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# Psychocentrism and Homelessness: The Pathologization/Responsibilization Paradox

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ABSTRACT *Psychocentrism is a governing neoliberal rationality that pathologizes human problems and frames individuals as responsible for socially structured inequalities. The homeless community provides an important case study to examine the ways psychocentrism manifests among an excluded population. This paper explores the paradox whereby homeless individuals are simultaneously pathologized and responsibilized through psychocentric discourses in which their status as economically poor becomes individualized as a symptom of mental illness and/or addiction. Although medicalized understandings of mental and emotional distress pervade the homeless industry, the obligations of freedom in the neoliberal era mean that individuals alone are held responsible for their failures. The paper examines the ways individuals experiencing homelessness are compelled to embark on an entrepreneurial project of the self that requires them to accept blame for their social precariousness. Further, it deconstructs the narratives that regard social explanations as an excuse and a failure of individual accountability. I argue that the "shamed poor" adopt empowerment discourses touted by the homeless industry, which paradoxically encourage individuals to find strength in their personal failures and to work toward self-governance, devoid of historical, social, and cultural context.*

KEYWORDS homelessness; mental and emotional distress; mental illness; psychocentrism; neoliberalism; shamed poor; empowerment discourses

## Introduction

A paradox exists in how mental distress is framed in the homeless population.[1] Distress is often pathologized by "psy" experts, service providers, and in turn by homeless people themselves. The illness narrative suggests little hope of a "cure" and so individuals are advised to manage their

[1] I use the term "distress" to recognize the difficult physical and emotional situations people find themselves in while de-privileging medicalized discourses (Tew, 2005).
[2] The observation that distress is pathologized and managed through techniques of social control

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symptoms,[2] usually with psychotropic medication.[3] Enigmatically, individuals are also encouraged to take responsibility for their circumstances through various types of self-help programming, such as Alcoholics Anonymous/Narcotics Anonymous (AA/NA), anger management, and group-based cognitive behavioural therapy and treatment programs (Rimke, 2000). This paper relies upon Heidi Rimke's (2003, 2010, 2016) critical concept of psychocentrism to analyze the extent to which pathologization and responsibilization occur in the homeless community. Psychocentrism refers to "the outlook that all human problems are innate pathologies of the individual mind and/or body, with the individual held responsible for health and illness, success and failure" (Rimke & Brock, 2012, p. 183). Inspired by Foucault's (1977, 1988) work on normalization, psychocentrism describes how human emotion and ways of being are framed exclusively as artifacts of individuals' bodies and minds, and are thereby stripped of social, historical, political, economic, and cultural context. I concentrate on two of the 10 characteristics that make up psychocentrism, namely determinism and reductionism. Determinism refers to the physiological body (i.e., genetic code, neurochemistry, etc.) as the primary (and sometimes sole) vehicle for explaining individual action and behaviours. Reductionism refers to the ways that human experiences and problems are understood in the explanatory vacuum of the medical model (Rimke, 2010). These factors provide a unique contemporary theoretical lens through which to examine the dominant assumptions about the connection between distress and homelessness in Canada.

In this paper, I consider the complex relationship many homeless individuals have with their mentally ill identity in an environment that perpetuates the medical model while simultaneously holding individuals personally responsible for their varied experiences of social inequality. In particular, I focus on the ways homeless individuals frame their personal narrative as a series of poor choices and condemn those peers who position their marginality within social, structural, and historical frameworks as making excuses. Additionally, I argue that empowerment strategies propagated by service providers, psy experts, and self-help programs in the

[2] The observation that distress is pathologized and managed through techniques of social control emerged from the anti-psychiatry movement (Laing, 1960; Szasz, 1974) and the contemporary mad movement (Burstow, LeFrançois & Diamond, 2014; Burstow & Weitz, 1988; Shamrat, 1997).

[3] An abundance of research demonstrates the widespread use psychotropic medication in the prison system, particularly among women prisoners (Kilty, 2012; Maidment, 2006). Although there is scant literature on the number of homeless individuals with a prescription for antipsychotic medication, the overlap between the homeless and prison populations (Fischer, Shinn, Shrout & Tsemberis, 2008), the plethora of research on the subject of medication non-compliance among the homeless (Bradford, Gaynes, Kim, Kaufman & Weinberger, 2005; Muir-Cochrane, Fereday, Jureidini, Drummond & Darbyshire, 2006), and results from this research on the number of homeless individuals using psychotropic medication suggest a high proportion of psychotropic medication prescriptions in the homeless community.

homeless community encourage men and women experiencing homelessness to engage in self-governance and "fix" themselves independently from the structural barriers associated with homelessness.

This analysis stems from a broader research project investigating how homeless individuals are managed through their mental health status and how they negotiate these management strategies as a social group that is excluded and widely perceived as deviant. This study adds to the predominantly American scholarship on homelessness, individualization, shame, and "freedom" (Desjarlais, 1997; Feldman, 2004; Lyon-Callo, 2004; Wasserman & Clair, 2010) by using the concept of psychocentrism to uncover how social and cultural context is stripped away through medical logics of pathologization as well as the juxtaposition between medicalized discourses and personal responsibility. The analysis presented in this research is especially pertinent as policy-makers across Canada and internationally look to innovative models of service provision (including, but not limited to, Housing First) to reduce and ultimately end homelessness, which take varying positions on how mental health status and treatment are managed (see Goering et al., 2014; Shamrat, 2013).[4]

The paper begins with an overview of the scholarship on mental illness and homelessness and the need for more critical perspectives to properly assess the complexity of the homelessness crisis, followed by a description of the conceptual framework. Using psychocentrism as the theoretical foundation for the analysis, the paper also explores the obligations of freedom, the notion of the "shamed poor," and empowerment. Next, I provide a summary of the methodological approach. The remainder of the paper presents some of the findings of the research. I first explore how responsibilization discourses co-exist with deterministic understandings of illness to explain why homeless men and women blame themselves for their precarious circumstances. To do otherwise would amount to "making excuses." Second, I demonstrate that empowerment strategies employed predominantly in mental health and treatment programs buttress the psychocentric lens by positioning an individual's self-esteem and rational choice making skills as the key to escaping homelessness with little recognition of how social and structural inequalities negatively impact these efforts.

[4] The Housing First model is built on the premise that individuals should receive immediate access to housing of their choice with supports without having to meet housing readiness requirements (such as sobriety or medication compliance). Housing First recognizes that in order for people to work through trauma, mental illness, and/or substance abuse, it is imperative that they feel safe and secure in a stable home (Goering et al., 2014).

**Problematizing the Homeless as a Mentally Ill Type**

In academic writing, the relationship between mental illness and homelessness is often presented as innate. Even before the contemporary homelessness crisis swept North America in the 1980s, research on urban ecology and "skid row" attributed deviancy and degeneracy in part to mental illness, weak character, and addiction (Bahr, 1967; Olin, 1966; Rimke & Hunt, 2002). Today, approximately 35,000 Canadians are homeless on any given night and between 150,000 and 300,000 individuals experience homelessness annually (Gaetz, Donaldson, Richeter & Gulliver, 2013). The individualization of homelessness continues to pervade contemporary research, in particular through the essentialist discursive assemblage of deviancy, mental illness, and addiction (Greenberg & Rosenhack, 2008; McNaughton, 2008). Much of the social scientific research portrays marginalized people as essentially disordered and disorderly, dangerous, and innately different from the housed community (O'Grady, Gaetz & Buccieri, 2011).

The high rate of mental illness diagnoses is another sign of the pathologization of homelessness (Christensen, 2009). Estimates suggest that one third of homeless individuals suffer from mental illness (based on the medical model framework of distress), although rates range from 10% to almost 70% (Allen, 2000; CPHI, 2009). The majority of this research comes from the psy disciplines and is made up primarily of survey data on the epidemiology of mental illness and service evaluations (Barreira, Macias, Rodican & Gold, 2008; Insel, 2008). The psy disciplines' approach presents medicalized truths via psychocentric discourses. Some psy research acknowledges the impact structural factors such as class, race, gender, heteronormativity, colonialism, and disability have on homelessness and how distress may contribute to exclusion (Paradis & Stermac, 2001; CPHI, 2009), but this research still largely relies upon medicalized understandings of individual deficit (see Lyon-Callo, 2000).

People experiencing homelessness are characterized as abnormal because they have no choice but to perform common human behaviours in public spaces (e.g., drinking alcohol; engaging in sexual activity; urinating; sleeping). These activities are subject to targeted surveillance and over-policing (Sylvestre, 2010), which demonstrates the double standard between those who possess the privilege of privacy in their homes and those who do not. Rarely are the realities of living in public spaces fully considered when diagnosing a homeless individual with a mental illness (Mosher, 2002).

Bresson (2003) provides a critical perspective on mental illness diagnoses among the homeless, suggesting that they act as techniques of social control. Borrowing from Foucault's (1988) analysis of the rise of madness, Bresson (2003, 312; see also Desjarlais, 1997; Mathieu, 1993) argues that it is politically beneficial to correlate mental illness and homelessness because it responsibilizes individuals for being "fragile" and "vulnerable," thus shifting

responsibility away from governmental institutions and broader social structural problems and policies. Snow, Baker, Leon and Martin (1986) find that the very nature of homelessness and its adaptive responses (e.g., inappropriate dress and appearance, depression, agitation, unresponsiveness) are pathologized as individual rather than systemic failures. Reducing the state of homelessness to a mental pathology does a disservice to those who must navigate an unpredictable, insecure, and sometimes-dangerous social environment. Meanwhile, those diagnosed with mental illness are not exempt from the obligations of freedom; instead, through mental health resources homeless men and women are called upon to take responsibility for their own social exclusion. The next section examines the formulation and application of this presumed freedom among homeless people.

## Homelessness and the Obligations of Freedom

True to neoliberal ideology, the entrepreneurial subject (Rose, 1999; Rimke, 2000) uses technologies of the self to assess, work on, and shape subjectivity. Neoliberal subjects are expected to use appropriate psy tools and strategies to shape their best self, such as yoga retreats, self-help books, counselling, or taking medication. However, just because one is free to self-govern does not mean that one does so *well* (Cruikshank, 1999). Modes of self-improvement are intimately connected with consumer culture, and economic inequalities make it difficult for those living in poverty to participate. Neoliberal freedom means that modern individuals are not merely "free to choose" self-regulation but are *obliged to be free* (Rose, 1999; Rimke, 2000).

The obligations of freedom come from a perception that as normal, healthy, and active neoliberal citizens we must self-govern to limit reliance on the state (Cruikshank, 1999; Rimke, 2000). The convergence of the private and the public realms partially explains the general public's hostility towards those on social assistance, and the individualization and criminalization of poverty (Mosher, 2002). Those who do not live up to normalized expectations are held personally responsible for their social failures. Borrowing from critical poverty scholarship (Allen, 2000; Chunn & Gavigan, 2004; Katz, 2013), I argue that homeless men and women feel compelled to exhibit "shame" in order to demonstrate their sincerity and worthiness to receive assistance and to access scarce services, including mental health, treatment, and housing resources. Participating in these services demonstrates their commitment to becoming economically and socially self-sufficient (Elias, 1978). Shame is "...a painful emotion responding to a sense of failure to attain some ideal state… In shame, one feels inadequate, lacking some desired type of completeness or perfection" (Nussbaum, 2006, p. 184). Homeless individuals are expected to display gratitude and deference to staff in the homeless industry, express self-criticism rather than social criticism,

and accept accountability by blaming themselves for their experiences as homeless, distressed, addicted, and criminalized (Rimke, 2011). The "otherness" of exclusion (Rimke, 2003) and degradation experienced by homeless individuals reproduce the psychocentric view that negative social experiences are the result of individual inadequacies. Rarely is consideration given to the ways that homelessness may cause or magnify the difficult experiences of mental and emotional distress, difference, and exclusion.

Failure to live up to the neoliberal obligations of personal freedom is viewed as socially unacceptable. This is especially the case for those calls for self-responsibilization that occur in populations with few resources to live up to normative ideals (Cruikshank, 1999), and where the distinction between freedom and coercion in governing strategies becomes blurred. The notion of empowerment is vital to understanding psychocentrism because it captures the notion that happiness, success, health, and vitality are achieved through individualized subjectivities and practices derived from experts. Cruikshank observes that turning attention to self-discovery and self-management does not remove power dynamics from the tactics of governing:

> The will to empower may be well intentioned, but it is a strategy for constituting and regulating the political subjectivities of the 'empowered'. Whether inspired by the market or by the promise of self-government and autonomy, the object of empowerment is to act upon another's interests and desires in order to conduct their actions toward an appropriate end; thus 'empowerment' is itself a power relationship and one deserving of careful scrutiny (Cruikshank, 1999, pp. 68-69).

Cruikshank suggests that empowerment is part of a broader political rationality that persuades people to seek out socially acceptable goals and to look to themselves to realize these ambitions. Empowerment strategies use concepts like poor self-esteem to individualize social issues as problems that should be worked upon by reinvigorating the desire for normality (Cruikshank, 1999). Rimke (2000) discusses the empowerment practices used in self-help discourses that promise happier, more fulfilling lives while concomitantly encouraging individuals to never feel satisfied with their current state; in short, individuals must constantly search for ways to modify and improve themselves. Rimke (2000, p. 62) observes that the self-help model is built on the "principle of individuality" which, "… assume[s] the social world to be the sum aggregation of atomized, autonomous and self-governing individual persons" rather than members of broader groups and communities, thereby negating the historical, social, and economic bases of life and living.

## A Note on Methodology

I triangulated among three main methods in order to capture the nuance and contradictions in the practices and subjectivities represented in the homeless

community. I entered the field by volunteering in two emergency shelters and a soup kitchen in Ottawa, Canada for a year leading up to recruitment. In that time I gained insight into the environment and built rapport with individuals experiencing homelessness. I began conducting fieldwork in June 2011. The methodological design consisted of participant observation, interviews with individuals experiencing homelessness, and a focus group made up of key informants.

I held a variety of roles as volunteer, including but not limited to leading activity nights, serving food, providing assistance using the computer, and spending time in the lounge. Through my capacity as volunteer I conducted over 296 hours of participant observation. The shelters, both of which provide numerous health and social services, act as hubs in Ottawa's homeless community and draw many more people than strictly their shelter residents. In these settings I was able to gain knowledge of how people across the homelessness continuum negotiate their mental health status and experience. The themes that emerged from the data describe individuals' positions on identity and social control; they do not evaluate specific shelters or treatment programs. My participant observation took the form of unstructured observations, noting the physical characteristics, behaviours, body language, verbal behaviours, and actions of staff and homeless individuals I encountered (Wolfinger, 2002; Rimke, 2003). Conducting participant observation allowed me to witness how shelter staff and professionals engage with homeless people through mental health interventions. It also provided insider knowledge with regard to how the shelters function, the routines and rules imposed upon homeless men and women, and how social relationships are formed and maintained among homeless individuals, and between homeless people and staff.

I conducted 38 semi-structured interviews with 27 homeless men and 11 women, which corresponds roughly to the gender ratio among homeless people in Canada (Gaetz et al., 2013). Participants ranged in age from 29 to 63 with an average of 37 years of age, which is representative of the average age of homeless people in Canada. Seventy-three percent (28) of respondents were white, approximately 16% (6) identified as Indigenous, and 8% (3) identified as Black or bi-racial. Seventy-five percent (28) of respondents identified as heterosexual and 24% (9) identified as gay, lesbian, bisexual or asexual. Not all participants were living in a shelter at the time of the interview (eight lived in social or subsidized housing), but they had all experienced homelessness or precarious housing at some point, the average length of time being four years. All but six (32) respondents identified as suffering with distress in their lifetime and 73% (28) were currently prescribed psychotropic medication or had been in the past. Eighty-nine percent (34) identified as having an addiction and 84% (32) had experienced negative interaction with police or the criminal justice system more broadly.

My third source of primary information came from a focus group I held with professionals who work in the homelessness industry (frontline workers, case managers, chaplain, social worker, nurse) to gain information on how mental health/distress is produced and managed in shelters and in the community, the types of diagnoses and medication prescribed to homeless men and women, and a breakdown of available mental health services. In this way, the focus group supplemented and contextualized the narratives provided by homeless men and women; it was not designed to test the truth claims made in the interviews (Lofland, Snow, Anderson & Lofland, 2006).

Participant observation field notes, interviews, and the focus group were transcribed and coded using QDA Miner software. I conducted a critical discourse analysis to situate individual narratives within broader systematic and institutional social relations of power (Fairclough, 1985; van Dijk, 1993). This methodological design allowed me to analyze mental health experiences in the homeless community.

The next section explores homeless men's and women's narratives on their perceptions of mental illness, the discursive roadblocks to acknowledging the social and structural components to exclusion, and how mental health services seek to empower them by adopting a psychocentric framework as key to solving homelessness.

## "That gets me off too easy": Responsibilizing the Distressed Homeless

Many of the mental health and addiction services offered in the homeless community rely on a psychocentric perspective that targets individual deficit as the source of, and solution to, homelessness.[5] The call for marginalized people to be accountable for their homeless status is counterintuitive given that the same system promotes the pathologization of common problems facing people experiencing homelessness (e.g., sadness, aggression, trouble sleeping, lack of motivation). If mental illness, its symptoms, and potentially deviant behaviour are *destined* through bodily make-up, then blame is diverted and the pathologized character is guilt-free but hopeless (Bauman, 1988; Feldman, 2004). A poignant example was the sustained pressure in the 1990s and 2000s to find a "gay gene" that would supposedly reduce the stigmatization of homosexuality, but instead created the conditions to further pathologize sexuality (Hamer & Copeland, 1994).

Several focus group members equated distress with physical illness, as a way to reduce stigma and legitimize a medicalized approach to the issues facing those experiencing homelessness. A member of shelter management noted that no one feels embarrassed seeking medical care for a broken arm, and the same should be true when accessing mental health care. In contrast,

[5] The challenges of using the homelessness industry to tackle social inequality are expertly analyzed by Lyon-Callo (2000, 2004).

Schnittker (2008) found that biological explanations of distress do not necessarily reduce stigma, and in fact can have the opposite effect, where the public is more fearful of the potential dangerousness and unpredictability of those diagnosed with a mental illness (in particular schizophrenia). The fatalism of the medical model suggests that it is difficult or impossible to fully manage or treat the pathological individual (Rimke, 2011, 2016). Conversely, literature that problematizes the disease model of mental illness is often uncritical of the construction of a physical illness as a "true" illness (Sedgwick, 1982). Physical illnesses are not immune to blameworthiness despite obvious biological foundations. Individuals are often blamed for their physical ailments because they do not manage their risks, take preventative measures, or adhere to suggestions offered by health promotion discourses (Lupton, 1995; Rose, 2007). As per Goffman (1963, p. 5) a "tainted" or "spoiled" identity renders individuals as "not quite human" and subject to negative consequences on account of stigmatization. The responsibilization of patients occurs through medicalized moral judgments that individuals make bad choices and are thus at least somewhat deserving of their illness (Rimke & Hunt, 2002; Rimke, 2003). Therefore, if a biological explanation of illness does not *ipso facto* eliminate blame we can consider how responsibilization techniques exist in concert with the medical framework of distress, and how psychocentric discourses are disseminated by those in authority and internalized by homeless men and women.

With a few exceptions, most research participants claimed that distress was biologically derived, either through heredity or a neurochemical imbalance. Much of this perspective came from Gabor Maté (1999, 2008),[6] whose books are used as teaching tools to explain mental distress and addiction in some of the out-patient addiction treatment programs. A number of respondents suggested that their brain functioning was impaired in childhood and affects how the neuro-psychological circuits process self-regulation. Mustang, for example, espoused his view of the etiology of mental illness in this way:

> [It] is brought on, from my understanding, is brought on from the environment that's exposed to me from birth to… however long. So however I gone through stressors, trauma, whatnot, yeah, I believe something got interrupted, uh, while the brain was being formed or as it's aging or whatever.

Mustang, a 38 year-old Indigenous man, experienced severe abuse as a child and connects that trauma to his bi-polar diagnosis. For those who believe the cause of their mental illness is neurochemical rather than genetic, a space

[6] Briefly, Maté argues that a variety of biological and environmental factors influence mental illness and addiction, but at its core they are a manifestation of an abnormality in the brain caused by undeveloped or impeded dopamine receptors in the cerebral cortex, the part of the brain responsible for rational decision making and emotional control. Maté uses this logic to account for the symptoms of both attention deficit disorder (ADD) and addiction.

opens up to think about distress as at least somewhat socially produced, such as recognizing the impact of victimization in early childhood on future experiences of mental and emotional distress. This moves beyond the strictly naturalistic, essentialist, reductionist, and determinist qualities of psychocentrism that view humans as naturally rather than socially produced (Rimke, 2010). Nevertheless, the site of intervention remains contained within the pathological individual body/mind model.

The common refrain from participants was that, notwithstanding the biological nature of their condition(s) or the social context in which they lived, they must assume responsibility for the state of their lives should they wish to escape homelessness, manage their mental illness, and/or achieve sobriety. For example, Christine takes full ownership of her depression, obsessive compulsive disorder, and bipolar disorder diagnoses, as well as her addiction to crack cocaine. Christine had experienced homelessness for eight months prior to a month long jail sentence. When asked how living in a shelter affects her mental health, she responded: "Uh, no matter where I am, I can't blame the environment because that would be me being in denial." Other scholars (Lyon-Callo, 2000; Wasserman & Clair, 2010) similarly point to instances where homeless individuals feel compelled to reject structural explanations of homelessness. Unique to this analysis is the way mental health discourses are used to reinforce the psychocentric logic of victim-blaming discourses. Christine uses pop psy language like "being in denial" (a classic AA trope) to explain why she will not acknowledge the negative impact living in a homeless shelter has on her mental well-being. Christine spoke at length about how she abstained from illicit drug use for six years until she entered the shelter system (despite managing to stay clean in jail), as well as about experiences of violence in the shelter, and her feelings of infantilization and low self-esteem from having to ask staff permission for minor activities such as accessing the kitchen to make breakfast. Despite these problems stemming directly from her status as a homeless person, Christine engages in reductionism and determinism (Rimke, 2010) by judging herself and internalizing external distress factors as part of her responsibilization narrative. Christine is ashamed of her drug use, criminal record, and precarious living, admitting that she's embarrassed that she has been unable to quit using crack and escape homelessness. She adopts the shamed poor discourse by focusing on the perceived faults that she believes led her to homelessness, including her issues with co-dependency and lack of motivation, both psy problems (Rimke, 2000). When I asked Christine how she copes with the chaos of the homeless shelter, she replied: "I put myself here so I have to do it." For Christine, and many like her, the shame that comes with being homeless is articulated through neoliberal discourses of normalizing judgement and self-responsibilization.

Those participants who accepted responsibility for their distress claimed that to couch their precarious situation within a framework of social inequality would be to deflect blame from their personal choices and thus fail

to embrace the norms of self-governance. One such participant was Max, a 52 year old white man who was diagnosed with depression, struggles with cocaine and alcohol addictions, and was previously incarcerated. At the time of the interview he was living in subsidized housing, but then he lost his apartment and relocated to the shelter soon after. Max recognizes his past trauma as contributing to his mental illness and addiction, but feels he cannot let that mediate his level of accountability:

> I was raped by, uh, by men, you know. It wasn't in prison, this was when I was younger and uh, several times. And I've a really hard time blaming my life and my addiction on something that happened forty years ago, but everybody says, that's what people say, no it's, that's what you need help with, but to me that's too much of an excuse, that gets me off too easy... You know 'cause we all, you know, I don't think there's anybody without problems. Some, you know… I think it's a factor but I don't, I don't think I can let myself off that way.

Max, who has participated in dozens of mental health and addiction programs over the years, adopts Maté's understanding of the impact of trauma on brain development using the disease metaphor of mental illness and addiction; however, he feels his past victimization cannot excuse the daily decisions he makes to drink and use drugs. He attributes his sometimes crippling depression to his inability to be assertive, stay motivated, and be content with everyday life. Like other respondents, Max frames distress as biologically informed. By reducing their struggles to the individual mind, devoid of social context, homeless men and women's bodies remain the site for surveillance and intervention by psy authorities. Any previous or current victimization, although understood as acting as a causal feature in abnormal brain development, does not diminish the felt responsibility to make rational decisions according to socially accepted norms and to live with the consequences of those choices (Bauman, 1988; Rose, 1999). In order to simultaneously perform the roles of the shamed poor and responsibilized citizen, individuals must hold themselves accountable for their status as homeless. As Maruna (2001, p. 132) notes, those seeking redemption are expected to assume "complete and unmediated blame" for their marginalization. The effect of the psychocentric framework is tautological: the homeless person must accept the individualization of poverty and precariousness in order to be accepted into the programs offered in the homeless community, and these same services promote the reductionist perspective that the intersectional inequalities facing many in the homeless community can be managed through self-governance.

Research participants who took personal ownership for their homelessness accused those who referenced social, historical, and cultural factors to explain their marginalized status of "making excuses." Self-governance is a coveted trait in the neoliberal era and is emphasized by empowerment programming in the homeless community and other institutions of social control (Maruna,

2001). This normative value stands in opposition to a nuanced explanation of the multifaceted ways our lives take shape. As the participants claimed, making excuses does not allow you to perform the shamed poor role, one that calls for uncompromising responsibilization.

Seamus, a 42 year-old white man who was new to the shelter at the time of the interview, was frustrated by those who use mental illness as an excuse for their marginality:

> I think a lot more of it is done by choice or by decision. Sorry, not by choice by decision. They make a bad decision at one point and it maybe snowballs, and they make…then they end up making more bad decisions. And that, those decisions may very well be based on a mental illness… It's, 'cause I always thought, growing up, always, even though I was mid-20s, I'm like, these guys are just weak. They could have got help before if they needed [it], they're not that bad, they were just lazy and blah blah blah.

This discourse harkens back to the 19th century vagabond typology (Castel, 2003), which presented the homeless as manipulative and lazy. Upon further probing, Seamus remarked that despite recently becoming homeless himself, he maintains his opinion that homeless people are weak, and their position as homeless is at least in part deserved because of a failure to take action to solve their mental and emotional distress when it first appeared. Significantly, however, Seamus did not identify as having a mental illness or addiction, although he recognized his drinking as a factor in losing his wife, children, and home, and that he lost several bartending jobs because he drank too much while working. Seamus has trouble identifying himself as "lazy" and "weak," but acknowledges his increased social exclusion as coming from his poor decisions. Regardless, he is adamant that citing any mitigating socio-political and structural factors detracts from the autonomy of the individual to make decisions, which to him amounts to excuse-making for poor decisions and inappropriate behaviour. This rhetoric was echoed by many study participants who characterized other homeless individuals as failing to live up to the modern neoliberal project of the self that accepts personal responsibility and factors such as social inequalities as counterproductive to the goal of self-governance.

## "Breaking myself down to nothing": Empowerment Through Psychocentrism

As I have demonstrated, although many members of the homeless community take up the biomedical model of distress, they simultaneously responsibilize and pathologize themselves as homeless, mentally ill, and/or addicted. Further complicating this paradox is that many homeless men and women embrace mental health services, which are based on a determinist rationale, in an attempt to embrace entrepreneurial subjectivity. Many interview

participants received counselling, were prescribed psychotropic medication, and participated in group-based programming. Wasserman, Clair and Platt (2012) explain that individuals experiencing homelessness will accept their own repression because they internalize the rhetoric that they are a "problem" and adopt solutions that perpetuate the status quo, in this case the stereotype that homeless people must be mentally ill and/or addicted to have become homeless in the first place.

The politics of empowerment play out in distinctive ways when the target population is marginalized and oppressed. Empowerment strategies within Canadian women's prisons provide a useful example to think through how empowerment exists within disciplinary techniques meant to manage "risky" and "dangerous" populations (Castel, 1991). Critical criminologists (Dell, Fillmore, & Kilty, 2009; Hannah-Moffat, 2000) argue that Correctional Services Canada (CSC) appropriates the term empowerment from feminist vocabularies that use it to highlight structural inequality and patriarchy, and instead apply it to penal policy that blames deviancy on criminalized women's low self-esteem and irresponsibility. Empowerment strategies directed toward women in prison target the prisoner as a rational decision maker who can make virtuous choices if she wants to be a contributing member of society (Hannah-Moffat, 2000). Such psychocentric attitudes, programs, and practices do little to account for the structural impediments to living a "responsible lifestyle," such as poverty, sexism, racism, addiction, or single parenthood (Kendall, 2000). For example, if a woman is unable to secure employment after receiving workplace training, she is blamed rather than the strained labour market, the lack of affordable child care, or the repercussions of stigma due to a criminal record. Although women's correctional policy may call for women to reformulate their lives through their own free will (Hannah-Moffat, 2000; Pollack, 2009), the reality of achieving this kind of transformation when their social circumstances have not improved is little more than empty psychocentric rhetoric. Like women's prisons, mental health and treatment programs offered in the homeless community profess a sense of empowerment without the material conditions to facilitate change, thus fueling the notion that remaining homeless is a personal failure.

A number of participants stated that their homeless peers waste time trying to find excuses for their marginalization. Instead, they argue that time is better spent transforming and improving the self, hallmarks of the psychocentric approach (Rimke, 2000). For example, Milan, a 38 year-old white man who has experienced homelessness for nine years, lamented that the men he lives with at the shelter complain too much:

> Well instead of complaining all day long, make steps to improve your life, you know? All there is, is complain, complain, complain I hear. Just go and change

> your life, do something about it. If you want to be here, or if you don't want to be here, just don't complain about it.

For Milan, people who blame factors external to themselves are missing key opportunities to work on the project of the self-reformation. Change is found at the site of individual action, and homeless men and women must find ways to "do something about" their personal deficits rather than "complain" about structural inequality that seems insurmountable, especially for those struggling to meet their basic daily needs. Milan attempts to be a "prudent subject" (Hannah-Moffat, 2000, p. 31), by taking psychotropic medication for his bi-polar diagnosis and participating in out-patient addictions treatment in order to pursue his education. His sense of empowerment comes from focusing on what resources he can use to achieve personal success. He believes that striving for a socially acceptable form of self-improvement (Cruikshank, 1999), such as obtaining a university degree, will allow him to escape marginality. Acknowledging the structural barriers that come with his decade of homelessness would minimize, if not eradicate, this sense of freedom and hope for a promising future, and so Milan accepts the reductionist quality of the psychocentric model of empowerment.[7]

Given the prominence of self-blaming discourses revealed above, it is not surprising that participants found that the psychocentric approaches advanced by mental health and treatment programs in the homeless community worked to boost their self-esteem and encourage a responsibilized lifestyle (Cruikshank, 1999; Rimke, 2000), regardless of the programs' poor success rate in moving people out of homelessness. Daniel offered compelling insights into how his therapy with a life coach and participation in an out-patient addiction treatment program reinvigorated a sense of responsibility that he lost before he "stepped out of the machine":

> I'm breaking myself down to nothing and I was really given the opportunity to assess who am I? You know and without any pressure, no, no inner fear or persuasion. It's all up to me... So I can say ah those guys aren't doing this and this but, really it's all a choice. Life is all choice. Every day, you know as soon as you open your eyes you make a choice… That empowers you when you realize that everybody is in life exactly where they've chosen to be…But you constantly have to take responsibility, take ownership over your choices and realize that nobody did this, nobody caused that. It was the way I reacted. Instead of responding, you know and on and on and on. Then it becomes empowering because you click, I'll choose different next time.

Daniel echoes Seamus' sentiment that personal problems derive from bad individual choices. His narrative brings together the notions of self-blame and responsibilization as well as empowerment discourses that are reinforced

[7] The importance of hope in encouraging marginalized individuals to be managed by mental health and treatment programs regardless of the outcomes is noteworthy. In an environment characterized by many as hopeless, the optimism these programs provide is powerful.

through a psychocentric logic. For Daniel, empowerment comes from having the personal power to escape homelessness and distress. Notably, in the past Daniel had a seemingly typical life with a house, wife, children, and a successful career in the public service, until he "broke" himself and has since experienced homelessness for 10 years. However, if he broke himself, then arguably he can "fix" himself too. Daniel's comment that he is "breaking myself down to nothing" exemplifies the reflexive self-objectification of self-help programs (Cruikshank, 1999; Rimke, 2000). The responsible, objective, fearless Daniel will mould and build a new and improved self. In keeping with the goal of empowerment strategies, he engages in self-scrutiny in the hope that eventually he will be able to take on the project of self-governance, and will no longer have to rely on professional surveillance and the disciplinary strategies of the homeless sector to manage him.

Empowerment strategies reinforce double standards and the shamed poor subjectivity by distinguishing between those who are and are not deserving of assistance (Chunn & Gavigan, 2004; Katz, 2013). Only those individuals who adhere to dominant norms (including the individualization of social problems) are permitted to access the few community resources available. Empowerment strategies require active participation on the individual's part, as exemplified in Daniel's claim that "it's all up to me," thus reinforcing the idea that people experiencing homelessness are "exactly where they've chosen to be." Empowerment strategies use the psychocentric notion that homelessness is caused by personal deficits and failures and only those who take ownership for their precariousness will benefit from the programs used to manage the homeless population.

## Conclusion

The individualization and pathologization of social problems is fundamental to the neoliberal rationality that social subjects are governed through obligated freedom. The psychocentric paradigm plays out in a distinctive way among individuals experiencing homelessness, who must constantly negotiate the discourses that diagnose distress as biologically derived, but simultaneously call for them to be accountable for their social situation. The shamed poor subjectivity requires that homeless people strive to be good, neoliberal citizens by regarding the self as the site for reformation and normalization. Those who reject the reductionist model by contextualizing their homeless and distressed status within social, cultural, political, economic, and historical factors are negatively judged by their homeless peers for making excuses and failing to take ownership over their lives.

Homeless men and women are expected to be empowered by the psy resources offered in the community. Unfortunately, many of the programs focus on psychocentric projects such as self-esteem building and

responsibilization strategies with the aim of achieving a normalized self without the material changes necessary to escape homelessness. Psychocentricity is problematic for individualizing and pathologizing homelessness because it decontextualizes the structural and systematic bases of social inequality and the related social injustices faced by those trying to survive poverty in contemporary society, and limits broader discussions and policies looking for solutions to homelessness.

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