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Editorial:
Diagnosing Injustice, Assembling Possibilities

A Special Issue for the 8th In Sickness & In Health International Conference

This special issue of Aporia stems from the 8th *In Sickness & In Health* (ISIH) international conference that took place February 13-15, 2024 in Auckland in Aotearoa New Zealand. Under the powerful leadership and vision of our friend and colleague Prof. David Nicholls and his collaborators, this edition was the first in the wake of the Covid-19 pandemic. Privileging an in-person meeting for some much needed 'gathering of minds', this edition brought together critical health scholars and graduate students, both familiar and new to the ISIH community, eager to unpack global and local health phenomena.

Much inspired by the organizers' post humanist and new materialist intellectual leanings, ISIH 2024 was a vibrant gathering that revolved around four resonant themes:
diagnosis • destruction • voice • assemblage

These themes are more than conceptual frames: they capture how healthcare is performed, consumed, controlled, resisted, and reimagined. They expose the material and symbolic terrains in which healthcare unfolds—from the intimacy of embodied experience to the broad architectures of policy, power and discourse.

The ISIH conference drew together both seasoned and budding researchers committed to interrogating contemporary health systems, illuminating the politics of care, and unsettling normative assumptions about health, illness, health work, and healing. Mapped onto questions of equity, epistemology, and justice, discussions spanned a wide spectrum of critical questions: from the entanglements of technology and the body, to the legacies of colonialism, to the aesthetic and discursive spaces through which health is imagined, governed, undermined and reinvented. This special issue showcases four contributions that exemplify this critical orientation, each engaging the conference's themes while inviting new ways to think, feel, speak and act as clinicians, thinkers, educators, and researchers in the health domain.

The first article by Keith Tudor addresses the field of psychotherapy as a site of tension, possibility, negotiation, and contradiction. Taking up the theme of diagnosis and its associated ideologies, the article critiques the rigid alignment of psychotherapy with dominant health paradigms shaped by Western medical and regulatory frameworks. Through an incisive analysis, the article disrupts binary constructions of 'wellness' and 'disorder'. The profession of psychotherapy, it argues, is at once inside and outside healthcare. In exploring the contested and fluid identity of psychotherapists as both healers and patients, professionals and dissenters, the piece reflects the theme of voice by foregrounding internal critique within a field that is both insulated and made porous by its own logics. The case of psychotherapy regulation in Aotearoa New Zealand exposes the risks of state-sanctioned registration: namely, the domestication of radical approaches under the guise of professional legitimacy. Here, destruction is both metaphor and mechanism, signaling the erosion of critical autonomy when professions become captured by medical orthodoxy.

A second article, also from the Aotearoa New Zealand context, turns the spotlight onto the prison as a "subjectifying machine", a term drawn from Foucauldian thought. This piece by Seán Manning and colleagues vividly illustrates how institutions shape identity through various forms of violence, containment, and exclusion. Centered on men with extensive incarceration trajectories, the paper dismantles rehabilitation models that presume—and seek to 'restore'—an autonomous, self-regulating subject. Instead, it suggests that the assemblage of criminal subjectivity, formed through adaptive performances of masculinity, loyalty, and risk, is less an individual pathology than a social, cultural and structural phenomenon. By resisting the fiction of the "agentive self," the author underscores the limits of conventional therapeutic models, challenging us to confront the deleterious realities of carceral health. The article's emphasis on power, marginalization, and identity in politically charged environments echoes many central themes of the conference.

A third article brings a critical lens to the policy landscape that shapes the mental healthcare system of the province of Québec, Canada, where thousands of people continue to lack meaningful and integrated care and supports. Using discourse analysis grounded in Anselm Strauss's understanding of social order as negotiated order, Pierre Pariseau-Legault and his collaborators explore how policy reforms have increasingly constrained the field of psychotherapy, with nurses in particular facing significant practice challenges in a space governed by legal uncertainties and competition. Mental health interventions are increasingly framed as depersonalized and decontextualized technical

tasks, which undermines their relational core and erodes professional agency. This devaluation of therapeutic labour reflects, and perpetuates, a hierarchical system that continues to privilege certain professional voices while leaving others in precarious states. The article speaks powerfully to voice in the context of policy-driven epistemic violence, as well as the obstinate maintenance, rather than the destruction, of outdated policy and regulatory frameworks. This enduring landscape exists to the detriment of revitalized frames for professional autonomy and the assemblage of care hinging on comprehensive relational community-based models.

Completing this special issue is a compelling commentary by Kelly Gregory and colleagues on diagnostic delay in women's healthcare. Here, diagnosis is not simply a seemingly neutral, well-rehearsed biomedical act, but a profoundly gendered, embodied, and political experience. Drawing on feminist and critical phenomenology, the commentary critiques the epistemic and institutional conditions that perpetuate and normalize delayed diagnoses for women across a range of health conditions. Importantly, it moves beyond cataloguing the reasons for such delays, asking instead who or what benefits from this delay, and how stigma and silence come to regulate women's help-seeking behaviour. Through critical phenomenology, the author calls for a methodology that holds both structural power and lived experience in view, an approach that resonates with the ISIH conference concern for voice and assemblage.

Together, these contributions offer more than critique: they articulate alternative frameworks for the way identity is constructed and performed, to examine how care work can be deployed across a wide variety of physical, discursive and political spaces, and to imagine how health justice can be pursued. They expose how norms are reproduced, how subjectivities are forged, and how the boundaries of health itself might be redrawn. In their distinct yet overlapping engagements with diagnosis, destruction, voice, and assemblage, these papers affirm the importance of critical scholarship in a moment when healthcare systems are both under strain and under scrutiny. Mirroring the 2024 edition of the ISIH international conference, we propose this special issue as both a reflection and a provocation, toward health futures that are more equitable, embodied, meaningful, and responsive to social and political complexity.

Amélie Perron, RN, PhD, FCAN
Editor in Chief

Éditorial:
Diagnostiquer les injustices, assembler les possibilités

Numéro spécial issu de la 8ème Conférence internationale *In Sickness & In Health*

Ce numéro spécial d'Aporia est issu de la 8ème Conférence internationale *In Sickness & In Health* (ISIH) qui s'est tenue du 13 au 15 février 2024 à Auckland en Aotearoa Nouvelle-Zélande. Sous la direction et la vision de notre ami et collègue le professeur David Nicholls et de ses collaborateurs, cette édition a été la première à être organisée dans la foulée de la pandémie de Covid-19. Privilégiant une conférence en présentiel pour un « rassemblement des esprits » bien nécessaire, cette édition a réuni des chercheurs en santé critique et des étudiants de cycles supérieurs, à la fois familiers et nouveaux dans la communauté ISIH, désireux de décortiquer les phénomènes de santé mondiaux et locaux.

Très inspiré par les orientations intellectuelles post-humanistes et néo-matérialistes des organisateurs, ISIH 2024 a été un rassemblement dynamique articulé autour de quatre thèmes résonnants : diagnostic • destruction • voix • assemblage

Ces thèmes sont plus que des cadres conceptuels : ils illustrent la manière dont les soins de santé sont dispensés, consommés, contrôlés, problématisés et réimaginés. Ils exposent les terrains matériels et symboliques dans lesquels les soins de santé se déroulent—de l'intimité de l'expérience corporelle aux grandes architectures du politique, du pouvoir et du discours.

La conférence ISIH a rassemblé des chercheurs chevronnés et en début de carrière engagés à interroger les systèmes de santé contemporains, à mettre en lumière les dimensions politiques du soin et à remettre en question les suppositions normatives sur la santé, la maladie, le travail dans le domaine de la santé et la guérison. Les discussions ont porté sur des questions d'équité, d'épistémologie et de justice, couvrant un large éventail de questions critiques : de l'enchevêtrement de la technologie et du corps aux héritages du colonialisme, en passant par les espaces esthétiques et discursifs à travers lesquels la santé est imaginée, gouvernée, érodée et réinventée. Ce numéro spécial présente quatre contributions qui illustrent cette orientation critique, chacune abordant les thèmes de la conférence tout en invitant à de nouvelles façons de penser, de ressentir, de parler et d'agir en tant que cliniciens, penseurs, éducateurs et chercheurs dans le domaine de la santé.

Le premier article de Keith Tudor aborde le domaine de la psychothérapie comme un lieu de tension, de possibilité, de négociation et de contradiction. Reprenant le thème du diagnostic et des idéologies associées, l'article critique l'alignement rigide de la psychothérapie sur les paradigmes dominants de la santé façonnés par les cadres médicaux et réglementaires occidentaux. Par le biais d'une analyse incisive, l'article perturbe les constructions binaires du « bien-être » et de la « maladie ». Il argue que la profession de psychothérapeute se situe à la fois en-dedans et en-dehors des soins de santé. En explorant l'identité contestée et fluide des psychothérapeutes, à la fois guérisseurs et patients, professionnels et dissidents, l'article reflète le thème de la voix en mettant l'accent sur la critique interne dans un domaine qui est, dans un même temps, isolé et rendu poreux par ses propres logiques. Le cas de la réglementation de la psychothérapie en Aotearoa Nouvelle-Zélande expose les risques de l'inscription sanctionnée par l'État : notamment, la domestication d'approches radicales sous le couvert de la légitimité professionnelle. Ici, la destruction est à la fois métaphore et mécanisme, signalant l'érosion de l'autonomie critique lorsque des professions sont capturées par l'orthodoxie médicale.

Le deuxième article, également issu du contexte d'Aotearoa Nouvelle-Zélande, met de l'avant la prison en tant que « machine à subjectiver », un terme tiré de la pensée foucaldienne. Cet article de Seán Manning illustre de manière percutante la façon dont les institutions façonnent l'identité à travers diverses formes de violence, de confinement et d'exclusion. Centré sur des hommes présentant un long parcours d'incarcération, l'article déconstruit les modèles de réhabilitation qui supposent—et cherchent à « restaurer » —un sujet autonome et autorégulateur. Il suggère plutôt que l'assemblage de la subjectivité criminelle, produite par des performances adaptatives de masculinité, de loyauté et de risque, est moins une pathologie individuelle qu'un phénomène social, culturel et structurel. En résistant à la fiction du « moi agentif », l'auteur souligne les limites des modèles thérapeutiques conventionnels et nous met au défi d'affronter les réalités délétères de la santé carcérale. L'accent mis par l'article sur le pouvoir, la marginalisation et l'identité dans des environnements politiquement chargés fait écho à de nombreux thèmes centraux de la conférence.

Le troisième article porte un regard critique sur le paysage politique du système de santé mentale dans la province de Québec, au Canada, où des milliers de personnes continuent de manquer de soins et de soutiens cohérents et intégrés. Au moyen d'une analyse du discours fondée sur la pensée d'Anselm Strauss au regard de l'ordre social en tant qu'ordre négocié, Pierre Pariseau-Legault et ses collaborateurs explorent la manière dont les réformes politiques ont de plus en plus limité le domaine de la psychothérapie, les infirmières en particulier étant confrontées à d'importants défis de pratique dans un espace régi par des incertitudes juridiques et par la

compétition. Les interventions en santé mentale sont de plus en plus considérées comme des tâches techniques dépersonnalisées et décontextualisées, ce qui sape leur essence relationnelle et érode l'agentivité professionnelle. Cette dévalorisation du travail thérapeutique reflète et perpétue un système hiérarchique qui continue à privilégier certaines voix professionnelles tout en laissant les autres dans une situation précaire. L'article parle avec force de la voix dans un contexte de violence épistémique induite par les politiques de santé, ainsi que du maintien obstiné, plutôt que de la destruction, de cadres politiques et réglementaires désuets. Ce paysage persistant existe au détriment de cadres revitalisés pour l'autonomie professionnelle et l'assemblage de soins s'articulant autour de modèles relationnels ancrés dans la communauté.

Ce numéro spécial est complété par un commentaire convaincant de Kelly Gregory sur les retards de diagnostic dans les soins de santé des femmes. Ici, le diagnostic n'est pas un simple acte biomédical en apparence neutre et bien rodé, mais une expérience profondément genrée, corporelle et politique. S'appuyant sur la phénoménologie féministe et critique, le commentaire critique les conditions épistémiques et institutionnelles qui perpétuent et normalisent les diagnostics tardifs pour les femmes pour un large éventail de conditions de santé. L'article ne se contente pas de cataloguer les raisons de ces retards, mais se demande plutôt à qui ou à quoi ces retards rendent service, et comment la stigmatisation et le silence en viennent à gouverner la recherche d'aide des femmes. Par le biais de la phénoménologie critique, l'autrice appelle à une méthodologie qui tienne compte à la fois du pouvoir structurel et de l'expérience vécue, une approche qui résonne avec la préoccupation de la conférence de l'ISIH pour la voix et l'assemblage.

Ensemble, ces contributions offrent davantage qu'une critique : elles articulent des cadres alternatifs pour expliquer la manière dont l'identité est construite et incarnée, pour examiner comment le travail du « care » peut être déployé dans une grande variété d'espaces physiques, discursifs et politiques, et pour imaginer comment la justice en santé peut être atteinte. Ils montrent comment les normes sont reproduites, comment les subjectivités sont forgées et comment les frontières de la santé elle-même peuvent être redessinées. Dans leurs engagements distincts, mais qui se recoupent, sur le diagnostic, la destruction, la voix et l'assemblage, ces articles affirment l'importance de la recherche critique à un moment où les systèmes de santé sont à la fois sous pression et sous surveillance. Faisant écho à l'édition 2024 de la conférence internationale ISIH, nous proposons ce numéro spécial tant comme réflexion que comme provocation, vers des avenirs de santé plus équitables, plus incarnés, plus significatifs et plus réactifs vis-à-vis la complexité sociale et politique.

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Abstract
Although the word psychotherapy, from the Greek (psyche + terapia) meaning soul healing, has multi-disciplinary roots, some of which date back to ancient Egyptian times, contemporary psychotherapy is predominantly aligned with health and healthcare. In response, the first part of the article interrogates the ideal of health and cure promoted by theories of psychotherapy; criticises the lack of critical practice regarding diagnosis; advocates a two continua approach to both sickness and health in psychotherapy; and argues that psychotherapy both is and is not a health practice. The second part of the article takes up the issue of the identity of psychotherapists and, by means of a review of different definitions of psychotherapy and of the more critical and radical traditions within the discipline and practice, argues that psychotherapists both are and are not health practitioners. The third and final part of the article offers a critical case study of the New Zealand Association of Psychotherapists' application for the state registration of its practitioners; and argues that such regulation and registration compromises the profession of psychotherapy, and thus that psychotherapy both is and is not a health profession.

Keywords psychotherapy; health practice; health practitioners; health professions; regulation

Psychotherapy practice, the practitioner, and the profession – In sickness and in health

KEITH TUDOR

Introduction

In the phrase "In sickness and in health", the conjunction "and" both juxtaposes and invites a dialectical consideration of the relationship between the two nouns "sickness" and 'health". Inspired by the original call for papers for the 8th International *In Sickness and in Health* Conference (held in Auckland, Aotearoa New Zealand), and the call for papers for this special issue of Aporia, this article discusses the sickness and health of the profession of psychotherapy. It discusses psychotherapy as a practice, with regard to its practitioner, and to the profession. It offers a critical perspective influenced by Marxist analyses of and perspectives on psychotherapy (Holzman & Newman, 1979; Parker, 2007; Sève, 1978; Tudor, 1997/2017), as well as post-modernist, deconstructive views of the practice and profession of psychotherapy (Burman 1994/2017; House, 2003, 2010; Parker, 1999; Parker et al., 1996), and indigenous critiques on what is, in effect a Western (and Northern) tradition of psychology and its therapies (see Shepherd & Woodard, 2012; Woodard, 2003). The critique offered in this article is theoretical, practical, and personal in that it draws on literature about the practice and profession of psychotherapy, it discusses the implications of such critique for practice, and it's personal in that, having long-argued for the professional regulation of psychotherapy, the author, who lives in a country in which the title "psychotherapist" is protected and regulated by the state (Aotearoa New Zealand), and practices psychotherapy chooses not to be a registered psychotherapist.

The purpose of the article is to question the positioning of psychotherapy as a health practice and, academically, a health science, as distinct, say, from a discipline in humanities and/or social science; and, therefore, to question the positioning of the psychotherapist as a health practitioner; and, finally, the

profession of psychotherapy as a health profession – all from a dialectical "both…, and…" perspective. Finally, it is hoped that the critical analysis advanced in this article is applicable not only to the practice and profession of psychotherapy internationally, but also to other professions situated in and beyond health and social care.

Psychotherapy practice

Although psychotherapy, from the Greek (psyche + terapia) means soul healing, and has multi-disciplinary roots, some of which date back to ancient Egyptian times, contemporary psychotherapy is predominantly aligned with health and healthcare, which, ironically, generally refers to ill-health and illness and the care of illness.

It is commonplace to date psychotherapy back to 1896 when Sigmund Freud introduced the term "psychoanalysis" (e.g., Norcross et al., 2011; Paris, 2013). There are, however, two problems with this particular carbon dating: firstly, that it equates psychotherapy with psychoanalysis, which is problematic as there are traditions of psychotherapy which are not psychoanalytic; and, secondly, it ignores other traditions that predate Freud. These include:

- Healing traditions – early Egyptian papyrus (c. 1550 BCE) refer to dementia and depression; in ancient Greece, Hippocrates of Kos (c.460–c.370 BCE) taught that melancholia has a biological cause (Kourkouta, 2002); and, thoughout the world, there are different and diverse traditions of indigenous healing. In their recent book, A Critical History of Psychotherapy, Foschi and Innamorati (2023) acknowledge the(se) ancient origins of psychotherapy, and the existence of mental health care from antiquity.

- Medicine – in the Western tradition, this includes the mental healing practices of Paracelsus (1494–1541), a Swiss physician; Franz Anton Mesmer (1734–1815), an Austrian physician who first developed a concept of what he called animal magnetism, which later came known as mesmerism, and later still as hypnotism; and the work of the English surgeon and writer, Walter Cooper Dendy (1794–1871) who, in 1853, introduced the term "psycho therapeia".

- Psychiatry – from the work of Philippe Pinel (1745–1826) who, as director of the Bicêtre and Salpêtrière asylums in Paris initiated a nonviolent and non-medical moral treatment which has been described as cultivating "a warm and trusting familial environment in which [patients] could feel that their mental condition did not in any way preclude participation in normal human activities." (Grob, 1966, p. 11)

- Academia – from 1811, when Johann Heinroth (1773–1843), the German physician and psychologist, who was the first to use the term psychosomatic, was appointed as (the first) Professor of Psychic (Psycho) Therapy.

- Lay practitioners and consumers – including, from the mid 19th century, spiritualists, the mind cure movement, and the mental hygiene movement (see Beer, 1908; Cautin, 2010; Tudor, 1996).

- Ministry – formally, from 1904, in the work of Elwood Worcester (1862–1940) who, as Minister of the Emmanuel Church in Boston, Massachusetts, developed a programme that "fused religious faith and scientific knowledge" in the treatment of functional nervous disorders (Caplan, 1998).

- Psychology – from work of Heinroth and of William James (1842–1910) who, amongst other things, investigated different levels of consciousness; of Lightner Witmer (1867–1956) who, in 1896, established the first psychological clinic, at the University of Pennsylvania, to assist children with educational impairments, and was the first to use the term clinical psychology to denote a distinct profession; and of John Watson (1878–1958) who claimed psychology as "a purely objective experimental branch of natural science [and i]ts theoretical goal [as] the prediction and control of behavior." (Watson, 1913, p. 158)

- Social work – from 1909 and the establishment of the first child guidance clinic in Chicago (although the term "Child Guidance Clinic" was not coined until 1922)

Reclaiming this multi-disciplinary history is important not only for historical accuracy, but also in order to challenge unitary thinking that views psychotherapy as (only) a health discipline (see Manning in Manning et al., 2017/2020).

In this context, it is interesting to note that, as psychoanalysis was finding and claiming its place and Abraham Brill, an American psychiatrist and early exponent of psychoanalysis, was arguing for this to be in medicine, Freud (1927/1959) argued that:

> Psycho-analysis is a part of *psychology*; not of medical psychology in the old sense, not of the psychology of morbid processes, but simply of psychology. It is certainly not the whole of psychology, but its substructure and perhaps even its entire foundation. The possibility of its application to medical purposes

> must not lead us astray. Electricity and radiology also have their medical application, but the science to which they both belong is none the less physics. (p. 72, my emphasis).

Moreover, Freud (1926/1959) was strongly against prohibition and restriction of the practice of psychoanalysis, arguing that, "If [such] prohibition were enacted, we should find ourselves in a position in which a number of people are prevented from carrying out an activity which one can safely feel convinced they can perform very well". (p. 234)

The differences between Brill and Freud regarding the question of analysis and lay (i.e., non medical) analysis was to become key in the development not only of the practice of psychoanalysis but also of the discipline, profession, and professionalisation of psychotherapy (see pp. 13-14 below).

In the hundred years since these debates – let alone the nearly 4,000 years since the Egyptian references to dementia and depression – Western psychotherapy comprises a multiplicity of different approaches (now over 1,000) drawing on very different influences. Some of these forms and influences encompass critical and radical perspectives, namely: Marxist psychoanalysis, mutual analysis and co-counselling, anti-psychiatry, Marxist humanism, radical psychiatry, feminist therapy, red therapy, social action psychotherapy, pink and queer therapy, social therapy, ecotherapy, anti-oppressive practice, process-oriented psychology, indigenous therapy, and power-sensitised counselling (see Tudor & Begg, 2016). However, notwithsanding such traditions (about which most psychotherapists know very little, primarily as this critical perspective does not appear in the curricula of their education/training programmes), mainstream psychotherapy is strongly aligned to the medical model of health and illness and to framing its work in terms of diagnosis, treatment, and cure – and, indeed, despite the best endeavours of Carl Rogers who emphasised the client (Rogers, 1951) and the person (Rogers, 1961), to referring to the people with whom they work as "patients". One example may be found in the history of the New Zealand Association of Psychotherapists (NZAP) (since 2024 the Association of Psychotherapists Aotearoa New Zealand [APANZ]), with regard to the establishment of which, Manchester and Manchester (1996) made the following observation:

> The setting of the membership fee at "one guinea" may have been a reflection of the [then] current acceptance of a strong limkage between psychotherapy and medical and psychiatric practice and that the linkage with medical practice was seen to be necessary to promote legitimacy and public acceptance. (p. 21)

Here, as part of the wider, interdisciplinary project of deconstructing the terms "diagnosis", "treatment", and "cure", and of separating psychotherapy from the medical model of health, I offer a brief sketch of some objections to each of them, as well as some alternatives that do and could further influence psychotherapy practice.

Diagnosis

The English word diagnosis come from the Greek words dia (= apart) and gignōskein (= to recognise or know) which, together, gives us "to distinguish or discern". In its different forms psychotherapy has numerous ways of distinguishing what people present as causes or sources of concern or distress; of discerning between different states of being, self, and personality; and of knowing. Yet, when it comes to "diagnosis", most training courses in psychotherapy teach trainees the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association (APA) (now in its fifth edition [APA, 2023], justifying it as what they (the trainee/practitioner) need in order to be able to work with psychiatrists. In the same vein, the Advanced Clinical Practice qualification offered by the APANZ requires its candidates to include "clinical diagnosis" as part of its written work assessment (NZAP, 2020). Apart from the fact that there are a number of criticisms of the *DSM*, one of which is that its increasing number of diagnoses is pandering to the insurance industry (e.g., Ede, 2021), this strategy represents a serious own goal in the education and acculturation of psychotherapists as it prioritises psychiatric knowledge over psychotherapeutic knowledge with its own, theories, concepts, and models of diagnosis; and colludes with a social level power play (Steiner, 1974) in which psychiatry (and, similarly, psychology) is seen as superior to psychotherapy. As Duncan et al. (2004) put it (some 20 years ago):

> It is time to dethrone diagnosis as the flower of mental health and stop using the excuse that we misdiagnosed to get paid. The only reason we use it for reimbursement is because we haven't articulated the pitfalls of diagnosis to funding sources, nor have we offered anything different. (p. 30).

Rogers (1951) offered a different perspective:

> Therapy is basically the experiencing of the inadequacies in old ways of perceiving, the experiencing of new and more accurate perceptions, and the recognition of

significant relationships between perceptions.

> [Thus] In a very meaningful and accurate sense, therapy is diagnosis, and this diagnosis is a process which goes on in the experience of the client, rather than the intellect of the clinician. (p. 223, my emphasis)

Treatment

Similary, the word treatment is used across different traditions in psychotherapy, extensively and largely uncritically, e.g., Freud (1912/1964), Rogers (1939), Berne (1966), Rangell (1985), Arroyave (1986), Donner (1991), and Arden (2008). In transactional analysis, one of the requirements for its qualifying written exam is to have a "treatment plan" (ITAA, IBoC, 2022, Section 8.5.3.10, p. 14). As with diagnosis, from a critical perspective, it's important to think about and use different words such as "therapy" or even "psychotherapy"! Rogers (in Rogers & Russell, 2002) put this well in an interview recorded in the last year of his life and published posthumously:

> Too many therapists think they can make something happen. Personally I like much better the approach of an agriculturalist or a farmer or a gardener: I can't make corn grow, but I can provide the right soil and plant it in the right area and see that it gets enough water; I can nurture it so that exciting things happen. I think that's the nature of therapy. It's so unfortunate that we've so long followed a medical model and not a growth model. A growth model is much more appropriate to most people, to most situations. (p. 259)

So, rather than "treating" people prescriptively, I suggest that it is important to consider what soul healers actually do, and that our methods may include; listening, analysing, directing, touching, empathising, confronting, minding (Tudor, 2018) – and much more.

Cure

Whilst the word and concept cure is also more often associated with the medical model (e.g., Berne, 1961/1975), interestingly, it was also used by radical psychiatrists to emphasise the aspiration of and their commitment to facilitating change – "therapy means change, not adjustment" (The Radical Therapy Collective, 1975) – in the context of their critique of interminable analysis that, while encouraging and/or providing insight, doesn't necessarily result in any change. Nevertheless, the word cure carries a certain idealised view of health and the promise of a permanent resolution of a condition, and the concept carries the implication that the medical or medicalised practitioner decides what constitutes cure. Concepts which reflect other purposes and outcomes of psychotherapy, include insight, connection, authenticity, liberation, and social purpose (see Tudor, 2018).

Finally, on the question of the nature of the practiceof psychotherapy, Totton (1997) has long argued that psychotherapy is "a spiritual and political practice" (p. 129); and Aron and Starr (2013) reminded us that "for a long time psychoanalysis was as much a social movement, a movement for reform in education, social policy, and culture as it was a treatment method" (p. 28). Thus, psychotherapy is not a de facto health practice (i.e., from the fact) but rather ex contextu (from the context). Moreover, as long as health practice is dominated by the Western allopathic medical model, if psychotherapy has any ambition to reach parts of the person – and parts of the world – that other therapies don't reach, it needs to remain open to other descriptions of psychotherapy or soul healing and embrace the reality that psychotherapy both is and is not a health practice.

The psychotherapy practitioner

Following on from the first part of this article, this second part turns its attention to the issue of the identity of psychotherapists, specifically as health practitioners, which I argue has been influenced by three forces: firstly, the early splits in psychoanalysis and differences and divisions within psychotherapy; secondly the small but articulate critical and radical tradition within psychotherapy; and, thirdly, the increasing professionalisation of the discipline, part of which has led some countries in the world, including Aotearoa New Zealand, to legislate and restrict the use of the term "psychotherapist".

Early splits

As with many disciplines, psychotherapy has both suffered and developed from splits between founders, followers, and subsequent proponents. Freud himself had a number of close associates, including Alfred Alder, Carl Jung, Otto Rank, Wilhelm Reich, and Sándor Ferenczi, all of whom split from Freud in some way, and all of whom Freud rejected (see Grosskurth, 1991). At one point, as Makari (2008) reports it: "Freud declared Adler's ideas as too contrary, leading to an ultimatum to all members of the [Psychological Wednesday] Society (which Freud had shepherded) to drop Adler or [themselves] to be expelled, thereby disavowing the right to dissent."This dynamic has continued not only in psychoanalysis – see Kirsner's (2009) study of what he refers to as Unfree Associations – but also in the wider field of psychotherapy in which there are disciples who generally want to consolidate what they consider to be the core principles, theories, and practice of the original approach, and to exclude those who don't adhere to these (see, for example, Steiner et al., 2003); and other colleagues who, as a result of theoretical and/or personal disagreements, break away from a parent institute and/or organisation, and found their own branch or school of psychotherapy and/or professional association(s).

These splits have led to psychoanalysts and psychotherapists identifying with their different theoretical orientations or modalities, not least to distinguish themselves from others. Add to this, practitioners who associate themselves with the different forces in Western psychology, i.e., psychoanalysis, behaviourism, and humanistic psychology, and the schools and modalities within each of them, and we have a plethora of practitioner identities. What also interests me is how this has become quite personal and individualised. For instance, when I qualified as a transactional analyst in the mid-1990s (as that was my qualifying training), I registered with the professional body in the United Kingdom as a transactional analysis psychotherapist. One of my close colleagues, who had undertaken exactly the same training, registered as a relational psychotherapist as that's how she wanted to identify and be identified. I notice a similar tendency with graduates from the psychotherapy programme at Auckland University of Technology (AUT) which, technically is a generic programme based on a broad approach to relational psychotherapy, who identify themselves variously as arts and creative therapists, body-mind therapists, gestalt therapists, and integrative therapists, but, predominantly as psychodynamic and/or psychoanalytic psychotherapists, not least, I suspect, as these identities have higher status in the eyes of the main professional associations in this country.

Critical and radical perspectives

Earlier, I referred to a number of critical and radical perspectives (Marxist psychoanalysis, mutual analysis, and so on), each of which have also spawned associated identities, thus: radical psychiatrists, feminist therapists, and so on. Indeed, one of the radical aspects of radical psychiatry was that its proponents were not psychiatrists but, by claiming that identity, were reclaiming the definition of psychiatry also as soul healing. Interestingly, Freud (1926/1959) himself wrote approvingly of "peasant healers"; and, in the same spirit, Southgate and Randall (1976/1978) coined the term "the barefoot psychoanalyst".

Critical and radical perspectives offer an alternative to an over-adaptation to norms of identity. In Aotearoa New Zealand, when the state registration of psychotherapists came into force in 2009, those of us who chose not to register with the psychotherapists' registration Board had to choose another identity. These encompassed: analyst, counsellor, family therapist, kaiwhakaruruhau, minister, psychodramatist, transactional analyst, traumatologist, and wahine Māori social and mental health care provider (see Tudor, 2017/2020b). Although some registered psychotherapists criticised the use of these terms, I would argue that they represented – and still represent – a conscious and conscientious objection to state control of professional identity.

In their book *A Psychotherapy for the People*, Aron and Starr (2013) note the significance that:

> Freud and the early analysts were at the margins of their society. Being at the margins gave them the edge and allowed for the intervention and development of psychoanalysis. Being at the margins is what allows for reflexive self-awareness, the ability to look at oneself as both subject and object, without being caught up in one pole or another. (pp. 8–9)

One example of this independent thinking with regard to the practitioner concerned a colleague who was training as a transactional analyst. She had had a lot of personal therapy but thought that she had to do more in order to fulfil a requirement that she had to undertake personal therapy during training, to which she was also somewhat resistant (her word). What she actually wanted to do was to work with a spiritual director (which represents a different identity). Checking the requirements as outlined in the international Certification and Examinations Handbook (ITAA IBoC, 2022), this was – and is – entirely possible as the Handbook neither specifies "personal therapy" or that personal work has to be undertaken with a psychotherapist. The colleague was mightily relieved and subsequently appreciated a period of personal work with a spiritual director.

Professionalisation

The third influence on the identity of psychotherapists has been the increasing professionalisation of the field and its practitioners.

Caplow (1966) identifies four steps in professionalisation, which here, I apply to the changing identity of psychotherapists, specifically in Aotearoa New Zealand.

The first step – which is marked by "[T]he establishment of a professional association, with definite membership criteria designed to keep out the unqualified." (Caplow, 1966, p. 20)

With regard to psychotherapists in Aotearoa New Zealand, this took place in 1947 with the establishment of the NZAP, whose founding constitution provided that:

> Membership shall be open to persons of either sex, medical or lay… who are engaged in psychotherapy of an approved form… which is scientific in the sense that… [its] methods are based on a knowledge of psychopathology. This provision is made notwithstanding the fact that psychotherapy is as much an art as a science. (quoted in Manchester & Manchester, 1996, p. 21)

The second step – which is marked by "[T]he change of name, which serves the multiple function of reducing identification with the previous occupational status, asserting a technological monopoly, and providing a title that can be monopolized" (Caplow, 1966, p. 20)

Two examples of this in Aotearoa New Zealand are the founding of the New Zealand Society of Physiotherapists in 1950, to distinguish themselves from masseurs, and following regulatory legislation (see Tudor, 2017/2020a); and the NZAP, which has changed its nominal identity over the years from its initial title (in 1947), to (in 1974) The New Zealand Association of Psychotherapists, Counsellors and Behaviour Therapists (Incorporated), to (in 1981) The New Zealand Association of Psychotherapists and Counsellors (Incorporated), back to (in 1987) the NZAP. This last change appears especially significant as, in this country, psychotherapists appear particularly concerned to distinguish themselves from counsellors. Most recently (last year), the Association changed its name to the Association of Psychotherapists Aotearoa New Zealand, a move that was prompted by its commitment to a bicultural perspective on psychotherapy (see Green & Tudor et al., 2014; Hall et al., 2012).

The third step – which is marked by "[T]he development and promulgation of a code of ethics which asserts the social utility of the occupation, sets up public welfare rationale, and develops rules which serve as further criteria to eliminate the unqualified and unscrupulous." (Caplow, 1966, p. 21)

With regard to the NZAP (now the APANZ), this may be dated to 1986 when, some three years after a preliminary report of A Code of Ethics for the Association was first circulated, the NZAP Council adopted a Code of Ethics (Manchester & Manchester, 1996). With regard to the public welfare rationale, this was first hinted at by Ernest Beaglehole, a founding Fellow of the Association and Professor of Psychology at the University of New Zealand in Wellington who wrote that "we may safely say that New Zealand at the present time could absorb well over ten times as many psychotherapists as are at present available." (Beaglehole, 1950, p. 41). I use the word "hinted" as Beaglehole actually wrote about the low numbers of psychotherapists in private practice. It wasn't until this century that the public welfare rationale for the registration of psychotherapists was made more explicit by Paul Bailey (2000, 2004a, 2004b), who led the charge on behalf of the then NZAP for state registration of psychotherapists, for a critical perspective on which see Bailey and Tudor (2017/2020) and Tudor (2017/2020b). It is at and in this stage that professions provide safety for the public through codes and/or frameworks of ethics and professional practice, including complaints procedures; establishing training standards; and so on – but, significantly, as a self-regulated profession.

The fourth and final step – which is marked by "[A] prolonged political agitation, whose object is to obtain the support of the public power for the maintenance of the new occupational barriers." (Caplow, 1966, p. 21)

Again, with regard to the APANZ, this agitation may be seen throughout its history – see Manchester and Manchester (1996) and Carson et al. (2006), and is critically summarised by Dillon (2017/2020).

As something of an antidote to these inexorable steps to professionalisation through the state registration of psychotherapists, I note that Freud (1929/1956) referred to the practitioner as characterised "by good training and supervision, by certain qualities... and by… being a decent human being which, fundamentally, cannot be legislated for or regulated" – and the fact that in most countries of the world, psychotherapists are not state registered and not necessary identified as health practitioners. Thus, we may say that psychotherapists both are and are not health practitioners.

The psychotherapy profession

In most countries of the world, including Aotearoa New Zealand, psychotherapy as a field or discipline is regarded as a health profession. The final part of the article offers some critique and deconstruction of this perspective and position.

Firstly, in a rare and interesting article discussing the question of whether psychotherapy is an autonomous scientific discipline, van Deurzen-Smith and Smith (1995) suggest that what characterises an autonomous discipline is that it "1)... must be theoretically distinct from any adjacent discipline... [and] 2)... must possess a theory which is irreducible to any adjacent theory". To this I would add a third criterion: that it must also have practitioners and theoreticians who identify primarily with the discipline. In other words, psychotherapy can be – and is – a profession in its own right rather than being apologetic that it is not psychology or psychiatry – and the same stands for its practitioners. Unfortunately, this is not the case in a number of countries in which training as a psychotherapist is restricted to medical doctors or psychologists. Moreover, if it were to take inspiration from Freud, Beer, Totton, and Aron and Stark, psychotherapy might even position itself as a social movement for reform in education, social policy, and culture, and/or a profession that has something to say about the spiritual and political. I look forward to the day when, in response to a social crisis such as an earthquake, a mass shooting, or an election, the media interview a psychotherapist with some expertise in the field, rather than a psychologist simply because they're

a psychologist; and I look forward to the day when the All Blacks (New Zealand's national men's rugby team) employ a psychotherapist to deal with group relations (about which psychotherapists and group analysts have some expertise), rather than a sports psychologist (who hasn't necessarily undertaken their own personal therapy let alone their own group therapy). With regard to psychotherapy being more of a social movement, this is reflected in initiatives and organisations such as:

- Psychotherapists and Counsellors for Social Responsibility (https://www.facebook.com/PCSocResp/)
- The Radical Therapist (https://www.theradicaltherapist.com/)
- The Radical Therapist Network (https://www.radicaltherapistnetwork.com/)
- The Red Clinic (https://www.redclinic.org/statement).

Secondly, with regard to discipline, psychotherapy education/training programmes in the tertiary sector appear across the arts, sciences, and health. At AUT, the Department of Psychotherapy & Counselling was, for 30 years, located in the School of Public Health & Psychological Studies in the Faculty of Health & Environmental Sciences. In 2019 this School was disestablished, and the Department moved to the School of Clinical Sciences in the same Faculty. However, it could equally have been – and be – located in the new School of Public Health & Interdisciplinary Studies within the same Health Faculty or, looking elsewhere in the university, within the School of Education – Te Kura Mātauranga within the Faculty of Culture and Society, or the School of Communication Studies – Te Kura Whakapāho within the Faculty of Design and Creative Technologies. This is not simply a question of semantics but rather a matter of strategy. For instance, at AUT, in 35 years of being located in the Health Faculty, the discipline of psychotherapy has never enjoyed the same level of funding for its clinical papers or courses as has psychology (for its counselling psychology programme) or, in other New Zealand universities (for their clinical psychology programmes).[1]

Thirdly, there is the problem that health is, as noted earlier, at least from a Western allopathic perspective, framed in terms of and conflated with illness. Thus, those colleagues in the then NZAP who were keen to get psychotherapists regulated and registered under the Health Practitioners Competence Assurance Act 2003, were, in effect signing up to a medical model of health, competence, assurance, and regulation, some of the implications of which are only just being seen and understood (see Tudor, 2021).

Fourthly, there is the issue (if not problem), that, with state registration and statutory regulation, the profession has ceded its sovereignty. Now, the state decides what constitutes a psychotherapist, and, beyond that – and, I would say, beyond its purview – what constitutes a supervisor, a visiting educator, and a training programme. As a result of this and other factors, since 2009, in Aotearoa New Zealand, there are fewer psychotherapists working in the public sector, and fewer psychotherapy training courses. The good news (at least as far as this author is concerned) is that the one training course in the country that the Psychotherapists' Board did not previously recognise, and the one which has most incorporated spiritual and indigenous traditions and values in its curriculum, teaching, and learning, i.e., Hakomi, is the one of the few courses that has increased numbers of students.

Thus, we may say that psychotherapy both is and is not a health profession.

Conclusion: In sickness and in health

As I was finishing this paper, I remembered a short article I wrote nearly 30 years ago about the contribution that psychotherapy makes to positive mental health (Tudor, 1997). Looking across various psychotherapeutic traditions and modalities, I identified:

- Love and work (attributed to Freud by a number of authors, notably Erikson (1950), and by Alberini (2020) who writes that Freud them the "cornerstones of our humanness." (p. 38)
- Happiness, efficiency, and adaptation (from Jones, 1931).
- Co-operation, connectedness, and social interest (from Adler, 1933/1938).
- Emotional maturity – from Jung (1951) and Klein (1960) – and emotional growth and maturity (from Winnicott, 1988).
- Friendship (from Erich Fromm, 1956).
- Being fully-functioning (from Rogers, 1959), and the capacity to live life (from Guntrip, 1964).
- Self-actualisation (from Maslow, 1961/1993), and the self-actualising tendency (from Rogers, 1963).
- Autonomy (from Berne, 1964).

Reflecting on these concepts, I think many, if not all of them could be taken as criteria for describing and assessing the

1 In the time between this article being submitted and published, there has been another reorganisation of the Faculty of Health & Environmental Sciences at AUT and the Department has been moved to another School, that of Community & Public Health.

health, ill-health, or sickness of psychotherapy itself. So, as a final reflection or reflexion, I ask and answer a series of questions related to this:

1. Is psychotherapy itself happy, efficient, and adaptive?

   I would say not entirely. With regard to its sense of (it) self, psychotherapy and psychotherapists can appear anxious, and somewhat apologetic in relation to its older siblings in the "psy" professions (psychiatry and psychology). It doesn't always know how efficient or effective it is (for instance, in presenting itself as based on research); and, if anything (as I have argued), it is over-adaptive to external forces and systems.

2. Does it express social interest through co-operation and connection?

   I think it tries to, but that this is expressed more internally (i.e., within the profession) than externally in relation to the public, the media, government, and other professions.

3. Is it emotionally mature?

   I would say yes, though with occasional exceptions.

4. Thinking about psychotherapy in terms of friendship with other disciplines and professions, I would say that, too often, we're on the back foot, and, as it were, waiting to be picked for the team, rather than actively making friends and influencing people such as policy-makers and politicians.

5. Is psychotherapy fully-functioning?

   Certainly not!

6. Does it have the capacity to live life?

   Certainly, but with more confidence in itself than engagement in life outside therapy.

7. Is it self-actualising?

   Absolutely, though I would question what "self" or aspects of itself it is actualising (see Tudor & Worrall, 2006).

8. Is it autonomous?

   No, as, for the most part, it's far too concerned to adapt to others and, in some countries, to other "psy" professions and the state

I have been involved in psychotherapy for just over 40 years, firstly as a client, then as a trainee, a practitioner, a supervisor, a trainer, and an academic (see Tudor & House, 2019). Insofar as my relationship with psychotherapy is one of co-habitation if not marriage, I have certainly experienced it for better and for worse, for richer and for poorer, in sickness and in health, and something that I love, cherish and profess (and of which I am critical), and that this will probably continue till death do us part.

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Abstract
Aotearoa New Zealand has a high rate of imprisonment, seventh or eighth among 36 OECD countries. The experience of imprisonment, isolation from family and the wider community, the company of a population where violence, misogyny, drugs, risk-taking and rule-breaking are normalised, sees the emergence and practice of a criminal subjectivity. This confers mana, a loyal peer group, mentors and a career, on a population well-endowed with obstacles to these ends.An intoxicating, adaptive, performative subjectivity emerges, is practiced every day, and is not readily given up, accounting for the failure of manualised rehabilitation and treatment models which locate the problem in the individual subject. The prison, a subjectifying machine that perpetuates drug use, violence, poverty, family harm and disenfranchisement, which reduces participation in the wider democracy, mitigates against individual change. Using the philosophy of Michel Foucault, in this paper the authors reflect on method in working with men with extensive prison experience, without relying on the idea of an agentive self – an unlikely fiction among graduates from the prison system.

Keywords psychotherapy, subjectivity, prison, violence, agency

Throw away the manual! Reflections on psychotherapy and crime

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Introduction

This paper contains reflections on psychotherapy with men who have considerable experience of imprisonment, a population concerning whom it is said, with some justification, that nothing works (Newbold, 2008, p. 385). The conclusions presented here are based on over three decades of group and individual psychotherapy with men who have histories of serious criminal offending, on experience gained from working in a prison, in a therapeutic community treatment facility that specialises in treating parolees, and in a community-based Stopping Violence programme to which men and women are referred by the criminal and family courts and by themselves.

This work is presented under the conference theme, "In Sickness and in Health," as part of an attempt to consider violence, addiction, and criminal identity as issues for consideration within a health framework. This paper and its predecessors (Manning, 1995, 1997; Manning et al., 2024; Manning & Nicholls, 2020) argue that criminal justice structures, institutions and procedures tend to create and perpetuate subjectivities that are more, not less, likely to embrace crime, violence and illicit substance use. The movement to treat addiction as a health issue rather than as a matter for criminal justice systems has international backing in harm reduction interventions including decriminalisation (for instance, Dertadian & Sentas, 2025; Russell et al., 2024) and legalisation (Godlee, 2019) of controlled drugs. In the case of violence, there is an increasing tendency for the courts to refer to community-based programmes rather than take punitive measures (Manning et al., 2017). Police and court diversion and restorative justice options (Winfree, 2004) arguably reduced the population of New Zealand prisons by approximately 20% between 2018 and 2022 (NZ Dept. of Corrections, 2023b). This work attempts a theoretical exploration of criminal subjectification in prison,

further arguing that current criminal justice institutions may not be the most useful societal response to illicit drug use, violence, or other crime.

What follows is a Foucauldian discourse analysis of the subjectification of men in prison, in part by the structure and supposed science of the prison system, by the operation of disciplinary practices, and by the adoption of practices among prisoners. It is suggested that the emerging subjectivity includes criminality as one of its more common aspects. Seen through the experiences of a psychotherapist, the article concludes with a focus on working psychotherapeutically with this subjectivity.

Examples given below are deliberately generic, describing aspects common to many people in the male prison population. It would not be possible to identify an individual described in the text.

Theoretical and philosophical background

What follows draws extensively on the work of Michel Foucault. In a 1982 interview, two years before his death, Foucault says of his objective that he had attempted to create a history of how human beings are made subjects. He identified three stages in his work, the first looking at the sciences, the second at the subjectifying of the person, and the third at the way we subjectify ourselves (Foucault, 1982/2002, p. 326).

We can see the first mode, his critique of science, in his early work on madness, on the clinic and the physician's gaze (1961/2006, 1965; 1963/2003). The second, dominated by four books; The Order of Things (1966/1989), The Archeology of Knowledge (1972/ 2010) Discipline and Punish (1975/1995), and the first volume of The History of Sexuality (1978), spans his explication of an épistémè governing what can be thought in a given historical era, his description of the creation of docile subjects by means of discipline in schools, factories, barracks and prisons, and his adoption of the term *dispositif*– indicating a deployment of ideas, institutions, customs, ways of understanding that control, produce, and distribute knowledge in a society, that allows and inhibits ways of thinking and doing things. Foucault's description of disciplinary power relations merged over the next few years into the twin notions of biopower (1975/2003), a way of governing us as a population, and governmentality (1978/1991), referring to a set of mechanisms and institutions that operate as self-government of our behaviour, our thinking, even the way we feel, as individuals. Nikolas Rose wrote two books, Inventing Ourselves, and Governing the Soul (1998, 1999), elaborating on exactly how this happens, how we are formed and how our behaviour is directed and limited by discourse and dispositif.

The third mode, the study of the way we turn ourselves into subjects, is evident in papers, lectures and interviews given in the late 1970s and early 1980s (Foucault, 1982/1994, 1982/2002, 1984/1994, 2000), in his studies of ancient ethical practices (1982/1994), and his pulling together of the theory of power, resistance and the subject (1982/2002) prior to his death in 1984.

Whether Foucault really planned his work as systematically as he suggests, or whether this scheme, moving from the nature and conditions of knowledge to the knowing subject, is a matter of hindsight and secondary academic analysis, we cannot say, but certainly in his later works he refers to the concept of freedom, and to the ability of the human subject to work upon itself, to change itself. However, although he mentions 'freedom' in a number of places in his late work, for instance in his 1983 Discourse and Truth lectures at Berkeley (2019), he does not suggest the idea of self-determining agency in the neoliberal sense (Harvey, 2005; Kelly, 2013).

Unlike other attempts to base a principle of the self on Foucault's late work, in which it is claimed that he revisited the idea of the subject, allowing it an agentive (Besley, 2002; Besley & Peters, 2007), or at least actuarial (Kurz, 2009) property, the current work reads Foucault as consistent in his formulation of the self as subjectified by history, by discourse, by épistémè, and by dispositif. His later ideas about how humans subjectify themselves is not read as discarding this perspective, but as describing how, by means of practices we derive from our history and the discursive forces that prescribe us, we constitute ourselves – what he terms technologies of the self (1982/1994).

Foucault's twin notions of épistémè (1966/1989) and dispositif (1978) can be somewhat startling, as they imply a demand that the writer, analyst, and, in this case, the therapist, not only look for the subjectifying power acting on a subject or patient, but also on the writer, analyst and therapist, and further, on the nature of writing, analysis and therapy.

The term dispositif represents a powerful idea. Agamben accords it central importance in Foucault's thought (2023) and traces its genealogy from the Greek oikonomia, usually translated as 'household management,' from which we derive the English word 'economics'. This was a concept used by early Christian theorists to explain the holy trinity without reinventing polytheism. Turning to Latin as the church spread through the Roman empire, the church fathers translated it as dispositio (ibid p. 256). Agamben suggests that Foucault's meaning is linked to this early Christian legacy. The dispositif, often translated, as in the title of Agamben's essay and in a translation of a 1977 interview with Foucault (1980), as apparatus, is the way things are organised – an assemblage of

discourses, ideas, institutions, and customs including "the said as well as the unsaid," (ibid, p. 194), which is responsible for what he calls a "strategic elaboration" (ibid, p. 195) which can have unexpected consequences. He cites the prison, designed as a response to criminality, the result of which is to create delinquency. This latter observation is echoed by Agamben (2023) almost half a century later, discussing the "apparatus" (dispositivo in the original Italian) of the prison.

So although an assemblage like the prison can be consciously designed for a specific purpose, the emergent dispositif has a completely different strategy (ibid, p. 195-6). Foucault does not elaborate further, and one of the aims of the current work is to do so. We have discussed elsewhere a kind of family background commonly found in prison inmates, in which aggressive, abusive figures are introjected and identified with (Manning, 1997) and also how a certain kind of criminal subject is created in prison (Manning et al., 2024; Manning & Nicholls, 2020).

Here we will explore how Foucault's work can inform a psychotherapeutic approach to the criminal subject. In doing so, we are aware of Foucault's warning about theory – that analytical work requires ongoing conceptualisation rather than proceeding from a fixed theoretical position. There cannot be a 'correct' theory. Any attempt to suggest that Foucault's thought is correct or true must involve a contradiction, since in his work, truth, whatever is correct, is determined by dispositif. There are no correct theories, and no ultimate truth. This paper is offered in this spirit, as an ongoing conceptualisation.

This paper is introduced in this fashion firstly to address the common idea that Foucault maintained that the human subject is constituted by subjectifying discourse, by history, by dispositif governing what can be thought, including thinking about ourselves at a particular time, and that therefore any claim to individual agentive ability to fashion ourselves must be shaped and limited. Applying Foucault to education, counselling and the culture of self, Besley and Peters (2007) put it that since ontology is historicised, there cannot be an essential self .

Secondly, though Foucault is often seen as an intellectual with little influence beyond the academy (Sugrue, 2022), we are suggesting that Foucault's work can be useful to psychotherapy, necessarily abandoning the 'self-as-enterprise' (Kelly, 2013) approach common in many forms of therapy. This paper, which is about psychotherapy with criminal subjectivity, is part of a series of papers and presentations, so, for context, there follow two notes – one on imprisonment and its subjects, another on the subject in prison – before discussing how one might work therapeutically with men who have become the inhabitants and the subjects of what Foucault called the carceral (1975/1995, p. 239ff).

Imprisonment and its subjects

Our prisons (taking Aotearoa New Zealand as an example, but these patterns are likely to be repeated elsewhere) excel in incarcerating indigenous Māori people - 52% overall, and 65% of women prisoners, compared with 16-18% in the population. We imprison the poorly educated (70% with literacy that is judged inadequate for daily life); the brain injured (63%); those with a psychiatric diagnosis (62% within 12 months compared with 21% in the population as a whole); the poor; the traumatised; the addicted, and those who have had the authorities involved in their lives since childhood (73%) (Lambie, 2018a, 2018b, 2018c, 2020). One Chief Executive of the New Zealand Department of Corrections comments:

> When I joined Corrections . . . . one thing I noticed was the complex link between trauma, vulnerability and crime. Many of our most challenging offenders were raised in poverty and grew up exposed to gangs and overwhelming violence. When they arrive at Corrections, many are in poor physical health, are presenting with mental health or substance abuse disorders, are homeless and unemployed, and are lacking even basic literacy and numeracy skills. (Chief Executive's Overview, NZ Dept. of Corrections, 2018, p. 4).

It does not seem a coincidence that prisons as we know them appeared at roughly the same time as industrial machines. In the industrial age, people's labour became disposable and therefore people who are not well equipped to operate within the dispositif of mainstream means of production and profit tend to be "warehoused", as one imprisoned commentator puts it (Case, 14 February, 2019). They do not fit in, they are a nuisance, and they are sometimes dangerous, so we put them somewhere safe for a while. We store them. Prison is not much more purposeful than that (Newbold, 2007, 2008; Reiman & Leighton, 2020).

One of the most disturbing things about the environment in prison is the amount of time spent doing nothing. Most prisoners, by their own account, spend most of their time without purposeful activity, most of it indoors in the company of others also doing nothing but sitting around talking. (There are classes but only a minority of prisoners are able to pursue

education in a serious way, because it is only available to those with a low security classification, and shame about literacy deters many.) This space is filled with a kind of rehearsal, planning illicit activities, analysing crimes, telling 'war stories' – tales of past exploits – and fantasising about violence, drugs, and sex, including violent sex with drugs.

A former prisoner who, following a 'rehab' programme, had determined to change his life but had returned to prison, was horrified, seeing what he had always known, but now viewed through a new lens. He saw men rehearsing crime, objectifying women and exalting their use and abuse as sexual objects, ridiculing homosexuals, and, as he put it, 'strutting around,' with a particular walk, practising a role, a sujet that allowed them to have a measure of something like pride.

It is beyond the scope of this paper to discuss why we have prisons, but Corrections officers, prison officers, police, lawyers, and judges tend to agree that imprisonment does not rehabilitate, nor does it deter, and our previous work has justified this statement, (Manning et al., 2024; Manning & Nicholls, 2020) as has other literature (Foucault, 1975/1995; Newbold, 2007, 2008).

Prisons are described in official language, in annual reports, in political policies, by staff on the ground, and even by prisoners, as designed. That is to say, a popular myth has it that the dispositif that governs them is consciously, scientifically constructed, and, as Greg Bird writes in a recent book on the subject, "The era of dispositif is marked by an obsession with engineering . . . . As the vast assemblage of machinery took hold of humanity . . . ." (Bird, 2023)

Literature on the history of prisons (Morris & Rothman, 1995; Newbold, 2007, 2016) provides ample evidence to refute the idea that they are scientifically planned. Certainly, there have been many attempts to design prisons and other forms of punishment, according to humanitarian, scientific, and retributive principles, but their overall structure, the way the carceral functions, suggests, as Valier puts it, that it "unfold[s] in the shadow of monstrosities" (2004, p. 1). A person commits a horrifying crime, and the system is abruptly changed, usually towards increased security and decreased contact between prisoners and the outside world, limiting contact with families, occupations, and creative interests. The history of prisons has more to do with fear and political expediency (Newbold, 2016, Chapter 9) than design.

We might agree that some individuals in our population are just so dangerous, whether by subjectification, genetics, or by abuse as children, that we can think of nothing else to do but to lock them away to keep everyone safe. However, it is questionable how many such people exist, and extreme differences between nations as to the numbers of people they imprison suggests that the practice of imprisonment is more determined by culture than by need. Aotearoa New Zealand currently imprisons about 170 people per 100,000 of population, while the USA has about 700, and Japan and the Scandanavian countries have less than 100 (NZ Dept. of Corrections, 2023b; OECD, 2016). Cultural differences between these numbers are expressed in policing and sentencing trends. Aotearoa New Zealand's prison population rose steadily until 2018, and then dropped by 20% in the four years until 2022, arguably because of a determined effort by police and district courts to find some alternative for young men who come to their notice.

The subject in prison

This story has appeared elsewhere, but is repeated briefly here, to introduce this section. On a regular visit to prison, it turned out that the first man on a specialist's list that day was no longer in the prison, presumably transferred to another facility for a reason no one could explain. There were three officers in the visits hall, a large area with a grid of small tables and stools all bolted to the floor, in which several inmates were waiting, one per table, to see their visitors. The specialist, requiring a measure of privacy, was allocated a glass-walled room with a camera in the ceiling. An officer, perhaps meaning to be light-hearted, pointed to the inmates, all dressed in identical brightly coloured one-piece garments, and said, in a voice that everyone could hear, "Don't worry, look, pick another one, anyone, they are all the same."

Shocking though the officer's crassness was, he was indicating something that any visitor could see. Once seen, it is as though the world has turned, as it does at times, and the observer understands something that perhaps was not attended to until that moment but which can no longer be ignored.

Men in prison do appear similar in many respects. In this sameness of appearance is a rebellion, a defiance, a predictor of non-conforming lifestyle outside the prison. Aggressive and exploitative attitudes are common, and there is a distinct "us and them" framing of social relations. Violence, including sexual violence, is enthusiastically endorsed. There is a belief that one must stand up for oneself, preferably in a threatening or violent manner. All of these factors combine to create a sense of control, of personal power quite at odds with the fact that these are prisoners – incarcerated in the most authoritarian institution in society, and, compared with citizens in the surrounding society, apparently powerless.

Thus this subjectivity fostered by imprisonment is adaptive: it works in a certain world; it conveys status and friendship; it provides havens, protection, mentoring and a career of sorts. Prison, far from being a deterrent, becomes a kind of home. Having been there, it is not more difficult, but easier, to go

back. In the world outside prison, of course, it does not help in adapting to mainstream society, serving instead to create a pathway leading back to prison.

Foucault's book Discipline and Punish – The Birth of The Prison describes a historical shift from sovereign power to disciplinary power, in which the school, the factory, the military, and the prison operate via discipline to create what he refers to as "docile subjects" (Foucault, 1975/1995, p. 135ff). This description of disciplinary power relations will, over the next few years, morph into the twin notions of biopower (1975/2003), a way of governing a population, and governmentality (1978/1991), the set of mechanisms and institutions that operate as self-government of our behaviour, our thinking, even the way we feel, as individuals.

This theory supports the observation that there develops a sameness among prisoners, a familiar subjectification, but it is not enough, since prison populations do not appear (to use Foucault's terminology) as docile subjects. In Discipline and Punish, Foucault develops the idea of resistance emerging inevitably alongside power relations. He names "agitations, revolts, spontaneous organizations, coalitions" (1975/1995, p. 219), and three years later, he writes that there is no escaping either power relations or resistance. There is no way, in his view, to be outside the influences of power and resistance – there is no "exteriority" (1978, p. 95). Resistance emerges alongside power, both being distributed throughout society. However, if I consciously resist and cite Foucault in justification, I am misreading him. The conscious act of resistance must itself be an effect of a certain subjectification, an effect that emerges in response to a power relation. We cannot suppose that there is an agentive function that resists, only that it arises in us as its agents. Power and resistance are two sides of a coin, inseparable, and the subjects of the resulting discourse(s) enact the struggle, but not because we decide to.

By 1982, Foucault's ideas about the creation of the subject will have developed another layer of complexity. In a paper entitled The Subject and Power Foucault describes how power relations create the subject, and at the end of the paper he gives us two pages under the heading, Relations of Power and Relations of Strategy, in which he continues the discussion of the relationship between power and resistance that he began in 1978. Briefly, and without elaboration, he mentions "principles of freedom . . escape or possible flight" (1982/2002, p. 794) in a struggle with every power relationship, each retaining its specific nature, each becoming a "limit, a point of possible reversal" of the other.

Indeed, we are likely to have some idea that to resist subjectifying power feels like a struggle to be free, but freedom remains undefined, and in this context it looks like another form of subjectification. As one YouTube lecturer puts it, resistance and discourse are each other's horizon (Guignion, 21 May 2022). That is to say, discourse generates resistance, which in turn becomes discourse, generating further resistance. If power relations and discourse create us as subjects, resistance also creates the self, as it becomes discourse in its turn. We can suggest that it is the discourse emerging from this process that is the subjectifying power in prison which explains the sameness among prisoners. It can be conceptualised as a kind of knowledge shared between them, indicated by various gestures and practices. Claassen (2024), quoting the work of Schutz and Luckmann, points to, for instance, a way of walking which identifies a subject as belonging to this or that group. There are hand gestures, manners of greeting, head movements, tones and language, all technologies of the self – practices that operate in the manner of governmentality to create the subject and identify him as a member of a community. The work of Nikolas Rose (1998, 1999) elaborates on exactly how this happens – how our behaviour is formed and our sense of self emerges from daily practices, largely out of awareness, so that, in a literal sense, we are what we do.

The emergent paradox is that the prison does operate at the level of population to create docile subjects. That is, the idea of imprisonment works in the manner of governmentality among those of us who have never been there. While a majority among the population at large may use the idea of prison as a self-regulating mechanism – a technology of the self – reinforcing conformity to social norms, or docility, the inside of prison has a very different effect among its residents, acting as a self-perpetuating machine that creates subjects who lack docility and must be imprisoned, not just in the present, but in the future. Recidivism rates among prison inmates thus vary between approximately 50% and 75% in the 24 months following release (NZ Dept. of Corrections, 2024, p. 206ff), a figure that continues to increase over the first five years after release (Nadesu, 2009).

Therapy with the prison subject

Clinical psychology offers cognitive-behavioural and criminogenic approaches, usually in the form of highly manualised group-based programmes in prisons and in the community, aimed at using strategies to analyse and avoid situations and impulses that lead to offending. Such programmes do have an effect, though in Aotearoa Zealand that effect rarely exceeds a 10% reduction in recidivism (NZ Dept. of Corrections, 2018, 2019, 2020, 2021, 2023a). Because of the high numbers of indigenous Māori people in Aotearoa New Zealand prisons, there is also an emphasis on rehabilitative programmes based on indigenous principles (NZ Dept. of Corrections, 2023a). The development of these approaches

is ongoing and has the participation of tribal authorities, but so far the results have not been encouraging. At the time of writing the most recent Corrections Department Annual Report admits that the results of many programmes designed to reduce recidivism do not achieve statistical significance (NZ Dept. of Corrections, 2024, p. 201). The same report indicates that only one of eight programmes assessed demonstrated a measurable effect on recidivism.

Notwithstanding the undoubtedly genuine efforts by well-trained staff and consultants in Corrections, there is reason, then, to pursue alternative approaches. A hypothesis put forward here and in our previous work is that change is difficult within the criminal justice system because what is targeted is not a symptom, or even a diagnosis, but a criminal subjectivity that is arguably created and certainly reinforced by aspects of the criminal justice system itself, particularly by imprisonment (Manning, 1995, 1997; Manning et al., 2024; Manning & Nicholls, 2020). Rather than deter or rehabilitate, prison culture and the dispositif governing it tends to create habitual criminal subjects out of troublesome young men. The Aotearoa New Zealand culture of criminal gangs is largely created in prison (Gilbert & Newbold, 2017; Newbold, 2007, 2016). (We are not considering female crime here, as it is probably a qualitatively different phenomenon.) What therapeutic interventions aim to change, then, is not a disorder in the usual sense, but a kind of subjectivity. It is tempting, though wrong, to call it a personality disorder, a variety of diagnosis very much out of favour among clinicians (Frances, 2013; Lilienfeld & Latzman, 2018; Mulder & Tyrer, 2023; Mullen, 2011), and one which the World Health Organisation has radically revised in ICD-11, abandoning the familiar labels, including antisocial personality disorder (WHO, 2019).

There are a number of formulations of the origin of the self, or, more correctly, the sense of self, that are congruent with a Foucauldian description of subjectification. From Damasio's multi-volume thesis of its origins in basic homeostatic mechanisms, and their consequent neural and mental maps of the body (1994, 1999, 2003, 2011), to Samson's (2017) extension of Deleuze and Guatarri (Deleuze, 1992; Deleuze & Guattari, 1988) and DeLanda's (2006, 2016) work on rhizome and assemblage, to the brain. Such models differ in their focus, but all allow an emergent self, a constantly developing potential rather than a fixed, enduring construct, resulting, as Samson puts it, from a balance between diachronic and synchronic forces.

Lest we be accused of essentialising a criminal subjectivity, the argument advanced here is that in prison diachronic factors – the development of a subjectivity through repeated interactions between organism and environment – are extremely constrained because the outside, the environment of the prison, is constant, repetitive, and compelling. Clothing and walls have constant, bland colouring; the staff all wear the same clothes and follow a constant behavioural regime, with language, tone and topic heavily influenced by training. Other inmates, arguably the most powerful element in transactions between individual prisoners and their surroundings, exhibit a repetitive, predictable routine of verbal and nonverbal signals, and the progress of every day is largely the same as the last. It is not surprising, then, if there appears to be a sameness among prison inmates, especially in gang-heavy prison populations – 37% at the latest count (NZ Dept. of Corrections, 2024) – as gangs, particularly "patched" gangs, encourage sameness in their members' behaviour (Gilbert, 2013).

In this manner of thinking, the constituent factors of the psyche are not so much the personal history, although there are often important elements in the culture-of-origin (rather than the family-of-origin); but rather in what discourse does to that history. A criminal self, seen in this way, is not a pathology. Calling it a personality disorder is missing the point, locating the problem within the individual.

Between the 17th and 18th centuries the idea of the self comes to represent a secularisation of the soul (Bazzano, 2021, p. 292). The idea is still with us – an essential something within, at least lifelong, if not eternal. Much of psychotherapy literature continues this tradition, as do indigenous approaches to health, though the latter tend to use the collectivist concept of identity as an enduring self-description, rather than the individualist self (for instance, Durie, 1998, 2001, 2004). Some Western models echo this nuance. Daniel Stern's sense of self, for instance (1998) refers to the way our selves are constructed and sensed as our interaction with our social world develops. The school known as narrative therapy, based on the work of Epston and White (1990), uses the idea of a self-narrative, adapting Foucault's analysis of the subject formed from available stories. In these formulations a personal narrative is what comprises our experience of ourselves, and thus the self. Besley, for instance, critiques "therapy culture" as a structuralist pretension, suggesting the neo-Foucauldian narrative approach as an antidote (Besley, 2002, p. 125).

This approach is linked explicitly with Foucault's notion of governmentality. Besley and Peters (2007) hold that governmentality, a form of power, defines and controls the individual self, implying that the culture of therapy can be seen as a technology in the service of producing docile citizens.

Besley and Peters give a good account of how one can approach understanding the subject in educational and

counselling environments. Their neo-Foucauldian approach "avoids interpreting neoliberalism as an ideology, political philosophy, or an economic theory and reconfigures it as a form of governmentality" (ibid, p 132). Their view of how change takes place begins with confession, which "is both a communicative and an expressive act, a narrative in which we (re)create ourselves by creating our own narrative" (Besley & Peters, 2007, pp. 31-32). This account insists that in his later work Foucault changed his hypothesis, allowing the self to constitute itself, and credits the teacher or counsellor with an ability to understand how the old narrative was formed and to assist the subject to create an alternative in which they are in control, agents of their own destiny.

This view is not without its critics. One review notes that change is often in the direction of a neoliberal discourse, suggesting that the direction is led, if not by the therapist, then by a discourse of psychotherapy, which produces subjects who are good at neoliberal agendas – negotiating risk and probability (Kurz, 2009).

Moreover, Foucault's later work on technologies of the self is misunderstood as implying the freedom of the individual to shape their own narrative. Luepnitz (1992), bringing a Foucauldian sensibility to narrative therapy, suggests that it applies the same technologies of the self that allows the state to rule. Again, there is no 'outside' to power relations.

Claim is laid to a discursive therapy in a chapter by Law (1999), whose analysis of male violence uses Foucault well, but when it comes to the new narrative to be created, not only does the therapist know best, but the goal to be achieved is highly specific, involving "taking responsibility", and "holding to account" (Law, 1999, p. 117). While these may seem, on the face of it, perfectly reasonable objectives for the population being studied here, almost every subject has experienced and resisted numerous attempts by authorities to elicit "accountability". Underlying Law's admirable work to reduce male violence, we may suspect a popular discourse in which a defendant is "held to account" (an ill-defined term but one enshrined in sentencing law (New Zealand Parliamentary Counsel Office, 2002)). The defendant then realises the error he has made and is henceforth reformed. It is precisely against this discourse that resistance-become-discourse operates.

There have been other accounts in the literature of a discursive therapy. Kaye's approach explores "discursive regimens" by which we are subjectified (1999, p. 32), but of course this assumes the privileged position of the therapist, upon whose ability to analyse discourse the method depends.

Foucault's position toward the end of his life, sometimes interpreted as the "return of the subject" (Dews, 1989), is nuanced and ambiguous. Foucault writes of a "historico-practical test" of our limits, and working upon ourselves as "free beings", implying some sense of personal agency, and then, on the same page, of how our possibilities for movement are "limited and determined" (Foucault, 1984/1994, p. 54), re-establishing his earlier stance, that there is no outside to subjectifying power relations.

Here Foucault seems to be saying that we can work on ourselves, in a manner reminiscent of freedom, or individual agency, but what we cannot know is the extent to which what we are doing is determined. We can know that we are capable of things, but not of what we are capable. Foucault does not imply that we can escape discourse, which is important as we consider how to move forward with defining a therapy along Foucauldian lines. The identification of discourse with language as indicated by Kelly (2019) is a key element. Kelly explores the implications in a lecture that focusses on a passage from Foucault's The Order of Things, in which he suggests that we can, by using language, put pressure on it, and thus on discourse, making it "shift imperceptibly upon itself" (Foucault, 1966/2002, p. 403).

From this perspective, when a man (or anyone, though we are here concerned with men) is talking in therapy, these are not his words, even not his experience – they are taken from the cultural discourse(s) in which he participates. Of course, what he is describing may have happened to him, at least in some form, that is not in question, but the way he describes it, the words he uses, the kind and degree of emotion accompanying the spoken language, are all governed by influences of which he is unlikely to be aware.

Subjective experience in Foucault does not mean a phenomenological experience – it means the experience of subjectification, determined by discourse, by rules about what can and cannot be expressed and how, by what is visible and said, and what is invisible and unsaid. We cannot rely on our self-reflective experience to guide us. We have to look beyond the self to the "historical ontology of ourselves" (1984/1994, pp. 53-54). The aim becomes "to learn to what extent the effort to think one's own history can free thought from what it silently thinks, and enable it to think differently" (Foucault, 1978, p. 9).

Consider a vignette: A 37-year-old Māori man who walks, talks, and looks like a gang member suffers panic attacks in public and is disturbed by recurring violent thoughts, impulses and dreams.

A therapist might respond in several ways. We could ask about the traumatic beginnings of his anger in an abusive and neglectful childhood. We could encourage the adoption of a new way of thinking, a cognitive alternative to anger and shame. We could place the anger in a larger narrative, which we frame as external, a story that he is following, and explore alternative stories about him that could be adopted, changing

the narrative. We could offer interpretations such as that he is identifying with his abuser(s) since that is a more powerful position than being a victim.

All of these approaches have considerable literature to support them, but there is good reason to believe that they do not work well with the kind of subjectification one finds in prison.

Having studied the symptom, if it can be called that, we can initiate a conversation about discourse, asking, where do these things come from, the panic and the anger? Childhood trauma will be suggested, and perhaps prison, but then another question emerges, concerning how fear and anger got into childhood and prison.

Some might suggest that "hard times" for the family might have something to do with it. The story, the genealogy, can go back generations and involve forces in society as a whole, racism, colonisation, disenfranchisement, and the history of a people.

Of course, we can discuss trauma, narrative, identifications and introjections – these are all interesting discussions. We can structure our conversations, or not, as long as the question where did that come from? is occasionally asked.

This involves working within a paradox. Attempting to harness discourse or resistance is a non sequitur as it is not possible to examine discourse except from discourse. One then must be engaged, not in a scientific enterprise but an ethical one, that of perusing an examined life (Grosz, 2013). This means that psychotherapy, defined along these lines and for this purpose, is distinct from those approaches to psychology that promise change, liberation, or autonomy. Working with men who have spent considerable time in prison, and who belong to a criminal culture, we encounter inequity, ethnicity, poverty, educational deficits, and poor housing, in the room, as psychotherapists describe the experience. Access is an issue, with psychotherapy remaining largely the domain of the wealthy, excluding the great majority of those who have experienced these social determinants. Moreover, this is a population among whom hyper-arousal, hyper-vigilance, paranoia, and impulsivity are common, so it is inadvisable, possibly even cruel, to seek further unruly tendencies by investigating the unconscious.

Importantly, we do not try to control the direction of any change that the practice produces. We allow the practice to have its effect. Of course, as a practice of freedom, as Foucault suggests, this does not mean that the individual is liberated – Foucault remained cynical about that idea. It means that there is another set of influences available to shape whatever subjectivity emerges, It is not a question of the professional knowing best and prescribing – there is an engagement of the self with the self, an involvement of the subject with the subject. No promises are made. In Foucauldian terms this is an ethical exercise (1982/1994).

Although psychotherapy's technologies are typically one-to-one, it makes more sense to consider the we operating here, out of awareness – incorporating cultural and historical memes and discourses, gestures typical of predecessors, attitudes practised in the present, randomly modified by usage, and thus the meaning also becomes modified, and the cultural beliefs and practices, the discourses in fact, shift a little. For this reason, group therapy is preferable, as subjectifying practices are available for study in the room, and members can experience themselves and others, and themselves with others. It is much easier to see the typical gestures, ways of sitting, tones of voice and voice-gesture combinations that indicate criminality in others than to see them in ourselves.

Beginning with the observation that the highly-manualised programmes of intervention delivered in prisons produce disappointing results, considering various formulations concerning subjectivity and the development of a sense of self and applying notions derived from Foucauldian philosophy, we entitle this article with the suggestion to throw away the manual in favour of a discourse-based approach to therapy.

As a final remark, there must be political action as well as therapeutic engagement. Foucault has been accused of relativism (Chomsky & Foucault, 2006; Habermas, 1987), of overinvolvement with hedonism and aesthetics (Simons, 2000), and with undermining the potential for political action. His life, however, belies these attacks. He repeatedly involved himself in political movements on local (university politics at Vincennes), national (prison reform) and international (intervening in an execution ordered by Franco) levels (Macey, 1993/2019). The answer is to stop sending people, particularly young men, and even more particularly young indigenous men, to prison.

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3

Abstract
Access to mental health care remains a pressing global issue. In response, policymakers have devised strategies that span from self-care to psychotherapy, hoping to ease the strain. However, reforms over the past two decades have significantly restricted access to psychotherapy, limiting the number of professionals, such as nurses, allowed to practise under stringent conditions. This article examines the effects of Quebec's public policies on the practice of psychotherapy and mental health interventions. A critical discourse analysis, grounded in Strauss's theory of negotiated order, was conducted on 48 policy documents and public discourses. The findings reveal that mental health interventions have become disconnected from their therapeutic essence, reduced instead to technical tasks. This shift perpetuates a hierarchical professional landscape, subordinating these practices despite their reliance on the relational dynamics that define effective mental health care. For the nursing profession, the implications are profound. The profession's contribution to providing timely access to community-based mental health services is being overlooked, stymied by outdated perceptions and policy restrictions.

Keywords discourse analysis, negotiated order, psychotherapy, mental health, primary care

Mental health nursing and the negotiated order: A critical analysis of psychotherapy discourses in Québec (Canada)

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Introduction

Timely access to mental health services is a global concern (Organisation mondiale de la santé, 2022). In Canada, one in five citizens experiences a common mental health issue (Commission de la santé mentale du Canada, 2017), yet many do not seek or receive the necessary care. As of October 2024, approximately 15,000 people in Quebec were waiting for primary mental health care services within the public sector (Ministère de la santé et des services sociaux, 2023), where mental health services are among the most vulnerable parts of the healthcare system (Champagne et al., 2017). This figure excludes those deterred by the poor state of services or the stigma surrounding mental health (Warin, 2017), as well as those opting for private care.

To tackle this issue, social policies have adopted a continuum of care, ranging from self-help initiatives to psychotherapy. This strategy is designed to deliver personalised services to those with mental health concerns while aiming to reduce wait times and improve cost-efficiency (Moroz et al., 2020; Rivero-Santana et al., 2021). Roughly 90% of common mental disorders—defined by Lebrun-Paré et al. (2023) as anxiety, mood and substance-related disorders—could be treated in primary care settings (Fleury, 2014). Integrating psychotherapy into these services could cut costs by 20% to 30% (Moroz et al., 2020).

However, the shortage of professionals authorised to practise psychotherapy remains a barrier. Public discourse often highlights a shortage of psychologists, many of whom opt for private practice (Roy, 2016; Lapalme et al., 2018). Yet in

Quebec, psychotherapy has been regulated to include several professional groups, such as doctors, social workers, and nurses (Gouvernement du Québec, 2009). The underappreciation of healthcare workers' contributions to mental health services is not unique to Quebec. In Australia, for instance, mental health nurses "are vanishing from government funded schemes that subsidize psychotherapy and psychological treatments in primary care," giving way to professional monopolies (Hurley et al., 2020).

In Quebec, where mental health services remain largely inaccessible and the public sector struggles with staff shortages, the regulation of psychotherapy has produced systemic effects. Understanding the power dynamics surrounding this regulation is critical to grasping its consequences on intervention practices. These dynamics shape the boundary between what are deemed legitimate practices and what are considered illegitimate or even reprehensible.

Not officially authorised to practise psychotherapy, the lack of recognition for healthcare workers who provide mental health support warrants further examination. This article thus aims to explore how public policies regulating psychotherapy in Quebec impact the social and professional configuration of mental health practices. In doing so, it addresses two key questions below:

1. What are the negotiation dynamics behind the distinction between psychotherapy and other mental health interventions?

2. What are the potential consequences of these dynamics on the development of mental health practices in Quebec?

Social and historical context

The evolution of professional boundaries is pivotal in shaping the landscape of mental health professions. These boundaries not only delineate what constitutes legitimate and illegitimate practices but also influence the formation (or lack thereof) of interprofessional alliances. The professionalisation of psychotherapy illustrates this dynamic in North America and Europe. In the wake of World War II, American psychiatrists and psychologists endeavoured to establish a monopoly over the practice, fostering a corporatist relationship that oscillated between competition and cooperation (Buchanan, 2003). This ambition was propelled by the rise of clinical psychology, which sought independence and legal recognition while mirroring medical professional practices (Wiener, 1953; Buchanan, 2003). Conversely, the psychiatric field aimed to maintain its control over the treatment of mental health issues (Benjamin, 2005; Prud'homme, 2014).

It was not until the 1970s that psychology as a profession came to dominate the psychotherapy landscape (Benjamin, 2005). However, the absence of a clear definition of psychotherapy, coupled with diverse traditions of practice, exacerbated interprofessional tensions (Szasz, 1974; Buchanan, 2003). While it was recognised that nurses commonly practised psychotherapy informally during this era, their established subordinate relationship to psychiatric medicine meant they did not threaten the competitive dynamics between professions (Buchanan, 2003; Hurley & Lakeman, 2021). Lego (1973) highlights the centrality of this subordination in the struggle for professional recognition among psychotherapist nurses:

> "Unless we as nurses can support our contention that we offer a psychotherapeutic service that differs from that offered by the other disciplines, we cannot justify our practice of psychotherapy" (Lego, 1973, p. 147).

In Quebec during the early 1980s, similar dynamics of interprofessional negotiation emerged. Like some psychiatric nurses, social workers engaged in "indirect" psychotherapy, informed by a social understanding of mental disorders, which posed "little threat to the internal equilibrium of institutions," in contrast to psychologists who openly challenged medical authority (Prud'homme, 2014, p. 108, free translation). This encroachment of various professions into the psychotherapeutic domain compelled psychologists to distinguish themselves. They distanced themselves from shared intervention areas, integrating behavioural and cognitive approaches into their practice, while psychiatrists increasingly "aligned themselves with an organic understanding of mental illness and increasingly defined themselves, after 1960, by the use of medication" (Prud'homme, 2014, p. 109, free translation). Nevertheless, psychology's quest for emancipation from medical oversight faced ongoing administrative subordination (Prud'homme, 2014).

From 1980 to the early 2000s, extensive interprofessional discussions aimed to regulate the title of psychotherapist and the practice of psychotherapy (Trudeau et al., 2015). In Quebec, as in many other jurisdictions, including the United States and Australia (Buchanan, 2003; Hurley et al., 2020; Hurley & Lakeman, 2021), psychotherapy remained informally regulated for an extended period, a situation that continues in certain Canadian provinces (Association canadienne de counselling et de psychothérapie, 2023). This changed in 2012 with the enactment of legislation amending the Professional Code and other legislative provisions in the field of mental health and human relations (Gouvernement du Québec, 2009, hereafter Bill 21). The amendments aimed to enhance the protection

of individuals receiving psychotherapy services, reserving the title of psychotherapist and the practice of psychotherapy for designated professionals, including nurses, under specific conditions established by the Regulation respecting the psychotherapist's permit. These conditions will be elaborated upon later in this article.

More than a decade after this regulation was passed, only 41 nurses hold a psychotherapist permit (Ordre des psychologues du Québec, 2023), while approximately 5.8% of Quebec's 83,000 nurses work in mental health (Ordre des infirmières et des infirmiers du Québec, 2023). Recently, the rollout of the Quebec Program for Mental Disorders (QPMD), inspired by the guidelines of the National Institute for Health and Care Excellence (NICE), established a continuum of interventions ranging from self-care to psychotherapy. The programme's overarching goal is to enhance access to mental health services and their efficiency through a stepped-care model, providing services tailored to individuals' conditions at the appropriate time (Rivero-Santana et al., 2021). Within this framework, psychological interventions and psychotherapy are treated as two distinct activities.

Theoretical and methodological considerations

This study is grounded in a critical epistemology. To address the research questions, we conducted an analysis of documents reflecting public discourses surrounding the regulation of psychotherapy in Quebec between 2003 and 2023 (n=48). The dataset is presented in Table 1. Alongside this, scientific literature was reviewed to establish the historical, social and political context of the research problem. To support our discussion, we employed Strauss' theory of negotiated order (1992a, b) and adopted a methodological approach inspired by Foucauldian discourse analysis (Arribas-Ayllon & Walkerdine, 2017). This approach involved particular attention to discursive elements preceding the adoption of the current legal framework, agreements between professional groups, and counter-discourses that emerged following the changes in the professional ecosystem. This project was submitted to the Research Ethics Committee of the Université du Québec en Outaouais (2024-3013) for ethical declaration.

The concept of negotiation is central to various theories of social regulation (Allain, 2004). Strauss (1992a), in his study of daily interactions within a psychiatric hospital, introduced and elaborated the theory of negotiated order. Later, he expanded this framework (1992b) to analyse how power dynamics shape social relations and structure the everyday life of organisations. Strauss' theory departs from functionalist perspectives, emphasising instead the processes of appropriation, negotiation and implementation of both formal and informal rules and roles. Social order, he argues, is continuously constructed through the transactions of actors within the professional ecosystem (Strauss, 1992b). As he observed, order is "something at which members of any society, any organization, must work" (Strauss, 1992a, p. 88, free translation). Allen (1997) further explored these negotiation dynamics in her critique of the boundaries between nurses and physicians. Echoing Strauss, she advocated for a systemic perspective that foregrounds the underlying conditions of negotiation rather than focusing solely on individual actions.

Data collection was undertaken by the first author and analysed using Foucauldian discourse analysis (Arribas-Ayllon & Walkerdine, 2017). This deductive and interpretive method (Sam, 2019) is widely used in critical psychology, where it helps to reveal "the historical conditions through which psychological knowledge has played a part in shaping the conduct of individuals in Western societies" (Arribas-Ayllon & Walkerdine, 2017, pp. 110-111). Foucauldian discourse analysis allows for an examination of the social and historical conditions that contribute to the emergence of regimes of truth, which determine the legitimacy of specific knowledge at a given time, shaping the possibilities and meaning of action (Foucault, 2012; Khan & MacEachen, 2021).

The analysis was conducted by the first author, with preliminary findings reviewed collectively by the remaining authors. The first author's positioning as a mental health nurse helped to make sense of data coherence from an internalistic perspective, which was further enhanced during the discussions. Details of the methodological approach are outlined in Table 2.

Findings

The data analysis identified four key themes that shed light on how public policies shape psychotherapy and other mental health interventions. A summary of the results pertaining to these themes can be found in Table 3. The intricate dynamics of negotiation and their implications for practice will be examined in greater detail in the following sections. Unless otherwise noted, the cited material has been translated from French to English by the authors, with assistance from an OpenAI language model.

Psychotherapy: between charlatanism and professional legitimacy

Although the dynamics of professional negotiation aimed at securing the scope of psychotherapeutic practice are not new, a turning point in the governance of psychotherapy in Quebec occurred in 2003. A television report titled

Table 1. Dataset

	Author(s)	Date of production	Title*	Category**
1	Association des psychothérapeutes du Québec	2022	Letter sent to Lionel Carmant in response to the launch of the Inter-ministerial action plan for mental health	Public discourse
2	Bérubé, S., Boudou-Laforce, E., & Gagné, A.A.	2019	Law 21: a Categorization with Perverse Effects	Public discourse
3	Coalition des psychologues du réseau public québécois	2022	The Solution to the Psychologist Shortage in the Public Network Lies in the Formation of a Psychologist Union	Public discourse
4.1-4.10	Collège des médecins du Québec, Ordre des Conseillers et conseillères d'orientation du Québec, Ordre des ergothérapeutes du Québec, Ordre des infirmières et infirmiers du Québec, Ordre des psychoéducateurs et psychoéducatrices du Québec, Ordre des psychologues du Québec, Ordre professionnel des criminologues du Québec, Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec & Ordre professionnel des sexologues du Québec (ci-après, Collège des médecins du Québec et al.) – Guide interordre (4.1), outil d'aide à la décision (4.2), Vignettes cliniques (4.3-4.10)	2018	The Practice of Psychotherapy and Related Interventions: Finding the Boundary Between Different Professionals' Interventions and Psychotherapy	Social policy
5	Conseil consultatif interdisciplinaire sur l'exercice de la psychothérapie (Ordre des psychologues du Québec)	2012	Advisory Opinion of the Interdisciplinary Advisory Council on Complementary Issues Regarding Animal-Assisted Therapy	Social policy
6	Conseil consultatif interdisciplinaire sur l'exercice de la psychothérapie (Ordre des psychologues du Québec)	2012	Advisory Opinion of the Interdisciplinary Advisory Council on the Practice of Psychotherapy: Summary of Conclusions	Social policy
7	Conseil consultatif interdisciplinaire sur l'exercice de la psychothérapie (Ordre des psychologues du Québec)	2015	Final Mandate Report 2010-2015	Grey literature
8	Corporation des Zoothérapeutes du Québec	2014	Bill 21 and Animal-Assisted Therapy	Public discourse
9	Desjardins, N. (in collaboration with the Association des psychothérapeutes du Québec)	2021	The 1600 Psychotherapists are Here to Help!	Public discourse
10	Desjardins, N. (in collaboration with the Association des psychothérapeutes du Québec)	2020	For Universal Access to Psychotherapy: Psychotherapists are Ready!	Public discourse
11	Drapeau, M.	2016	The Regulation of Psychotherapy in Quebec: A Step Forward, Two Steps Back?	Commentary or editorial
12	Drapeau, M.	2020	For Universal Access to Psychotherapy	Commentary or editorial
13	École de formation professionnelle en hypnothérapie du Québec et Ordre des Psychologues du Québec	2015	Agreement Regarding Services that May Be Offered in Compliance with Bill 21 by Practitioners in Hypnosis Who are Neither Psychologists, Physicians, nor Holders of a Psychotherapy Permit	Social policy
14	Fédération Interprofessionnelle de la santé du Québec	2012	Review of the Professional System: The Impacts of Bill 21	Grey literature
15	Gauvreau, C.	2017	Perverse Effects: The Law on the Practice of Psychotherapy Has Excluded Charlatans, but Also Competent Professionals	Public discourse
16	Government of Ontario	2023	Regulated Health Professions Act	Legislative text
17	Government of Quebec	2023	Professional Code	Legislative text
18	Government of Quebec	2023	Regulation respecting the psychotherapist's permit	Legislative text
19	Government of Quebec	2009	Bill No. 21	Legislative text
20	Government of Quebec	2009	Journal of Debates of the Standing Committee on Institutions Tuesday, June 16, 2009 – Vol. 41 No. 23	Legislative text
21	Government of Quebec (Ministry of Health and Social Services)	2019	Getting Help or Support for Common Mental Disorders: Information Document for the Public (QPMD)	Social policy
22	Government of Quebec (Ministry of Health and Social Services)	2020	Support Document for Detection, Intervention, and Referral for Adults with Symptoms Associated with Common Mental Disorders in General Social Services – Summary of Recommendations from Steps 1 and 2 of the Quebec Program for Mental Disorders: From Self-Care to Psychotherapy (QPMD)	Social policy
23	Government of Quebec (Ministry of Health and Social Services)	2020	Information Document for Institutions – Quebec Program for Mental Disorders: From Self-Care to Psychotherapy (QPMD)	Social policy
24	Government of Quebec (Ministry of Health and Social Services)	2021	Common Mental Disorders: Detection and Service Pathways (QPMD)	Social policy
25	Government of Quebec (Ministry of Health and Social Services)	2022	Generalized Anxiety Disorder and Panic Disorder in Adults: Detection, Referral, and Treatment – Clinical Practice Guideline (QPMD)	Social policy
26	Government of Quebec (Ministry of Justice)	2016	Report on the Implementation of Chapter VI.1 of the Professional Code Relating to the Regulation of Psychotherapy	Social policy

Table 1. Dataset (cont'd)

	Author(s)	Date of production	Title*	Category**
27	Government of Quebec (Office of Professions)	2005	Sharing Our Expertise: Modernization of Professional Practice in Mental Health and Human Relations (Trudeau Report)	Social policy
28	Government of Quebec (Office of Professions)	2021 (April)	Law Amending the Professional Code and Other Legislative Provisions in the Field of Mental Health and Human Relations: Explanatory Guide	Social policy
29	Government of Quebec (Office of Professions)	2021 (January)	Law Amending the Professional Code and Other Legislative Provisions in the Field of Mental Health and Human Relations: Explanatory Guide	Social policy
30	Government of Quebec (Office of Professions)	2013	Law Amending the Professional Code and Other Legislative Provisions in the Field of Mental Health and Human Relations: Explanatory Guide	Social policy
31	Working Group on Optimizing Training in Psychology and Mental Health	2023	Mental Health: Trainings That Meets the Needs of the Population	Social policy
32	Lapalme, M., Moreault, B., Fansi, A.K., Jehanno, C. (Institut national d'excellence en santé et en services sociaux)	2018	Equitable Access to Psychotherapy Services in Quebec	Grey literature
33	Larin, V.	2021	Mental Health: Quebec Opens the Checkbook to Hire Private Psychologists	Public discourse
34	Lorquet, E.	2012	Legal Affairs: Opinions of the Interdisciplinary Advisory Council on the Practice of Psychotherapy	Grey literature
35.1-35.14	Memoranda Submitted Regarding Bill No. 21 (n=14)	2009	Special Consultations on Bill No. 21 - Law Amending the Professional Code and Other Legislative Provisions in the Field of Mental Health and Human Relations	Memorandum submitted to a parliamentary commission
36.1-36.31	Memoranda Submitted Regarding Bill No. 50 (n=31)	2008	Special Consultations on Bill No. 50 - Law Amending the Professional Code and Other Legislative Provisions in the Field of Mental Health and Human Relations	Memorandum submitted to a parliamentary commission
37	Government of Quebec (Ministry of Health and Social Services)	2022	Social Anxiety Disorder: Detection, Evaluation, and Treatment – Clinical Practice Guideline (QPMD)	Social policy
38	College of nurses of Ontario	2023	Psychotherapy and the Controlled Act Component of Psychotherapy	Social policy
39	Ordre des psychologues du Québec	2023	2022-2023 Annual Report	Grey literature
40	Ordre des psychologues du Québec	2022	Recognized Courses for the Psychotherapist Permit to Meet Regulatory Requirements	Grey literature
41	Radio-Canada	2003	Dangerous Therapies	Public discourse
42	Regroupement des intervenants et Thérapeutes en Médecine Alternative et Ordre des Psychologues du Québec	2015	Agreement Regarding Services That May Be Offered in Compliance with Bill 21 by Practitioners in Hypnosis Who Are Neither Psychologists, Physicians, nor Holders of a Psychotherapy Permit	Social policy
43	Rességuier, V.	2022	Psychologist Shortage in the Public Network: A Record Number of Positions to Fill	Public discourse
44	Rességuier, V.	2022	Psychologists in the Public Sector: "The Problem is That Our Expertise is Not Respected"	Public discourse
45	Roy, C.	2016	Affirmation of the Profession: What Are the Challenges for Quebec Psychologists?	Editorial or commentary
46	Savard, P. & Lussier-Valade, M.	2019	Supportive therapy: a mini-guide to practice (first edition)	Grey literature
47	Than, V.	2022	The silent epidemic: Quebecers' mental health and the challenge of access to psychotherapy	Grey literature
48	Trudeau, J.B., Desjardins, P., & Dion, A.	2015	Psychotherapy - A necessary and legally recognized framework in Quebec	Commentary or editorial

* Freely translated from French to English by the authors
**In order to constitute the data corpus underpinning this analysis, we sought to differentiate between public discourses (e.g., newspaper articles or letters addressed to the media, excerpts from websites), legislative texts (laws and regulations), social policies stemming from these legislative texts (e.g., guidelines), commentaries and editorials published in academic journals, memoranda submitted to parliamentary commissions, as well as grey literature (e.g., practice guides, internal organizational documents available to the public).

"Dangerous Therapies" from Radio-Canada (Document 41 - Radio-Canada, 2003) sparked a significant public scandal, leading to a particularly swift institutional response:

> The shocking report on dangerous therapies clearly illustrates the danger faced by individuals who entrust their mental health, or even their lives, to just anyone—charlatans and self-proclaimed psychotherapists of all kinds. The day after the broadcast, a preparatory meeting was held at the [Office of Professions] to establish a committee of experts on modernising professional practices in mental health and human relations. (Document 48 - Trudeau et al., 2015).

The collective awareness and outrage that followed these events catalysed a major initiative, culminating in the publication of a report aimed at modernising professional practice in mental health and human relations (Document

Table 2. Foucauldian Discourse Analysis

	Steps*	Analysis process
1	Selecting a corpus of statements corresponding to the issue	Inductive approach leading to the identification of various types of discourse related to the practice of psychotherapy in Quebec, such as public discourse, legislative texts, social policies, comments and editorials, memorandum submitted to parliamentary committees, and grey literature.
2	Problematizations: description of the material conditions that contributed to the discursive construction of the issue	Relating the issue to the context that contributed to or followed the adoption of laws and regulations governing the practice of psychotherapy in Quebec. The period is limited to the years 2003-2023, as it refers to the social and historical context during which psychotherapy was institutionalized through regulatory means in Quebec. Scientific writings addressing the historical, social, and political conditions associated with the issue were also consulted and added to the dataset.
3	Technologies: identification of rationalities involved in the issue	Identification of disciplinary, professional, social, and political issues, including those related to psychotherapy and access to mental health services in Quebec. Identification of scientific knowledge, controversies and debates associated with psychotherapy and mental health intervention practices.
4	Subject positions: identification of the moral location of subjects and institutions involved in the issue	Analysis of discursive elements associated with the expected conduct of subjects based on their social position, including their qualifications and the guidelines outlining mental health intervention practices.
5	Subjectification: Description of the ethical constitution of social practices	Analysis of power dynamics associated with mental health intervention practices, particularly the existing tensions between practices constructed as or distinct from psychotherapy.

*Adapted from Arribas-Ayllon & Walkerdine (2017)

27 - Office of Professions, 2005). This effort subsequently resulted in legislative changes under Bill 21 (Document 19 - Government of Quebec, 2009). Several principles guided this approach, notably the principle of competent accessibility, which "ensures that the patient receives the appropriate service, provided by a competent person, at the right time, in the desired location and for the required duration" (Document 27 - Office of Professions, 2005, p. 5).

As a result, increased regulation of psychotherapy began to delineate the legitimacy of certain practices while legally defining psychotherapy and specifying the individuals authorised to practice it under certain conditions. Since 2012, the Professional Code (Document 17 - Government of Quebec, 2023) and the Regulation respecting the psychotherapist's permit (Document 18 - Government of Quebec, 2023) have defined what constitutes psychotherapy, granting the Ordre des psychologues du Québec the authority to issue psychotherapy permits:

> "Psychotherapy is psychological treatment for a mental disorder, behavioural disturbance or other problem resulting in psychological suffering or distress, and aims to foster significant changes in the client's cognitive, emotional or behavioural functioning, interpersonal relations, personality, or health. Such treatment goes beyond help aimed at everyday difficulties and exceeds a support or counselling role" (Document 17 - Professional Code, 2023, Art. 187.1).

Critics argue that these legislative changes promote a dogmatic approach to psychotherapy, excluding many clinicians who have historically practiced it while reinforcing the dominance of evidence-based models and hegemonic intervention practices (Document 15 - Gauvreau, 2017).

> Beyond the ostensibly noble idea of public protection, Bill 21 has resulted in many competent therapists being unable to practice under the banner of psychotherapy due to stringent requirements […] One might rightly question, how many capable therapists were sacrificed during this process and how many charlatans were genuinely eliminated (Document 2 - Bérubé et al., 2013).

Following the implementation of Bill 21, a professional hierarchy emerged regarding the control of the psychotherapist title and the practice of psychotherapy. The legal definition has created uncertainty surrounding the legality of certain practices and their recognition (or lack thereof) as psychotherapies, particularly concerning animal-assisted therapy, music therapy, art therapy, and couple and family therapy. It has

Table 3. Summary of results

	Categories	Results
1	Psychotherapy: between charlatanism and professional legitimacy	In North America, professional negotiation dynamics related to psychotherapy have been ongoing since the early 1970s. However, it was in 2003, when scandalous practices were publicly denounced, that discussions regarding the regulation of psychotherapy in Quebec took on a more concrete form. These discussions culminated in legislative changes under Bill 21. This law, enacted in 2012, legally defines psychotherapy and restricts its practice to a limited number of professionals under specific conditions. This reform also excluded many practitioners who had historically practiced psychotherapy.
2	Psychotherapy as a normative apparatus	The reserved title of psychotherapist and the practice of psychotherapy promote the establishment of a control apparatus that determines what can be said, written, and practiced regarding the human psyche. Additional conditions target eligible professionals who are neither psychologists nor doctors. Guidelines developed by the relevant Professional Orders establish further standards and provide terminological clarifications to distinguish interventions that are similar to, but do not constitute psychotherapy.
3	Subordinated practices	The issue of psychological treatment is the focal point of the negotiation dynamics aimed at regulating the practice of psychotherapy. The dissociation of psychological treatment from psychological interventions creates a hierarchy of practices. This distinction appears to run counter to knowledge on the effectiveness of psychotherapy. Practical difficulties are also observed, particularly due to the therapeutic potential of interventions that do not constitute psychotherapy. This situation can create significant ambiguity for clinicians responsible for determining the legality of their interventions.
4	Care as a technical object	Care practices seem reduced to their technical dimensions. The Quebec Program for Mental Disorders (QPMD) illustrates this trend by differentiating between cognitive-behavioral psychotherapy and "interventions using cognitive-behavioral techniques." This dynamic may lead to a loss of meaning for mental health professionals. Some adopt discursive strategies to preserve the integrity of their practice.

been determined that these modalities do not, in themselves, constitute psychotherapy, and clinicians are "obliged to distinguish [their] intervention(s) from psychotherapy in terms of code, method and objectives" (Document 34 - Lorquet, 2012, pp. 18-20). The same applies to hypnotherapy, for which an agreement states that "there is no doubt that hypnosis or hypnotherapy can be practiced and offered to the public by a clinician who is not a psychotherapist" (Document 13 - École de formation professionnelle en hypnothérapie du Québec and Ordre des psychologues du Québec, 2015, p. 1). It is noteworthy that this agreement favours the use of the term "practitioner" over "therapist." This distinction suggests important normative tensions, which will be discussed in the following section.

Psychotherapy as a normative apparatus

The adoption of legislative provisions to protect the title of psychotherapist and the practice of psychotherapy has been accompanied by an extensive control apparatus. Through a consensus among the relevant professions, this apparatus determines what can be said, written and practiced regarding the human psyche. While the disciplinary rationale justifies such a framework—whether for public protection or quality control—the analysis of the social and historical conditions associated with this rationale suggests the influence of interprofessional negotiation dynamics. These dynamics are particularly evident in the cooperative relationship between doctors and psychologists concerning psychotherapy, although this collaboration primarily reflects the dominant position of the medical profession (Garon-Sayegh, 2016), as reflected in the following passage:

> For psychologists, psychotherapy is central to their practice, with university programs providing the necessary training. In contrast, physicians may receive training in psychotherapy, especially if they specialise in psychiatry (Document 27 - Office of Professions, 2005, p. 93).

Consequently, both the Trudeau report and Bill 21 propose reserving the title of psychotherapist and the practice of psychotherapy for psychologists and physicians across all specialties, while "sharing" this privilege with other professionals subject to additional training requirements. This distinction between psychologists, physicians and other mental health professionals suggests the establishment of a professional hierarchy (Garon-Sayegh, 2016), rationalised by the unique nature of their training and oversight mechanisms, which, nonetheless, are common across professional groups.

> In general, the initial training of these two professional groups aligns with the theoretical and practical training standards identified by the Expert Committee for eligibility for a psychotherapy license. Consequently, the codes of ethics and surveillance programs of these professional orders attest to the quality of their members' practices, as well as their obligation to possess the necessary knowledge and skills without the need for a specific license (Document 27 - Office of Professions, 2005, p. 93).

It follows that the entire regulatory framework naturally favours psychologists, as the prerequisites for psychotherapy are embedded within their training. For "other" professionals, this new regulation imposes particularly restrictive conditions for practising psychotherapy. The Professional Code and the Regulation respecting the psychotherapist's permit reserve the practice of psychotherapy for members of seven professional orders: guidance counsellors, criminologists, occupational therapists, nurses, psychoeducators, social workers, marital and family therapists, and sexologists. For these professionals, obtaining a psychotherapy license, issued by the Ordre des psychologues du Québec, requires additional qualifications, including a master's degree in mental health and human relations, along with 765 hours of theoretical training and 600 hours of practical training focused on specific intervention content and models (Document 18 – Regulation respecting the psychotherapist's permit). This regulation also categorises practices not considered psychotherapy: accompaniment, support intervention, family and couple intervention, psychological education, rehabilitation, clinical follow-up, coaching and crisis intervention.

Ultimately, this regulatory framework establishes a prescriptive discursive regime, the effects of which on intervention practices are palpable. The document titled "The Practice of Psychotherapy and Related Interventions" (Document 4.1 - Collège des médecins du Québec et al., 2018) underscores an interprofessional consensus on psychotherapy, identifying its defining elements based on a legal, rather than epistemological, definition. Psychotherapy is characterised as the simultaneous combination of three elements, namely nature, object and purpose: i) a psychological treatment (nature), ii) addressing a "mental disorder, behavioural disturbance or other problem resulting in psychological suffering or distress" (object), iii) with the goal of "fostering significant changes in the client's cognitive, emotional or behavioural functioning, interpersonal relations, personality or health" (purpose) (Document 4.1 - Collège des médecins du Québec et al., 2018, p. 7, free translation). While it is acknowledged that many interventions performed by various clinicians share the same object and purpose as psychotherapy, it is the nature of the psychological treatment that delineates its boundaries, as asserted in the passage below.

> Discussions within the working group and observations in the field reveal that the defining element of psychotherapy, psychological treatment, clinically distinguishes it from related interventions offered by other mental health and human relations professionals (Document 4.1 - Collège des médecins du Québec et al., 2018, p. 8).

However, this normative clarification regarding psychotherapy reflects several discursive strategies that tend to blur its boundaries rather than clearly define them. The notion of psychological treatment, for example, is both directly and indistinctly equated with intervention, "which targets what which organises and regulates the psychological and mental functioning of the individual" (Document 4.1 - Collège des médecins du Québec et al., 2018, p. 8). Certain terminological clarifications are also proposed due to the widespread use of psychological terms and the associated risks of confusion and misunderstanding (Document 4.1 - Collège des médecins du Québec et al., 2018, p. 23). For instance, the term "therapy" is regarded as "highly prone to confusion," and the use of "beliefs" (croyances) is preferred over "core beliefs" (croyances fondamentales) to differentiate interventions that do not constitute psychotherapy. Other interventions, such as exposure and cognitive restructuring, are interpreted more permissively if employed competently without being classified as psychological treatment (Document 4.1 - Collège des médecins du Québec et al., 2018, pp. 23-31).

Subordinate practices

The documents reviewed for this analysis suggest that the issue of psychological treatment—and consequently the therapeutic potential of related intervention practices—has been at the centre of interprofessional struggles between psychologists and physicians since the 1950s (Benjamin, 2005). The discursive investment of psychotherapy in Quebec, whose definition remains debated internationally (Castelpietra et al., 2021), seems to reproduce a logic that subordinates other

mental health professionals to psychological expertise. In the public sphere, this subordination could explain the relative invisibility of other mental health professionals (Document 47 - Than, 2022), favouring physicians and psychologists in discussions about access to psychotherapy and mental health services. This is depicted in excerpts like the one below:

> Furthermore, mechanisms for communication between family physicians and psychologists must be established within an interdisciplinary care framework, which has proven to be more effective than isolated treatments (Document 12 - Drapeau, 2020).

This dynamic of subordination raises two significant issues for any mental health professional. On one hand, the definition of psychotherapy as psychological treatment presents certain paradoxes. These paradoxes become particularly evident when it is stated that psychotherapy, which "goes beyond help aimed at dealing with everyday difficulties and beyond a support or counselling role," is not limited to the treatment of mental disorders and does not depend on their severity or symptom intensity (Document 4.1 - Collège des médecins du Québec et al., 2018, p. 7). This particularly broad approach to psychotherapy may place professionals in a precarious position, where the risk of practicing psychotherapy illegally or the fear of being accused of doing so are ever-present. The QPMD further confirms a dynamic of responsibility for professionals when applying recommendations targeting specific therapies and psychological interventions:

> Thus, the recommendations […] require the clinical judgment of the professional to determine whether the intervention they are about to undertake constitutes psychotherapy under this law. This analysis by the professional should be conducted using the various interprofessional documents […]. (Document 24 - Ministère de la Santé et des Services sociaux, 2021).

However, this attempt to distinguish intervention from psychological treatment is not without difficulty. This challenge is concretely expressed when it is acknowledged that some interventions may, inadvertently and without constituting psychological treatment, modify the organisation, regulation and psychological functioning of an individual:

> A professional who aims to effect changes within their scope of practice and whose interventions do not address what organises and regulates the psychological and mental functioning of the individual is not practicing psychotherapy. Moreover, it is possible that interventions by professionals not authorised to practice psychotherapy may have collateral effects on what organises and regulates the psychological and mental functioning of the individual […]. (Document 4.1 - Collège des médecins du Québec et al., 2018, p. 12,).

A report on equitable access to psychotherapy in Quebec, produced by the Institut national d'excellence en santé et services sociaux (Document 32 - Lapalme et al., 2018), illustrates how this attempt to hierarchise practices becomes even more complex. Notably, this report indicates that the meta-analyses reviewed on the effectiveness of psychological interventions neither distinguish these from psychotherapy nor determine whether they meet its legal definition in Quebec, "Quebec being one of the few places in the world where psychotherapy is legally regulated" (Document 24 - Ministère de la Santé et des Services sociaux, 2021, p. III). More generally, the effectiveness of these interventions complicates differentiation based solely on their psychotherapeutic scope. One striking example of this is the following quotation:

> Overall, the effectiveness of various psychological interventions, including psychotherapy, is comparable. The observed differences are minimal and are more closely related to age group and type of mental disorder than to the therapeutic approach itself. The personal characteristics of the therapist and the client, as well as common factors across all psychological interventions, also contribute to their effectiveness (Document 32 - Lapalme et al., 2018, p. III).

Care as a technical object

The analysis of the documents selected for this research project also suggests a multi-focal fragmentation of mental health intervention practices, which, combined with the hierarchical dynamics of professions, reduces care to its technical dimensions. It is observed that the therapeutic dimensions of care are subjected to a categorisation that disregards the nature of the helping relationship, rigidifying the clinical process by isolating its components into interventions such as "accompaniment meetings," "support interventions," "psychological education," and "clinical follow-up" (Document 18 - Regulation respecting the psychotherapist's permit, 2023, art. 6). The categorization of these interventions is based on what differs from, yet shares many common areas with, the legal definition of psychotherapy, as specified in the following statement:

> The Office of Professions has, by regulation, established a list of interventions that do not constitute psychotherapy within the meaning of the law but are similar to it and defined these interventions. It

> should be noted that, according to the legal definition of psychotherapy, this treatment goes beyond help aimed at dealing with everyday difficulties and beyond a support or counselling role (Document 28 - Office of Professions, 2021, section 5, p. 2).

The QPMD further contributes to such fragmentation by prioritising cognitive-behavioural interventions, which, while not classified as psychotherapy, nonetheless draw on its techniques, as clarified below:

> Using Cognitive-Behavioural Techniques: In the context of the [QPMD], this refers to interventions that are similar to psychotherapy but are not psychotherapy, where cognitive-behavioural techniques may be used but do not correspond to psychotherapy as defined by law (Document 24 - Ministry of Health and Social Services, 2021, p. 39).

However, the interprofessional consensus issues a warning about the deleterious effects of such fragmentation. Mobilising a discourse centred on risk management, this document asks healthcare professionals to take responsibility when implementing interventions that diverge from a psychotherapeutic process:

> Caution should be exercised clinically to avoid isolating interventions or fragmenting the stages of applying a technique, which could potentially amputate the psychotherapeutic process of essential components for treating certain disorders. The risks of exacerbating the condition of individuals affected must, therefore, be considered to prevent harm (Document 4.1 - College of Physicians of Quebec et al., 2018, p. 16).

Consequently, several discursive strategies are deployed by mental health professionals without a psychotherapy licence to preserve the integrity of their practice while remaining "very vigilant in their choice of words" (Document 8 - Corporation of Quebec Zootherapists, 2014). Some studies show that clinicians may substitute the term "therapy" with "sessions" or "interventions," add the adjective "therapeutic" to the term intervention, vary their discourse based on the interlocutor, modify the discursive construction of intervention plans, and informally practise psychotherapy (Côté and Brodeur, 2019; Mimeault, 2016, pp. 89-93). Mimeault provides a rationale beneath this:

> Nevertheless, doubt and guilt, coupled with the ongoing challenge of explaining their practice, lead them to develop linguistic strategies and withhold certain meanings regarding their practice for fear of being judged impure or engaging in an illegal activity. A fear of de-professionalisation/technicalisation is present (Mimeault, 2016, pp. 112-113).

Discussion

This critical discourse analysis sheds light on the discursive framework that has shaped discussions around mental health intervention practices in Quebec over the past two decades. At the heart of this discourse lies the establishment of a legal and operational definition of psychotherapy, a critical battleground in the struggle for authority among various health professions (Buchanan, 2003). Although Bill 21 was designed to protect the public from certain so-called "dangerous" practices, it has inadvertently excluded numerous health professionals, including psychiatric nurses and social workers, who have long operated in the shadows of institutional oversight (Ujhely, 1973; Buchanan, 2003).

The resulting structural changes in practice and service organisation reflect a consensus across professions, yet they simultaneously underscore the overwhelming dominance of psychology. Our findings reveal a professional ecosystem rife with tensions, which reinforce the influence of psychological expertise. The most significant consequence of these tensions is the denial of recognition for the contributions of mental health professionals unauthorized to practice psychotherapy. This exclusion restricts timely access to essential mental health services and reportedly leads to a profound sense of disillusionment among clinicians (Mimeault, 2016).

Quebec's landscape features a notably high ratio of psychologists and psychotherapists, with over half operating in the private sector (Document 32 - Lapalme et al., 2018). Yet, as Garon-Sayegh (2016) indicates, reserving the title of psychotherapist for certain professionals, including nurses, does not guarantee that they will engage in psychotherapy. Factors such as ethics, professional deontology, specific competencies, work organisation and compensation models critically shape the conditions under which such practices can occur.

Our analysis further suggests that mental health nursing practices, by being discursively severed from their psychotherapeutic roots, may exist in a state of anomie (Mimeault, 2016). The broad legal definition of psychotherapy in Quebec (Brodeur et al., 2015) places many professionals in a precarious position, fearing illegal practice. There is a real risk that capable practitioners, who have historically provided various forms of psychotherapy, could face public condemnation and institutional disapproval (Côté and Brodeur, 2019). The historical context reveals that concerns

over charlatanism represent just one facet of the ongoing recognition struggle between clinical psychologists and physicians regarding the right to practice psychotherapy. The interplay between psychology and medicine—characterised by competition and collaboration—has led to the infusion of medical logics into psychological practice (Karasu, 1992; Buchanan, 2003).

The privileges these professions enjoy regarding psychotherapy are not exclusive to Quebec. For instance, in France, Castelpietra et al. (2021) highlight a paradox where psychiatry residents receive insufficient psychotherapy training, yet psychiatrists are entitled to the psychotherapist title without additional qualifications.

When examining the treatment of prevalent mental disorders, it becomes apparent that recent shifts in mental health service organisation, under the purview of the QPMD, have entrenched cognitive-behavioral intervention models (Document 32 - Lapalme et al., 2018). Care practices are thus confined to the application of cognitive-behavioral techniques, categorised as support, accompaniment, clinical follow-up and "interventions similar to psychotherapy" (Document 4.1 - Collège des médecins du Québec et al., 2018). This bifurcation of the therapeutic relationship is often justified through an evidence-based discourse promoting manualised psychotherapies—structured psychotherapeutic approaches adhering to specified guidelines (American Psychological Association, 2024). However, studies contesting the supremacy of manualised over non-manualised methods point to the numerous challenges of implementation (Mignogna et al., 2018; Truijens et al., 2019; Shedler, 2020). Notably, research indicates that common factors within the therapeutic relationship, rather than the specifics of any psychotherapeutic method, are crucial to effective outcomes (Document 32 - Lapalme et al., 2018; Kidd et al., 2017; Cuijpers et al., 2019).

Disciplinary implications

It would be an oversimplification to claim that mental health nurses regularly engage in psychotherapy without formal recognition or possess the requisite competencies in all contexts. The increasing complexity of mental health services and evolving professional hierarchies necessitate a more nuanced exploration of these dynamics. If nursing staff are prohibited from legally offering psychotherapeutic care, what services do they provide, and under what conditions?

Mental health nursing often straddles the line between administering medication, monitoring side effects and managing risk. Nonetheless, many mental health nurses deliver therapeutic support interventions that extend beyond mere technical, evaluative or medico-legal functions. They harness the common factors inherent in therapeutic relationships (Kidd et al., 2017; Cuijpers et al., 2019) and employ pragmatic strategies focusing on therapeutic communication, motivation, problem-solving, and the mobilisation of patient strengths. Unfortunately, the therapeutic potential of these interventions remains largely unrecognised, both within the profession and in the broader healthcare landscape. Despite professional hierarchies, mutual recognition is vital for grasping the significance of informal arrangements that facilitate effective practice (Strauss, 1992b).

Recognition of these practices is hampered by findings of inadequate mental health education in the nursing curriculum (Barry & Ward, 2016; Happell, 2010; Lakeman et al., 2023). The current implementation of the QPMD, alongside the dominance of cognitive-behavioral methods, starkly contrasts the largely biomedical nature of nursing education (Adam et al., 2023), likely intensifying the disconnect between theory and practice. Our findings advocate for a substantial overhaul of mental health educational programmes, particularly given the notable lack of graduate courses focused specifically on psychotherapy in nursing, even a decade after the enactment of the Law amending the Professional Code and related provisions in mental health.

However, caution is advised regarding the disciplinary dynamics that compel nursing staff to choose allegiances between the competing discourses of psychiatry and psychology. Further investigation into the psychosocial intervention practices employed by mental health nurses is essential to better define and conceptualise eclectic therapeutic practices within the discipline. Although current interprofessional consensus warns that the term "supportive therapy" could "lend itself to ambiguity" (Document 4.1 - Collège des médecins du Québec et al., 2018), this terminology may aptly characterise mental health nursing practice and could be more thoroughly integrated into practice and research.

Finally, management practices and social policies could benefit from increased flexibility in integrating professionals legally authorised to practise psychotherapy within public mental health services. Our analysis prompts a reconsideration of the distinction made by the QPMD between "interventions using cognitive-behavioral techniques" and cognitive-behavioral therapy (Document 24 - Ministère de la Santé et des Services sociaux, 2021). While this distinction arises from the legal framework governing psychotherapy in Quebec, it exposes critical issues regarding the recognition of practices "similar to psychotherapy but are not" (Document 4.1 - Collège des médecins du Québec et al., 2018). A more inclusive definition of

psychotherapy could enhance access to primary mental health services and facilitate the QPMD's implementation, albeit requiring substantial legislative amendments regarding the conditions under which psychotherapy is practiced. In Ontario, for example, the practice of psychotherapy remains accessible to nurses, yet the legislative framework differentiates between general practice and the higher-risk authorised practice of psychotherapy, which is subject to stringent criteria, including the severity of the mental disorder being treated (Document 38 - College of Nurses of Ontario, 2023).

Strenghts and limitations of the approach

This critical analysis rests on a comprehensive review of policies and public discourse surrounding the practice of psychotherapy in Quebec. It interrogated the structuring effects these elements have on social relations and mental health care practices. However, the approach is limited by its inability to examine the social interactions that emerge directly from these policies. Incorporating in-situ observations alongside individual interviews, as well as consulting internal organisational documents, could yield a richer, more nuanced understanding of the subordination and resistance strategies employed by various health professionals as they navigate the recent regulatory framework governing psychotherapy in Quebec.

Conclusion

This discourse analysis has scrutinised the structural effects of legislative reforms regarding psychotherapy practice in Quebec over the past two decades. The findings underscore an interprofessional negotiation dynamic that has shaped a legal definition of psychotherapy, simultaneously restricting its practice to a select group of health professionals under specific conditions. Furthermore, the non-recognition of intervention practices previously classified as psychotherapy has led to a discrediting sentiment among numerous clinicians.

The analysis reveals that current public policies are forced to contort in order to accommodate these restrictions, resulting in the differentiation of many mental health interventions from psychotherapy and consequently diminishing their formal therapeutic recognition. In light of the pressing challenges in accessing mental health services within the public system, it may be fruitful to reassess psychotherapy through the lens of reasonable competence, as this sector is heavily affected by professional negotiation dynamics. Such a re-evaluation would enhance nurses' agency in implementing therapeutic interventions in mental health that align with their scope of practice.

These considerations are crucial for shaping social policies aimed at enhancing timely access to mental health services and may well constitute a step forward in responsible management in mental health.

Note

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Commentaire/Commentary

A Case for a Critical Examination of Diagnostic Delays Among Women

KELLY GREGORY, CHERYL PRITLOVE, ROSS UPSHUR & PIA KONTOS

There are a number of diseases and conditions that have notoriously long diagnostic periods, many of which disproportionately manifest among women (Clarke, 1983; Kempner, 2014). Endometriosis, for instance, takes on average three to ten years to diagnose (Sims et al., 2021), and cardiovascular disease (Johnson, et al., 2021), ADHD (Young, et al., 2020), and pain conditions such as fibromyalgia (Qureshi, et al., 2021) and rheumatoid arthritis (Rosa, et al., 2020) represent other common examples. This phenomenon has also been identified in conditions not typically regarded as "women's diseases" such as diabetes and cancer (Westergaard et al., 2019). During a diagnostic delay – when the period becomes prolonged between experiencing a health challenge until the point at which a diagnosis is made – women continue to suffer from symptoms, lose confidence in healthcare providers and systems, and experience interruptions to their lives, relationships, and sense of self. While it appears evident that the timing and type of diagnoses are not distributed evenly across genders, what remains unclear is why – what is contributing to the reproduction of diagnostic delays for women?

While limited in number, there has been some promising work that has sought to explain this phenomenon. Several investigations have identified reasons for delayed diagnoses among women with endometriosis or cardiovascular disease. These include ineffective diagnostic testing (Ballard, et al., 2006; Almond et al., 2012), deprioritization in hospitals and emergency departments (Almond et al., 2012), pharmacological suppression of symptoms (Ballard, et al., 2006; Davenport, et al., 2022), a lack of physician knowledge or training about disease presentation (Denny & Mann, 2008; Almond et al., 2012; Davenport, et al., 2022), physicians' doubts about the value of a diagnosis (Davenport, et al.,

2022), physicians' dismissive attitudes and the normalization of symptoms by both patients and physicians (Ballard, et al., 2006; Denny & Mann, 2008; Almond et al., 2012; Davenport, et al., 2022; Drinkell et al., 2023), poor or imbalanced relationships between patients and providers (Denny & Mann, 2008; Drinkell et al., 2023); a patient's demographic characteristics (Drinkell et al., 2023), and a lack of patient knowledge, use of self-advocacy, or self-prioritization (Sjöström-Strand & Fridlund, 2008; Almond et al., 2012; Drinkell et al., 2023).

While the identification of these reasons for diagnostic delays are an important step, the majority of investigations fall short of explicating the context in which these factors are located, such as the socio-political structures and power relations that shape and constitute the very circumstances themselves. A notable exception is discussions of stigma surrounding women's health (Drinkell, et al., 2023) and more specifically, stigma surrounding menstruation, in the case of endometriosis (Ballard, et al., 2006; Seear, 2009; Davenport, et al., 2022). However, the only investigation, to our knowledge, which takes its central focus toward such structures is Seear's (2009) explication of how stigma plays a role in delaying help-seeking behaviour among women. Seear articulates the social sanctioning acts of stigma, such as ostracism, criticism, or the trivialization of pain, as evidence of how menstruating women are regarded as 'discreditable individuals' (Goffman, 1963). As a result of this stigma, they are deeply motivated to strategically conceal any discussion of, or materials related to menstruation. This concealment, labeled 'menstrual etiquette' (Laws, 1990), effectively inhibits any willingness to disclose menstrual normalcy, let alone menstrual problems, and offers a sociological explanation as to why women may hesitate to enact help-seeking behaviours regarding menstrual dysfunction. Seear concludes that further critical examination of diagnostic delays for women with endometriosis is needed, such as an exploration of why women's menstrual pain is normalized or who might benefit from such acts, in order to sharpen our understanding of this phenomenon (Seear, 2009).

Another significant gap in research on diagnostic delay is the experiences that women have with this phenomenon (Ashton, 1999; Ballard, et al., 2006; Denny & Mann, 2008; Almond, et al., 2012; Colella et al., 2021). When one considers the extensive research on the experiences of illness among women (see for example Werner & Malterud, 2003; Banks & Malone, 2005; Cho, 2019; Lajoie & Douglas; 2020; Heggen & Berg, 2021; Clerkley, 2022; Hintz, 2022), this gap is all the more apparent, particularly regarding the role of women's embodied knowledge in the process of diagnosis. The contribution of embodied experience to meaning-making processes is well established (Magrí & McOueen, 2022), and yet the salience of their embodied experience in the context of the diagnostic process has yet to be explored in relation to their help seeking behaviour. Based on Havi Carel's (2016) work in the phenomenology of illness, which characterizes illness in one's lifecourse as an interruption or divergence, it may be of significance to consider how women's lifeworlds are stretched and altered during periods of diagnostic delay, and how women make meaning of an absence of diagnosis that would have provided an explanatory framework and sense of motion towards a trajectory of care. Such alterity represents another important direction for research on the gendered nature of diagnostic delay.

The impetus for this commentary arises from a deep concern about the lack of specific and critical discourse on the ways in which gender has shaped the phenomenon of delayed diagnosis for women. Studies which have done so are few and have compartmentalized and decontextualized their findings. As a result, how social structures are intertwined with embodied experiences of diagnostic delay, and the ways the relationship between them serves to enable and/or constrain this phenomenon is poorly theorized and understood. Further still, there has yet to be an investigation which takes an intersectional consideration of gender as an interlocking and co-constituting social force that interacts with a range of other social characteristics; this is vital to appreciate the multiplicity of ways in which gender shapes diagnostic delays for a multiplicity of women. The social forces of gender are ever-present, from our social norms and expectations to our relational and embodied ways of being. As such, engaging a theoretical framework that holds the capacity to examine the interrelationship between these micro and macro dimensions, is imperative. In light of such a task, critical phenomenology holds much methodological potential.

From its inception, phenomenology has understood that a rendering of the world into facts of objectivity imparts an impoverished sense of meaning (Husserl, 1970). Through the refinement of many scholars, the tenents of phenomenology articulated the importance of subjectivity in the development of a fulsome understanding of the world, such as that of Alfred Schutz who broadened phenomenology's reach into the social sciences. Following the work of Simone De Beauvoir and Frantz Fanon who interrogated how uneven distributions of power shaped one's lived experience and opportunities, critical phenomenology has articulated how such a withholding of lived experience from our descriptions of the world acts to further marginalize those already at its margins (Stanier, Miglio & Dolezal, 2022). While Husserlian phenomenology has been typically concerned with the investigation of lived experience, an explicit inquiry into how social, political, and other structural influences shape this experience brings a critical lens

and a praxis of social justice to the tradition (Guenther, 2020; Magrí & McOueen, 2022). By engaging with a wide range of critical disciplines, such as philosophies of race and coloniality, disability studies, social and feminist philosophies, and the medical humanities, critical phenomenology has drawn its focus toward the relations between self, social experience, and social norms, and pays close attention to how categories of social identity, such as gender, are involved in self- and other-experience (Magrí & McOueen, 2022). Both classical and critical phenomenologies fundamentally understand lived experience as embodied; that the body has both material and perspectival qualities (Merleau-Ponty, 1945 [2013]). As a result, the body is understood both as an object that can be understood by medicine, but also as what it means to be human and contend with, or navigate through, human experiences such as health, illness, or death (Welsh, 2022). A method of understanding how the body is lived by women is paramount to understanding the gendered nature of diagnostic delays.

Critical phenomenology aims to expose forms of injustice that are hidden in the familiarity of our routine ways of being and thinking, by demonstrating how social norms such as white supremacy, patriarchy, or heteronormativity not only inform our social worlds, but also inform who we are and how we make sense of our experience (Guenther, 2020). It offers a carefully contextualized approach that stresses the active and the acted upon nature of the body, both of which are of paramount importance for feminist struggle and social change. As such it is our contention that critical phenomenology is well-positioned to capture the complexity of the gendered nature of diagnostic delay for women, support continued discussion and advocacy, and help effect change to this enduring and wicked problem.

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APORIA
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-Recognition of local knowledge(s)
-Critique of dominant discourses.

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