postmodern therapy ideas], but mostly it was about the folly of people in the medical system. I think I've got over that". Within a work environment where there was respectful collegiality across professional disciplines, Cal used the discourse of "both/and" to justify and support his self-position as someone who is tolerant and open to difference and contradictions. He had "got over" his antipathy towards the medical model, but also tempered his fervour for postmodern, critical therapy ideas, restraining himself from proselytising to others. Cal's stance drew on and invoked a postmodern therapy orientation to clients/patients – moving away from polarities and firm positions and cultivating in-between-ness. Stepping away from a binary of either postmodern therapies or the medical model, and employing the discourse of "both/and", helped Cal to enjoy his work relationships: "I can have lunch with people who I know I don't understand what they do fully, and I know they don't understand what I do fully, but we know it's working and we're not too bloody worried about it (laughs)". Cal used the discourse of "both/and" to explain his experience of peaceful, sustainable working conditions. He linked his retreat from "evangelism" and firm positions to his ability to accept compromise and difference among colleagues, while maintaining his identity as a postmodern practitioner. His example represents how therapists in this study applied postmodern therapy ideas to their thinking about their work situations. These ideas provided therapists like Cal with a rationale for freeing themselves from feeling stuck or torn between binary understandings of their work dynamics and accepting the messiness of human reality.

Therapists drew on other discourses, often in combination with postmodern and poststructural ideas, to support them in taking up positions of tolerance for

contradiction and ambiguity in their workplaces. Peter spoke of how boundary-riding in his workplace had become more comfortable and easy for him over time. In particular, he had discovered the ability to hold and value academic, social constructionist critiques of the enterprise of therapy at the same time as being committed to and content with his role as a therapist:

> I've come to realise that's where I sit. I used to want to be able to just sit in one of those two camps and feel at home in one of those two camps. And now I've given up the desire to do that. To sit in either place feels like I'd have to give up something which I really strongly believe in. And so what I do instead is to accept it's a less common place, but just finding a way to hold my critical beliefs about the dominant ways of doing therapy and doing mental health, at the same time as doing it [therapy and mental health work].

Like Cal, Peter's talk showed the influence of the "both/and" discourse. Despite the comfort and seeming coherence promised by belonging to only one "camp", Peter learned to tolerate and accept the ambiguity and tension involved in participating in and valuing these two camps. He depicted himself as moving in between outsider, social constructionist critiques of therapy and the mental health sector, on the one hand, and the inside workings of this sector, where he worked as a therapist, on the other.

When I asked Peter about the process of becoming increasingly comfortable with in-between-ness and his movements between these two camps, he invoked a national discourse of biculturalism:

> Well I think, I mean because I live in New Zealand the phrase that comes to mind is 'bicultural', because we know that people can cope with living between different worlds, and in fact if people are comfortable with or have enough of a meaningful attachment to whatever world they're involved in that they can feel quite enriched by drawing on both. And I suppose that's more how I see it now.

Peter connected "biculturalism" to people who live in Aotearoa New Zealand, referring to its status as an official discourse within the realms of public and political life within this country.[35] The numerous institutions that Peter represented in his role

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[35] Peter's comment alluded to the social and political context of Aotearoa New Zealand, where over the last thirty years biculturalism has taken shape as an official discourse referring to the relationship between the indigenous Māori people and the settler population. In concert with constitutional changes that took place in the 1980s, including reference to the Treaty of Waitangi in legislation, the then

as a clinical psychologist – his psychology training programme, professional association, and public sector health service – were all undoubtedly active in reproducing the national discourse of biculturalism and concerned with demonstrating its implementation (see discussion of codes of ethics in chapter 8). Peter reproduced a psychologised version of the biculturalism discourse, emphasising what is "known" about the personal, intra-psychic experience of biculturalism: that, with "meaningful attachment", "we know" that people can cope with moving between different worlds and cultures. Peter used this discourse as a means of further naturalising and supporting his own movements between different worlds: the public sector therapy world and the world of social constructionist critiques of therapy. It is a discourse that can emphasise hybridity, mobility and in-between-ness, and in this instance reinforced Peter's therapist identity as someone who is able to tolerate contradiction and ambiguity in working life.

For several of the group two therapists discussed in this chapter, whose experiences of working life involved reasonable comfort and contentment, Buddhist ideas and principles influenced how they positioned themselves. For instance, Jac explained her Buddhist-influenced philosophical position: "I think suffering is part of living, you know, that it's not a psychological pathology to experience suffering at times in our lives and to be silenced about speaking about that". While Buddhist and other Eastern philosophical principles – particularly the concept of "mindfulness" – have had significant bearing on the field of therapy in recent times,[36] the acceptance of suffering as part of living can also personally aid therapists as they negotiate work environments. As discussed earlier, Ruth described how she took up a Foucauldian-influenced position in her hospital workplace, which meant she would focus on her own sphere of influence to the extent that she could. I observed to her that it seemed like she was accepting of the inevitable tensions and conflicting forces at play within her workplace, and asked if she enjoyed her work there:

Labour Government also implemented a policy of biculturalism, which related to social service delivery, Māori language, and public rituals and practices (Spoonley, 2005, pp. 19-20). Spoonley observes that subsequent governments – even conservative ones – continued to adhere to bicultural policies, and that by "the 1990s, biculturalism had become part of the constitutional and policy environment of New Zealand" (p. 20).

[36] See, for instance: Acceptance and Commitment Therapy; Dialectical Behaviour Therapy; Mindfulness-based Cognitive Therapy; Mindfulness-based Stress Reduction.

Yes I do, I love working here. And, yeah, that term 'acceptance' I think is one that is okay for me spiritually and politically. And it's one that's also coming into psychology a bit more these days too, with an awareness that's coming in from eastern philosophies I suppose about what they call 'radical acceptance' in the face of overwhelming situational or life difficulties, which can actually be a valid and healthy coping ability. And so, like I mentioned, for me personally it's about long term survival in a system, or in any system actually, and I find it a really helpful way to remind myself about where I can be effective and where I can't. And it's perhaps philosophically guided by my understanding that life is not fair and the world is full of injustices and perhaps my agenda is not about striving for fairness and justice at the systemic level, it's about keeping my focus to where I can be effective with individuals in smaller systems.

From a Buddhist-influenced psychology perspective, "radical acceptance" "involves fully entering into and embracing whatever is in the present moment" (Robbins, Schmidt and Linehan, 2004, p. 40). It enables "true freedom", which is being without anxiety about imperfection: "This means accepting our human existence and all of life as it is. Imperfection is not our personal problem – it is a natural part of existing" (Brach, 2003, p. 21). Ruth linked the concept of radical acceptance to her goal of "long term survival" within the hospital system: from her account, accepting and embracing the reality of the present moment, with the knowledge that imperfection is a natural part of existing, supported her to focus on where it was possible to be effective and to tolerate the obstacles and tensions of her workplace. Her view on the inescapability of injustices – the inevitability of suffering – meant she narrowed her focus to her own realm of influence. Ruth related the discourse and practice of radical acceptance to her love and enjoyment of her job, suggesting it as a philosophy for having a sustainable working life in imperfect conditions.

Numerous group two therapists spoke and referenced discourses of tolerance for contradiction and ambiguity. I have examined several specific examples here, but more broadly most of the therapists in this chapter positioned themselves as accepting of compromise and imperfection, describing their efforts at enacting critical, postmodern therapy ideas as "a work in progress" and an imperfect project. Therapists used the discourses of tolerance for contradiction discussed in this section to explain and justify the personal comfort and contentment they experienced in their work

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situations: it seems that these ideas can support individual critical, postmodern therapists to accept and live with the inevitable tensions involved in participating in the therapy field in Aotearoa New Zealand. Tolerance for contradiction and ambiguity was informed and shaped by therapists' knowledge of postmodern/poststructuralist theories and by their therapy training and orientation. Understanding the world as inevitably "messy" and contradictory, and having suspicion of binary oppositions, reduced people's expectations of grand acts of resistance and justified their tempering of opinions and avoidance of proselytising. Therapists also linked tolerance for contradiction and ambiguity to Aotearoa New Zealand's cultural and political context of biculturalism, naturalising the experience of moving between "camps" and shifting positions. Likewise, Buddhist notions of the inevitability of suffering and the wisdom of "radical acceptance" also taught therapist-followers the necessity of tolerating and accepting contradictions and ambiguity. The examples of these therapists suggest that discourses of tolerance for contradiction and ambiguity can aid postmodern therapists in their negotiations of the therapy field – including medically oriented workplaces – and enable peaceful and sustainable working lives.

Nonetheless, it is important to acknowledge that these discourses seem to coincide with positions of relative privilege, either in terms of institutional hierarchies or sector mobility: the therapists who invoked these discourses while working within public sector workplaces – Ruth and Peter – possessed clinical psychology qualifications; social worker/counsellor Cal found it possible to benefit from the "both/and" outlook having moved out of the public sector. The clear value of maintaining a tolerance for contradiction is complicated by contextual factors, meaning it is unclear the degree to which these positions of tolerance are the origin of peaceful and sustainable working lives, or whether they are contingent upon the presence of pre-existing conditions.

It can also be said that while at a personal, individual level, discourses of tolerance seem helpful and sustaining, these discourses are also supportive of a neoliberal rationality. Although such a micro-political stance has been positively represented in this thesis, it will always involve questions of complicity with dominant power relations. In the context of the movement of forces structuring the therapy field of Aotearoa New Zealand – as it has been discussed in this thesis – it is worth noting how discourses of tolerance place upon individuals the responsibility for coping with

working conditions that are hostile to their therapeutic and political orientations. Again, as canvassed in the discussion of Ilcan (2009) above, the therapist is taking on an increasing burden of privatised responsibility, where autonomous professionals accept the necessity of having to be boundary riders, and to find ways to do this sustainably. It is perhaps unsurprising that an avowedly contradictory position itself suggests contradictions. At a personal level, it seems unquestionably positive to maintain mental, emotional and financial security through versions of "radical acceptance". And as this chapter has demonstrated, these therapists have enjoyed certain successes in their work situations and have secured space to practise therapy in the ways that they wish to. At the same time, this has involved in a sense becoming reluctant agents of neoliberalism, while the structuring forces of the therapy field remain largely unchanged.

PART 5

10.   Conclusion

This thesis brings to light a movement of therapy practitioners, across different professional disciplines, whose members are connected and motivated by postmodern therapy ideas; despite their differences and the isolation that some experienced in their work roles, as well as the individualised nature of the interview texts, this group of therapy practitioners was representative of a significant social movement within the field of therapy. Rather than concluding that the endeavour of therapy is untenable, or being reduced to paralysis in response to postmodern, poststructuralist and feminist critiques of the traditions of therapy, this movement has used these critiques to guide and formulate alternative theories and practices. My qualitative research project has revealed the presence of postmodern therapy practitioners across many spaces within the therapy field in Aotearoa New Zealand, including District Health Board mental health services, addiction services, tertiary and primary health services, schools and other education providers, community-based organisations, and privately operated therapy practices. These practitioners mobilised critical theories and assumptions of postmodernism, bridging the theory/practice divide by bringing these approaches into their work with clients/patients. While this thesis has not considered the experiences of clients/patients who encountered postmodern therapy practitioners, or appraised the actual work of practitioners, it has identified a distinct social group and phenomenon within the field of therapy in Aotearoa New Zealand, characterised by its members' command of particular forms of therapeutic capital and knowledge and their shared objectives and purposes.

In examining the working lives of postmodern therapy practitioners, and their efforts to actually *do* postmodern therapy work, I focused attention on the nature of the field of therapy in Aotearoa New Zealand over the 2000s. I have argued that neoliberal ideology has had considerable influence on the shape and character of therapy

services in this country, especially within the public sector, but also extending to the community sector and private practice. I have described how therapists were required to work within and negotiate professional environments that are focused on fiscal austerity, the quantification and commodification of the activities of therapy, and a market model of operations, where those managing and directing public services are commonly chosen for their commercial business and management skills, rather than their knowledge and experiences as practitioners. At the same time, my research has discussed the hegemonic status of medicine and science within the contemporary therapy field in Aotearoa New Zealand, charting a shift across public sector therapy services in the 1990s to increasingly medicalised conceptions of therapy and mental health. The official recognition and reproduction of medical and scientific discourses in the therapy field aids the project of neoliberalism, enabling greater gate-keeping and restrictions on access to publicly provided services and, with the demand for evidence-based practice, reinforcing an image of a public sector that requires "efficient", "proven", value-for-money services. Therapy practitioners in this study, trained in anti-pathologising, politicised approaches to therapy work, found themselves required to engage with the diagnostic/illness model of the *DSM* and be subject to a medicalised professional hierarchy. The predominance of neoliberal/managerialist, medical and scientific discourses and forms of capital within the contemporary therapy field complicated and obstructed the aspirations and objectives of postmodern therapy practitioners. The work environments within the therapy field, particularly in the public sector, were inconsistent with, and frequently hostile to, the professional skills and knowledge of these practitioners.

As explained in my methodology chapter, my research and the conclusions that I draw from it are inevitably limited. The knowledge produced in this thesis is shaped by my own authorship and interests and the context of its production. I identify with the participants of the research, both as a counsellor interested in postmodern approaches to therapy, and as a past worker within a therapy organisation under pressure from neoliberal and medical-scientific discourses who now operates a private practice. These identifications led the research in particular directions, as I pursued my dual research and professional interests in finding out how therapists resist and negotiate these dominant discourses: the participants' talk and strategies have influenced my own therapy and workplace practices. My alliance with the participants

also provokes compassion for their struggles and inevitably steers my analysis and conclusions in particular directions. Similarly, the research is also influenced by the contexts, positions and interests of the particular research participants. The research is not transparent nor all-encompassing: another researcher examining this topic, or different participants, would unavoidably produce different kinds of knowledge – but perhaps also share similarities. Likewise, qualitative research projects, given the smallness and selectivity of their samples, and the relationship between the researcher and the forms of data employed, are not intended to produce authoritative generalisations. My research findings are tentative, stemming from the texts of these particular postmodern therapy practitioners and subject to my own interpretive analysis. That said, I can and do make interpretive claims about the texts of these therapists. From my immersion in, and analysis of, the data provided by my participants, below I will suggest conclusions and make recommendations relating to the interactions between postmodern therapy practitioners and the controlling authorities within the field of therapy in Aotearoa New Zealand.

Parts 2 and 3 of the thesis revealed a schism between the postmodern therapy movement and the dominant forces of the therapy field. Part 4 focused on the methods and strategies employed by therapists to negotiate the therapy field and, where possible, resist the influence of its hegemonic forces and find ways to *do* postmodern therapy. From my analysis of the therapists' "boundary-riding" strategies, I suggest some significant conclusions. First, and importantly, my research indicates that critical, postmodern therapy work *is* taking place within the neoliberalised, medicalised therapy field in Aotearoa New Zealand, even in public sector services. This supports the theoretical position that hegemony and its discourses are never total or *complete*. Despite the official (neoliberal/scientised) discourses and management agendas that work to structure and govern the field, some clients/patients *are* encountering therapists who operate from a postmodern orientation. Therapists *are* resisting and subverting these dominant discourses and agendas and finding ways to practise alternative postmodern therapy approaches.

In itself, the evidence this thesis puts forward that resistance *is* taking place within public sector work organisations, despite their neoliberal-inspired policy directives and management structures, is significant. As discussed in chapter 7, neoliberalism

has been described as "colonising" economic and cultural life, becoming part of the collective "commonsense". Its discourses are so entrenched and far-reaching that they appear inescapable. However, this research contributes to the growing body of organisation studies that challenge the suggestion that neoliberalism is a Master, total and inescapable discourse and identity project. It looks at the specific organisational spaces and relationships of the therapy field in Aotearoa New Zealand. In doing so, I have demonstrated how workers within neoliberal regimes draw on a range of different and potentially competing social discourses: in this instance, membership within the postmodern therapy movement functions as a resource for the assertion of an alternative professional identity and for the development of a range of resistance strategies. The therapists in this study are neither passive recipients of dominant discourses, nor completely constrained by the force of managerialist bureaucracy and its instructions for working life.

While resistance to the dominant forces in the therapy field *is* taking place, within public sector services in particular, it seems that postmodern therapy is often a covert activity, especially when practitioners lack the legitimate capital and occupy lower positions within the hierarchy of professions. My research has revealed a hidden transcript of resistance within therapy workplaces, illuminating a range of subversive practices used by therapists to secure space for autonomous therapy activities and to protect themselves from scrutiny or sanction. The covert nature of postmodern therapy work within the public sector means, however, that the public, official transcript remains in place. As they keep silent, or translate their work into the dominant language of the therapy field, the ideas and ethical standpoints of postmodern therapy practitioners, and the successes or difficulties of their work, are excluded from official discussion and from the public image of their workplaces. The status quo appears to prevail. For many therapists, operating covertly and cultivating an appearance of conformity required extra work and energy, resulted in isolation, and was personally and professionally risky. My research suggests that the resistance strategies of postmodern therapy practitioners within public sector services – including covert activities, but also their (often thwarted) efforts to use official politics and to strategically "work" the contradictions and inconsistencies of the system – are frequently unsustainable.

At the same time, it seems that the kind of resistance that is most successful and personally tolerable for postmodern therapy practitioners in the public sector involves strategic acceptance of the arrangements of disciplinary power in workplaces and possession and use of the reigning forms of capital. This meant that therapists were most able to share openly aspects of their postmodern therapy perspectives and practices with colleagues when they possessed and displayed credentials and qualifications that wielded symbolic power. The therapists in this study who undertook such resistance gave evidence of its persuasiveness and of their consequent abilities to introduce new perspectives to seemingly conservative colleagues. Yet at the same time, the hierarchies and inequalities that structured their workplaces remained largely intact, with the therapists arguably reinforcing them. It seems no accident that the therapists most able to pursue these forms of resistance already possessed medical/scientific qualifications and/or were actively seeking to align themselves with medicine and science: no social workers in public sector services talked of successfully using official politics or infiltrating their work cultures. Publicly successful, sustainable resistance to the forces that dominate contemporary public sector therapy workplaces appears to be most possible for high-ranking therapists who are both prepared and best equipped to "play the game".

My thesis findings indicate that the public sector in Aotearoa New Zealand has lost, and is at risk of continuing to lose, politically-conscious, postmodern-inspired therapy practitioners from its workforce. This seems particularly apparent among the lower ranking professions of social work, nursing and general psychology, but also extends to clinical psychologists.[37] Numerous therapists discussed in chapter 8 had left the public sector as a result of "burn-out" or "blow-out", or because of a fundamental clash with their professional values; others were disillusioned and questioning their long-term desire to stay in their public sector workplaces. While private and community sector practice does not offer a complete escape from the pressures and influence of neoliberal and medico-scientific official discourses, these work spaces do promise greater autonomy and personal and professional comfort than many public

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[37] It is also, of course, possible that other therapy professionals who do not align themselves with the postmodern therapy movement are also leaving public sector services and also citing "burn-out", disillusionment and the unsustainability of their work as reasons for this. If this is the case, it should likewise be of critical concern to the directors and managers of these services and to the public service as a whole.

sector therapy services. The therapists in my study who have been lost to the public sector, or who are in danger of being so lost, brought a particular attitude to their work with clients/patients (as detailed mostly in chapters 3 and 4) that would seem to be of benefit to both clients/patients and to the sector as a whole. In their concerned approach to their roles as "social workers" for the "left hand" of the state, these therapists sought to mobilise in their work a postmodern ethical orientation that is avowedly alert to issues of power and social justice. It is concerning that the public sector in Aotearoa New Zealand should be losing therapists of this nature who arguably represent a progressive vanguard, offering significant alternatives in their field.

Given that, as discussed, numerous counselling and social work programmes in Aotearoa New Zealand teach postmodern therapy approaches to students, this trend is especially concerning. In addition to this qualification-oriented training, short courses or workshops on narrative therapy and other similar approaches also take place regularly throughout the country, organised privately or by particular interest groups, and directed at practising therapists. Therefore, on the basis of my research, I would recommend that, as well as teaching skills for ideal therapy situations – where therapists are free from external constraints or prescriptions – teachers and presenters also recognise the likely constraints experienced by therapists in their workplaces and engage in a pedagogy that addresses these non-ideal situations. The pragmatic realities of working life under neoliberalism and in medically oriented environments need to be explicitly incorporated into therapists' education and training. A critical feature of such teaching might be the cultivation among students of a personal tolerance for contradiction and compromise – applying postmodern theories to their personal and intra-psychic experiences – as I have suggested was helpful for some of the therapists in this study. This teaching would not be a simple remedy to the most hostile or oppressive work situations, nor is it likely to result in systemic, politicised changes within public sector workplaces. However, it may help therapists at a personal level to experience work as more sustainable and less damaging.

In addition, and in combination with this focus on the personal, subjective lives and experiences of postmodern therapy practitioners, educators could also develop teachings that focus on pragmatic boundary-riding practices for therapists. This might

include discussion of some of the resistance strategies canvassed in this thesis – for instance, ways of using official politics, asserting professional selfhood and ethics, the strategic use of silence, the skills of double-talk and presenting an appearance of conformity, the identification of avenues for "working the system", and methods of infiltration. It could also involve the formulation of other boundary-riding strategies. While such an approach may seem subversive, it would acknowledge and work with the very real conflicts that postmodern therapy practitioners seem to encounter in their actual work cultures: rather than perpetuating the silencing and "closeting" of therapists, which isolates and individualises their struggles, it would give greater cohesion to, and support within, the social movement that this thesis has described.

The twin forces of neoliberalism and medicalised mental health and therapy show little sign of abating. Indeed, as the current climate both nationally and globally is characterised by economic recession, fiscal austerity and the rationing and retraction of public services are likely to increase in prominence and monopolise government agendas (as is currently the case in Aotearoa New Zealand). However, as this thesis demonstrates, these forces are not masterful in any absolute sense: critics and opponents are active within the therapy field, and gaps and inconsistencies in managerial logic are ever-present and able to be exploited. While that managerial logic is perhaps unlikely to change in the near future, it might be hoped that the burgeoning social movement explored in this thesis can become more self-conscious, cohesive and collectivised and thus more able to sustain and resource itself and its members in challenging work situations.

Throughout this writing, I have at times brought my presence as the author to the fore and reflected on my relationship to the research. It seems appropriate and timely to do so again, as I bring the thesis to a close. At times I felt inspired while doing this research – both by the practices my participants described, and by their passion and tenacity. During interviews, and reflecting on transcripts, I also felt moved and concerned by some of their obvious struggles and hardships; and I hope that they are able to utilise strategies and/or find workplaces that enable them to work with ease and appreciation. At the same time, it has been gratifying and inspiring to hear their accounts and to learn of how these people have found ways to work – however fraught they may be – within the systems of the therapy field. At a personal level, the

work they do feels important, and I hope that they are able, despite inevitable contradictions and compromises, to continue doing it: in a culture increasingly dominated by narrow forms of valuation derived from the languages of science and economics, it is desirable that the "left hand" of the state is represented by individuals who are both critical and courageous, and who are able to work sustainably.

APPENDIX A

Information sheet for research participants

University of Canterbury

American Studies Programme

School of Culture, Literature and Society

INFORMATION

You are invited to participate in the research project –

THERAPY AS RESISTANCE?

The aim of my project is to examine how 'resistant' and self-consciously 'alternative' therapies/therapists negotiate dominant cultural structures and discourses. I am interested in examining the ways in which therapists/therapies have responded to critiques of psychology/therapy and how they work within, or try to get outside of, the terrain of therapeutic culture. In particular, I want to explore how such resistant and self-reflexive therapists conceptualise, enact and practice resistance, how they position themselves in relation to dominant understandings of therapy, and the challenges and negotiations involved in thinking about and doing therapy.

I hope to gather data from a number of different sources over the next 12 months. The process of data collection will mainly involve semi-structured interviews with therapists, counsellors, psychologists, educators, students and other professionals working within therapeutic environments and services. They will predominantly take the form of individual interviews and discussions, but may involve group discussion. Your involvement in this project will entail at least one interview, ranging in length from 1-2 hours. It may also involve a follow-up interview if you are agreeable. These

interviews will be transcribed and analysed. You have the right to withdraw from the project at any time, including the withdrawal of any information provided.

The results of the project will be used in my doctoral thesis and academic publications, but you may be assured of the complete confidentiality of data gathered in this investigation: the identity of participants will not be made public without your/their consent. To ensure anonymity and confidentiality tapes will be destroyed after their transcription. Pseudonyms will be used for all people. Typists will sign confidentiality clauses. Your transcript(s) will be available for you at your request.

In the application of these procedures I do not foresee any risks to you. Conscious, concerted efforts will be made to avoid causing you mental stress or emotional distress, or moral or cultural offence.

My project is being carried out under the supervision of Dr Annie Potts [contact information provided] and Dr Jessica Johnston [contact information provided] at the University of Canterbury. Please feel free to contact either or both of the above with any questions you may have. My supervisors and I would be happy to discuss any issues you may wish to raise, at any stage in the project. [My contact information provided.]

The project has been reviewed and accepted by the University of Canterbury Human Ethics Committee.

APPENDIX B

Interview questions

Intro/background

- Can you tell me about how you've come to be practising as a therapist/counsellor/social worker? What's brought you to your job/role now? Can you tell me a story of your background? How did you start doing this work?

- (note: take note of, inquire about if necessary age, gender, race/ethnicity, geography, sexuality, class background)

Nature of your practice – general

- Where do you work?

- Who do you work for?

- What sorts of other people do you work with? Interact with in your job/role?

- Who are your clients? – gender, race/ethnicity, sexuality, age, class etc

- How have they come to be your clients? Reasons for being your clients? How do they access you?

- What kind of therapy do you prefer/practise? What kind of training did you do, are you doing?

Philosophy/"doing" therapy

- What do you "do"? How do you work with people? Describe what you "do" – are you "doing therapy"? Would you call it something else?

- Can you tell me about your philosophy on working with people?

- How do you do therapy critically, alternatively? Is your practice "resistant", "alternative"? Political? How? How do you know?

- Where do you position themselves in relation to mainstream institutions? – Outsiders? Insiders?

- What are the goals of therapy? Your work with people? What's the purpose?

- What's your role as therapist? – describe your idea of your role.

- Are you an "expert"? In what ways do you subvert the notion of a "knowing therapist/unknowing client"?

- Are there any problems involved with working this way, working as a therapist? What pressures, tensions, problems do you encounter? Structures or organisations? How do you negotiate these? Can they be resolved? What would you like to do differently?

- How have they come to work in these ways? What/who has informed, influenced them? How have they formed their beliefs, ideas?

- Feminist therapists: how does feminist politics inform your practise, your idea of resistance through therapy?

- Diagnoses – do you use them? How? Can they be avoided? Negotiated?

"Recovery", transformation, change

- Do you want anything for your clients? What?

- What does change/recovery mean? Look like?

- Can you tell me any stories of how people you've worked with have changed/"recovered"?

Appraisal

- Why do you do this work? What sustains you?

- What do you enjoy, find satisfying? Dislike, feel frustrated by?

- Is it hard to maintain your position, enact your ideas?

- Are you satisfied?

- Any frustrations, dilemmas, problems that you encounter?

- Do you pose resistance? Are you successful? What is "success"? What does it mean? Look like? How do they know?

Is there anything else that you'd like to tell me? Anything you want to clarify?

Would you be willing to possibly agree to a follow-up interview?

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