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Discourses of Counselling and Human Concern

*[E]ssential to an experience is that it cannot be exhausted in what
can be said of it or grasped as its meaning.*

(Gadamer 1988: 67)

To suggest that counselling is best understood as discursive activity is not to diminish what can be at stake, for client and counsellor, in its conversational work. An ongoing challenge in counselling relates to how to regard the language used by clients and counsellors and what that use configures in terms of understandings, actions, and relationships. The heart of the challenge rests with recognizing that our concerns and actions do not name themselves; we do, in humanly constructed and variable languages, or discourses. The languages or discourses for concerns brought to counselling today convey origins and understandings that can challenge any shared sense of meaning. While counselling's words and language may vary, so too do our value-based meanings and the actions that follow from them. That is where notions of discourse come in. This chapter will focus on why discourse matters to counsellors, and why efforts to constrain its diversity, such as by medicalizing meanings and actions related to them, can be problematic.

Discourse, in one way I will use the term, refers to distinct systems or logics of meaning and informed action, like the discourse I have been calling medicalization. Such discourses operate like reality tunnels, as discrete ways of understanding, evaluating, and conducting life. At worst, that means one person's or group's reality is meaningfully walled off from the realities of others, because the linguistically based understandings of such realities are so different. One can stand back from patterns in such ways of understanding, communicating, and acting, and find a coherence that can be named, such as one might by identifying a discourse as patriarchy or globalization (Fairclough 1992). Inside such discourses, such meanings and logics often seem self-evident to those used to living by them. From outside, discourse patterns can be identified for how distinctly used words and logic cohere in recognizable systems of meaning. Along these lines, Wittgenstein (1953) wrote about how knowing a language (or discourse) can be like knowing a form of life. Counselling's pluralistic approaches to practice exemplify what I mean by discourses (Cooper and McLeod 2011; Paré 2013). Generally speaking, differences between discourses of counselling, or the counsellors taking these discourse up, have not been an issue.

There is another aspect of discourse central to our considerations. Discourse also refers to how communicative interaction occurs, how life gets navigated and negotiated between people, such as counsellors and clients. Discursively *navigating* life suggests uses of language to understand and address accepted realities, while discursively *negotiating* such realities can mean transforming such realities. Navigating and negotiating will be terms that help to identify the discursive tensions associated with this book's discursive view, terms we will revisit when considering how language gets *used* in counselling's conversational work.

Discourse can be confusing for having the two meanings described. On one hand it is noun-like, referring to distinct systems of meaning; while on the other, it is verb-like, referring to communicative interactions. For our purposes, I will usually refer to discourses in noun-like ways, such as when I describe medicalizing, neuroscience, or other discourses of counselling. However, the discursive or conversational work of counselling between clients and counsellors is where the tensions I will describe as medicalizing tensions will be central. The situated uses

of discourse (medicalizing discourse and others) influence (cf. Mills 1940) and inform how people navigate and negotiate what occurs in the conversational or discursive work between them.

Referring to counselling's discursive work as involving navigations and negotiations of meaning can seem odd. By a critical view of discourse, negotiations, like those between a client and counsellor, are tilted to favor professional and institutional sources of power (Peräkylä et al. 2008; Rose 1990). This is especially the case with expert discourses (Abbott 1988), like medicalizing discourse, where roles like "patient" or health-care "provider" find clear definitions. Not all counselling approaches adopt this expert-based view of dialogue between counsellors and clients, and among narrative, solution-focused, collaborative, and feminist counsellors' client-centeredness is often focal (Proctor 2002). This privileging of client meanings has also sometimes been translated to a practical focus on client preferences and untapped client expertise (Anderson and Goolishian 1992), though the extent to which counsellors can share power in their dialogues has been a source of debate among discursive counsellors (Monk and Gehart 2003). Negotiating conversational meanings and processes with clients—meanings and processes they invest themselves in—is no small challenge for counsellors ready to acknowledge how discourses influence such meanings and processes (cf. Strong 2002). Tensions arise in how discourses, such as medicalizing discourse, influence clients' and counsellors' choice of words and conversational turn-taking.

Science and Discourses in Counselling?

A common view of professional discourse is that any profession's current language and meanings reflects the outcomes of a Darwinian struggle settled by science. Science, accordingly, should resolve tensions since these would-be anomalies seem to need a better evidence-informed explanation (Kuhn 1962). Prior or alternative meanings and language, by this logic, should most appropriately be consigned to any profession's linguistic and conceptual scrap heap. Therefore, students of counselling's history can derisively read about magic, "quaint" spiritual

practices, or quack cures (Ehrenwald 1991) as part of the profession's embarrassing past. Critics, like Foucault (1968), Danziger (1997), or Cushman (1995), highlighted how varied historical understandings have been when making sense of and addressing human concerns. The notion that help for human concerns required professional expertise beyond a friend's or elder's wisdom and compassion is recent, if one looks beyond spiritual helping practices, such as confession. So, how is it that so many distinctive discourses developed within counselling? More to this chapter's point, how did a medicalizing discourse become so influential on counselling today?

Apart from sociologists, few scholars and professionals discuss science-informed professional counselling in discursive terms. The Tower of Babel is sometimes invoked when reflecting upon the different understandings and professional communications informing counselling discourses and approaches (e.g. Miller et al. 1997). A single, scientifically informed discourse of practice would seem an obvious answer to an unruly pluralism or dubious professional eclecticism. Still, counselling today continues to be learned using multiple discourses (cf. Heaton 2014), while efforts to standardize counselling under one professional discourse, medicalized or other, seem to generate profession-centered "tensions" (House 2004). Some of these tensions relate to how any discourse is partial in what it accounts for; something relevant seems inevitably left out of any discourse of counselling (Cecchin et al. 1992). So counsellors add new understandings; extending traditional discourses (or developing new ones) to account for concerns like cyber-pornography addiction, or to address neuro-motor cognitive skill deficits unthought of a decade ago (Pitts-Taylor 2016).

Back in the early 1980s when I took career steps beyond being a junior high school teacher to become a graduate-trained counsellor, I was captivated but torn by "the correct way" to understand and address clients' concerns. Early on, I recall reading psychoanalyst Theodor Reik's *Listening with the Third Ear* (1948), where each client utterance was linked to Freudian explanations that stretched any sense of plausibility (even Freud once said sometimes a cigar is just a cigar). I also read of the conversational wizardry of therapeutic greats like Milton Erickson and Virginia Satir, rendered by neurolinguistic

programmers (Bandler and Grinder 1975) into scripted protocols to help clients make profound changes. I sought a science-backed way of talking with clients that I could use correctly and effectively. My graduate education then was also my first encounter with the kind of algorithmic thinking that often informs a medicalizing—diagnose and treat—discourse. This thinking was seductively certain, clients’ concerns could be correctly understood and diagnosed, and properly treated with science-backed interventions.

Algorithms reduce complexities to actionable formulae (Steiner 2012) and require standardized understandings and practices (Bowker and Star 2000; Busch 2011) based on particular logics. Medicalization offers such a logic (Mol 2008) that has been translated into algorithms adaptable to counselling (Magnavita 2016) as well as self-care resources (Davies 2015). Protocols for obtaining salient information about client concerns, making sense of such information, and selecting interventions that should follow are consistent with the logic of a medicalized, algorithmic discourse (Magnavita 2016). In an era of EBP in counselling (Chwalisz 2003), such algorithms crystalize and operationalize protocols for a medicalizing discourse of practice, and extend the kind of seductive thinking I flirted with in grad school. Human concerns have correct diagnoses, and proper treatments to address them, goes the accompanying logic. The counselling approaches I later took up were modest and offered what one author referred to as “new languages of change” (Friedman 1993). They also addressed understanding and the constructive/deconstructive work of counselling as *discursive*.

Discourse/Discourses?

How do meaning and conversation—discourse—relate to what is understood, done, and accomplished in counselling? Answers to this question cue up strikingly different counselling approaches. Philosophers of language have also grappled with variations of this question. Charles Taylor (2016) recently cited two approaches to language use that have perplexed and polarized philosophers, and society in general. By one approach, language use *designates* meaning. Meaning of this kind is seen

to have already been accepted and our uses of words are thus intended to reproduce established meaning. While our words cannot “mirror nature,” to paraphrase Rorty (1979), designative meaning involves communicating through accepted and normal understandings that are often standardized as information, to be communicated and received as such. Language use that *constitutes* meaning has a different purpose, to make new human distinctions or “bething things” as Heidegger (1971: 151) once wrote. For reflecting team originator, Tom Andersen (1996), such uses of language are hardly innocent. While a designative approach sees language use as information exchanges for navigating experience, a constitutive approach sees language used pragmatically to negotiate experiential possibilities. For Taylor, the designative approach is monological (information transmissions/receptions) whereas the latter is dialogical (focused on negotiating preferred and effective, and sometimes new, understandings). Counselling straddles both approaches, navigating life by using established meanings while negotiating new meanings at other times.

Differences over Taylor’s two forms of language use play a significant role in tensions arising from a medicalized discourse of counselling. The DSM-5 and the protocols of EBP are based on a designative, informational view of language use, such that human concerns have correct names (diagnoses) which standardized interventions can address. Professional conversation is the designative means to exchange needed information for diagnosing and treating medical disorders—premised on an “information transmission-reception” metaphor of communication (Lakoff and Johnson 1980). Turnbull (2003) similarly refers to a “code model” of communication involving information exchanges enabled by a presumptively shared logic that encodes/decodes messages sent and received. Precision in using established or standardized meanings when conversing is therefore paramount by this view.

Contrast this view of meaning and communication with a constitutive view of counselling, as dialogue without standardized or foundational meanings (Loewenthal 2011). By the constitutive view, what gets communicated is not easily translatable to pre-established meanings and protocols. People have conversational or discursive work to do, because language is used, or negotiated, for *purposes* that may not

already be designated or preferred. Such negotiations have an element of linguistic improvisation between speakers by this constitutive view, as speakers “do things with words” (Austin 1962). They neither start from scratch, having to invent language; nor are their dialogues determined by established meanings. In Heidegger’s (1971) sense, designative language is already there, its constructive use makes it constitutive. Meaning-making in this sense involves situated uses of language to satisfy speakers.

Considerable ambivalence can follow either designative or constitutive approaches to discourse. On the upside, designative language use enables people to communicate in presumed and established ways—we can learn to reason, understand, and communicate as others do, or are supposed to do. Relatedly, constitutive use enables new ways of articulating and imagining experiences—one person’s depression may be otherwise understood as oppression, for example, for some counsellors (Wade 1997). On the downside, language can lose its ability to designate effectively over time; our terms can seem relics of previous cultural or institutional eras. A good example is derogatory terms used to describe learning disorders a century ago (moron, idiot). Returning to new constitutive uses of language, however, if these are not used in recognizable ways, they can seem eccentric at best; psychotic at worst. From a discursive perspective, what matters is what any use of language affords or constrains as possibilities (cf. Gibson 1979).

It can be the precision and standardization expected of people’s language use that can be a source of tension associated with a medicalized discourse of counselling. Medical discourse exemplifies a designative and authoritative quest for certainty since so much can ride on its precise terms and professionals’ uses of those terms. Spectacular advances in medical science (Dolnick 2012; Downing 2011) extended lives and improved many people’s quality of life. Such scientific advances underscore the capacity of medical science to effectively identify diagnosable concerns and treat them. A rigorously practiced and scrutinized science can be used to adapt new technologies, test new theories, and evaluate interventions, and avoid the kind of quackery Ben Goldacre (2010, 2013) calls “bad science.” Two human practices required for good science are representing and intervening; the former to identify, theorize, and

classify phenomena while the latter involves manipulating and testing relations between phenomena (Hacking 1983). Thus, medical discourse has constitutive as well as designative uses, such as when new theories or diagnoses are developed (i.e. constituted). The poststructuralist (Spector and Kitsuse 1977) challenge to medicalizing discourse relates to the constitutive or designative values inherent in standardizing diagnoses, and to understandings left out of a potentially totalizing description.

Health itself has become an expansionary (constitutive) term and discourse, such that to the World Health Organization (WHO), health now means being more than being symptom-free (Smith et al. 2006). Being healthy has become a cultural project of targeting new aspects of life as diagnosable and treatable disorders (Conrad 2007). Human concerns or aspirations can be translated into diagnosable disorders, such as when Post-Traumatic Stress Disorder (PTSD) was added to the DSM-IV (Morris 2015); or former “disorders” like homosexuality were removed from the DSM-III. PTSD is a good example of medicalizing discourse having benefits; while the changes in DSM-III speak to changing cultural norms. Medicalizing discourse articulates and animates a particular logic and has enabled new ways of representing and intervening to address formerly non-medical concerns (Clarke et al. 2010) such as obesity or inhibited sexual desire. Medicalizing discourse focused on psychiatric concerns has amplified the number of diagnoses and treatments recently (Conrad 2007; Rapley et al. 2011).

Central to Peter Conrad’s (2007) scholarship were “hyperactive” kids and adults who are now diagnosable and treatable for ADHD. ADHD exemplifies what a medical discourse’s terms can afford and constrain. What is afforded by an ADHD diagnosis varies, but can include access to special education resources, pharmaceutical management of behaviors that might otherwise compromise the diagnosed person’s capabilities and ways of relating, and understandings (self-understandings included) that recast the diagnosed person’s behavior in non-moral (i.e. bad) terms. The constraints (e.g. being medicated) may not outweigh the benefits afforded by the diagnosis. ADHD also suggests a further understanding of medicalization that relates to minimizing or “governing” *chronic* conditions that cannot be cured, but instead can be managed with symptom-relieving medications.

The “ing” of medicalizing discourse relates to the processes associated with medicalization; in this book’s case, as it pertains to counselling. Regardless of how well a medicalized discourse designatively accounts for a concern as diagnosable and treatable, there is inevitably something inadequate with its account. And so medicalizing discourse expands and modifies, constituting new meanings and practices needed to legitimize and extend what the discourse could explain. However, discourses, as we have discussed, can only partially account for any experience or phenomenon. ADHD is an example, and narrative therapists (Duvall and Beres 2011; Nylund 2000) seek conversations about what is unaccounted for in medicalizing discourse. Discourses develop or expand to address these unaccounted-for aspects, and for medicalizing discourse that means new diagnostic nuances, dissatisfactions with prior terms and discourses, and the development of new theories and research innovations. Medicalizing discourse has developed according to its own evolving terms, expectations, and logic. Counselling discourses develop to account for what medicalizing and other discourses leave out.

Medicalizing discourse also has come to legitimize what other discourses for understanding and addressing human concerns do not, given that it is developed through rigorously obtained scientific agreement on diagnosed conditions and the treatment or management of those conditions. This, for example, has been the view of advocates for evidence-based counselling (Chwalisz 2003). However, not all concerns brought to counsellors seem equally understandable or addressable in medicalizing discourse, or have even found consensus among health professionals (Frances 2013). The medicalizing discourse of DSM-5 and evidence-based treatments has stirred considerable professional controversy (Greenberg 2013), for what this medicalizing discourse’s meanings and practice may unnecessarily totalize. For counsellors, expected use of medicalizing discourse can constrain other preferred discourses of practice when these discourses are perceived to lack scientific legitimacy (Strong et al. 2012).

Counselling and psychotherapy have seen their share of bizarre and dangerous approaches and interventions, and science has played a role in evaluating and sometimes discrediting them (e.g. Levant 2005). While antipathy between practitioners and researchers is frequent, discourse

differences between social scientists persist over a “politics of evidence” (Denzin and Giardina 2008; Lerner 2004; Walsh and Gillett 2011). Such differences often relate to approach-related or research methods-related disagreements on what counts as evidence in how human concerns are to be categorized. The disagreements extend to how research methods are used to obtain and discern evidence of change. Particular tensions arise for counsellors who are meaning-focused in their discourses of practice (e.g. Barnett and Madison 2012; Lock and Strong 2012), since client concerns are understood and addressed in fluid ways inconsistent with other discourses of practice, like Cognitive Behavioral Therapy (CBT), that use more standardized, medicalized discourse. The upshot of such discourse differences is that science has not resolved them with “gold standard” evaluations (Timmermans and Berg 2003), nor has professional consensus in counselling (Cooper and McLeod 2011; Duncan et al. 2010) aligned behind a medicalizing direction.

I walk a fine line here, I know. For readers who have already grappled with how science, language, technologies, events, and human interactions of any kind become interrelated (e.g. Barad 2007; Latour 2013) the kinds of issues I have been raising will not be newsworthy or controversial. Badiou (2007), for example, regards the “mathematizability” of discourse as important; with sadness being potentially mathematized through measures based on biochemical or psychological discourse. Two scientific and quantifiable discourses for the same event or experience—which one gets things right? Different discourses are common within scientific and professional communities (cf. Potter 1996), and tensions may come with standardizing terms, measures, or conversational practices associated with their use (e.g. Antaki 2004).

Standards, for Lawrence Busch (2011), are “recipes for reality,” and when used in prescriptive or regulatory ways, counsellors sometimes push back (Postle 2007). Standards established through research also enable the development of different administrative resources, such as software and apps (Chun 2011), based on algorithms that reliably produce actionable judgments. Translated to counselling, such standards influence professional record-keeping, service rationing, and expected choice of interventions. This standardizing direction, though not transforming all counselling contexts, is a source of medicalizing tensions in counselling.

Medicalizing Discourse and Counselling

Standardizing counselling concerns under a common medicalizing discourse of practice may seem commonsensical for coordinated mental *health* services. However, counsellors have often approached clients' concerns through diverse approaches, developing and drawing from strikingly different counselling discourses to understand and address client concerns (e.g. Corsini and Wedding 2010). Social justice, existential, or relational discourses of practice suggest diverse ways for counsellors to engage clients. The assessment focus, the ways of assessing helpfulness, and even the role of the counsellor shifts dramatically depending on which discourse is drawn on for counselling (Paré 2013). While I doubt any counsellor would suggest that psychiatric symptoms are irrelevant to their preferred discourses of counselling, few would claim symptom diagnosis and treatment as the primary focus of their work either. Medicalizing discourse in counselling is based on diagnosing and treating psychiatric symptoms.

Where medicalizing tensions most frequently arise for counsellors is with justifying (Boltanski and Thévenot 2006) the work they do in the terms of medicalizing discourse, such as in administrative record-keeping, or in choosing approaches and interventions. In my research, some counsellors indicated that they infrequently experience such tensions since their payment or record-keeping procedures were not tied to use of diagnoses or related EBPs (e.g. Strong et al. 2012). Justifying, or accounting for one's practice solely on medical terms, tends not to be formally required of counsellors either. Some of the justifying arguably occurs in the court of public opinion, since people increasingly self-diagnose and self-identify using expert mental health understandings accessible to them through public media (Furedi 2004; Illouz 2008). Clients increasingly expect "treatment" based on a previously diagnosed concern, while needs to justify counselling on medicalizing terms seems to grow (Greenberg 2013).

Scientific (evidence-based) justification of clinical psychology practices hit full stride in the 1990s (Chambless and Hollon 1998), and drew from the methodologies of the Cochrane Collaboration on Evidence-Based Medicine (<http://uk.cochrane.org/>). The aim was to

subject psychological interventions to the same level of evaluation expected of new pharmaceutical interventions. Some might ask where the professional dividing lines between clinical psychology, counselling psychology, and counselling are (or should be) drawn. Is counselling a junior sibling within the larger psychological family (Young and Lalande 2011), or is it even a psychological profession some might wonder. Such questions highlight how potentially conflated the conversational practices of counselling have become with evidence-based mental health and expected psychological interventions (cf. Busch 2012). Arguably, counselling remains a practice used by psychologists as well as other mental health and medical professionals. Part of the perceived conflation of roles like counsellor and mental health professional may come with how these terms are frequently used synonymously. Wikipedia uses the umbrella classification of *mental health professional* (Wikipedia, n.d.) to describe health-care or community professionals who improve mental health and treat mental illness. To the lay public, such distinctions may seem moot, counselling is less a professional title and more a service, albeit one usually offered at a mental health center. To counsellors, however, public or administrative fuzziness over how psychology and psychiatry relate to how they practice can be a source of medicalizing tensions.

Counselling as Researchable Psychological and Psychiatric (Mental Health) Discourse

Some of this fuzziness over roles and terminology is traceable to assumptions carried over from psychological and psychiatric research. First, the assumption that the concerns of counselling are reducible to diagnosable and treatable disorders *in* clients is problematic for many counsellors. Additionally, regarding interventions as “treatments” to produce symptom-reducing effects, as is common for pharmaceutical interventions, further reinforces this premise (Gabbay and le May 2011; Stiles and Shapiro 1989). The challenge for counsellors comes with how clients present their concerns. Are parent–child conflicts inherently about diagnosable and treatable disorders *in* the child, a family

counsellor might ask? Is “trauma” or discouragement following a layoff a mental disorder? Does a husband’s refusal to help out with childcare and household upkeep require one to diagnose the upset wife? To front-line counsellors, such discursive choices illustrate how clients’ concerns can become translated into a psychiatric discourse that obscures or departs from clients’ everyday understandings and circumstances.

A second, seldom questioned, assumption is that psychological knowledge and medical knowledge overlap, or even that psychological knowledge is foundational to counselling (De Vos 2012). As Boorse (1977) indicated years ago, health tends to be a normative concept and clinical psychology has embraced this view in ways that have concerned critical psychologists (e.g. Rose 1990). In other words, counselling based on psychological knowledge tends to focus on normal psychological functioning which, at first glance, seems appropriate. On second consideration, however, critical psychologists see potentials for counsellors to become instruments of dominant culture, perpetuating a normative status quo that may be unjust (Hoshamand 2001). A growing convergence of psychological and medical ways of research and practice as part of a broader, coordinated response to “mental health” spurred a current evidence-based movement in psychology promising professional legitimacy (Strong and Busch 2013).

In turning to the research on psychological interventions for particular diagnosed disorders, the most recurrent and significant identified influence on client improvement is the quality of the therapeutic relationship (Duncan et al. 2010). To those preferring conventional medical research and discourse, this is tantamount to saying that—across different medical interventions—a doctor’s bedside manner is more effective than the medications or surgical procedures used. This could be seen as an argument for counselling, and less an indictment of psychological interventions for being modestly effective. Still, in an era when, to get paid or work in an institutional setting, for a counsellor to claim she or he is not using evidence-based interventions to treat clients’ diagnosed disorders can seem unprofessional (Sexton 1999).

A final, theoretical assumption pertains to how intervention is conceptualized and researched as a component of the conversational work of counselling. Returning briefly to the communication metaphors

discussed earlier in this chapter, it is the norm to see conversation as the means to do much of the work of counselling, to exchange information and give directives (Turnbull 2003). Thus, the conversational activities of assessment are understood as information exchanges, from which counsellors use assessment information to formulate a diagnosis and develop components of a treatment plan (cf. Seligman 2004). Therefore, interventions are seen as communicated by standardized prescriptions or psychoeducation through information exchanges clients are expected to take up to address their concerns. Unless improperly administered in non-standardized communications, interventions can be researched for their psychoactive effects, as in the example of research into the “dose effects” of psychological interventions (Shadish et al. 2000). Conversation in counselling is sometimes gauged by how effectively standardized interventions are administered to treat diagnosed disorders.

By a modern Newtonian logic of science, human concerns should be understood as engineering problems that have yet to find a correct solution (Toulmin 1990). In the social sciences, such a logic animates a current evidence-based approach to evaluating and prescribing psychological interventions, earlier adopted as legitimizing knowledge and practice in medicine (Goldacre 2010, 2013). While probably helpful in establishing standards of safe practice (Busch 2011) for counselling, evaluating counselling practices, as one might test medical procedures in randomized controlled studies, is where this logic can come up short. Human concerns are differently understood and responded to in counselling, depending on the discourses or approaches turned to. A medicalizing discourse of diagnosed DSM-5 mental disorders coupled with EBPs makes sense in medical contexts, but for counselling generally?

Pluralistic Discourses of Counselling?

Counselling is where different discourses in conversational use can be seen to critically and generatively interact as counsellors and clients talk together. Discursively oriented counsellors (i.e. those who focus on critically aware and resourceful uses of discourse) see their communications as more than information exchanges; rather, as reflexively contributing

to relational processes they shape with clients through their meanings and ways of responding to each other (Gergen 2009; Shotter 2016). This focus on reflexive communications can make it difficult to distinguish what should count as an intervention, and suggests attention instead be turned away from specific strategies to possibly relevant nuances in the professional relationship. Thus, even questions have been depicted as reflexive *interventions* (Tomm 1988) for inviting new understandings and actionable possibilities. How clients and counsellors respond to each other shapes both process (conversation) and outcomes (meanings). For a discursively oriented counsellor, each person's opportunity for talking and listening offers reflexive possibilities to respond in ways consequential for the developing conversation with a client, while potentially identifying and amplifying client-preferred directions and meanings (Tomm 1988).

Two research approaches will inform how tensions arising from medicalizing discourse in counselling will be examined: situational analysis (SA) and institutional ethnography (IE). SA (Clarke 2005; Clarke et al. 2015) was developed in response to inadequacies Adele Clarke (2005) associated with classical grounded theory (Glaser and Strauss 1967). For Clarke, the inductive ("bottom up") qualitative approach of classical grounded theory produced tension-free accounts of complex situations, by seeking a unified thematic account that ignores the kinds of discursive differences we have been discussing. SA is a method for identifying and representing complexities and tensions in situations by distilling varied data sources into elements salient to situations, making it possible to map relationships between these elements. For example, funding for counselling might be one such element as might be a counsellor's approach to practice. In what ways might both elements be connected to and influenced by medicalizing discourse, the SA researcher might ask? Situations, like those where medicalizing tensions occur, are changing and contested, so part of the analysis focuses on where and how such contests are occurring. Conceptually, SA will inform how one might "zoom in and zoom out" (Nicolini 2013) of situations where medicalizing tensions are evident. Zooming out will occur when examining medicalizing tensions culturally and institutionally, by looking at the discourses in play. Zooming in will help to highlight instances

where tensions influence clients and counsellors engaged in the conversational work of counselling.

A second research lens focuses on lived experiences and practices related to how dominance and resistance influence institutional and professional activities like counselling. IE (Smith 2005) is a feminist research approach that will inform reflections on the conversational work of counselling. IE offers an analytic lens useful in distinguishing between mandated or expected forms of institutional practice and the everyday practices of professionals engaged in front-line service delivery. Euphemistically, I came to think of this distinction as referring to the official and unofficial stories of practice, something brought home to me in supervising the doctoral research of Emily Doyle (2015), who contrasted such stories by speaking with staff in an addictions treatment center. Juxtaposing what institutionally is supposed to happen with what is experienced or done, is another way readers can relate their own experiences to those described here as medicalizing tensions in counselling.

It will be this zooming in and out, to consider how medicalizing discourse may shape macro and micro interactions of counselling, that will inform the reading ahead. Discourse will refer to the discourses of or approaches used in counselling interactions *and* the specific conversational work occurring within those interactions. To critical discourse analysts, and to institutional ethnographers, these systems of meanings are ideologies shaping important human interactions (Eagleton 1991; Smith 2005). Some may bristle at the word, ideology, being used to discuss medicalizing discourse, since it is derived from medical science. Thus, we will examine how medicalizing discourse was applied to aspects of life not formerly considered medical (Conrad 2007; Frances 2013), or to aspects of counselling where its individualistic diagnose-and-treat logic compels (or interpellates) (Althusser 1971) counsellor consideration. Medicalizing discourse influences not only externally observable interactions with clients and institutions, but also the “mental” reasoning (Wertsch 1998) or “inner dialogue” (Rober 1999) influencing how counsellors may (or do) clinically reason as they listen and respond to clients.

A common way to consider medicalizing tensions would be through social psychology’s “cognitive dissonance” theory (Festinger 1957),

where the focus is on cognitive consistency or disruptions to it. The purported consistency expected with cognitive dissonance theory is associated with the notion that personalities, and their understandings and actions, should stay consistent. Discourse theorists approach such tensions dialogically (Billig 1996; Wetherell and Potter 1992), turning away from personality attributes and toward differences over discourse positions (Harré and van Langenhove 1999) from which people might respond to each other as the source of their tensions. People can understand and act from more than one discourse position (i.e. they change “their mind”), so we needn’t confuse personality with consistency of discourse use. Counsellors, for example, might listen or converse from more than a single discourse of practice to understand and respond to a client’s grief over a recent tragedy, while resourcefully navigating and negotiating varied other discourse positions encountered when interacting with clients, agencies, and other professionals. Being aware of discourses and discourse positions can enable new forms of critical reflection and resourceful language use. In narrative therapy (White and Epston 1990) a common phrase is that the person is not the problem, that dominating stories (or discourses) can be linguistically identified, so that client-preferred alternatives can be considered.

Discourse analysts tend to look at such tensions in ways associated with identifying dominance of a discourse and how it is reproduced (Fairclough 1989) and through close examinations of what gets sequentially produced in people’s conversational interactions (Peräkylä et al. 2008). Through such a discursive view social realities are produced in both macro-kinds (culturally or institutionally) and micro-kinds (dialogically or relationally) of interactions. It is in this sense that readers are invited to consider how medicalizing and other discourses vie for counsellors’ and their own understandings and informed actions regarding human concerns.

Medicalizing tensions arise because other discourses of counselling can run counter to the diagnose-and-treat logic (cf. Mol 2008) associated with medicalizing choices. Very different clinical realities follow from these counselling discourses, though some are more reconcilable than others. In a proverbial free market of counselling discourses this would not be an issue, clients and fee-payers (not always the same)

could choose freely. This is not, however, how the economics, administration, or institutional practice of counselling has developed. The tensions this book will address are those which arise out of expectations (institutional, public, collegial) that medicalizing discourse be central to the understandings and practices of counselling.

For Foucault (1972), discourses were hardly neutral ways of understanding and communicating, something evident when a discourse's dominance is contested. It is hard these days to practice as a counsellor without encountering the influence of medicalizing discourse, be that in clients' understandings of their concerns, expected uses of diagnoses when seeking professional reimbursement, or in justifying one's ways of practice as ethical. In Chap. 3 we turn our attention more specifically to how the human concerns brought to counsellors came to be increasingly legitimized through medicalizing discourse.

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