

## ABSTRACT

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TECHNOSCIENTIFIC KNOWLEDGE-  
PRACTICES OF ADOLESCENT  
MENTAL HEALTH CARE WORK

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This study examines the technoscientific knowledge-practices of adolescent psychotherapy. Employing an interpretive, feminist version of grounded theory, 40 interviews with psychotherapists were analyzed. Building on Science and Technology Studies and the Sociology of Health and Illness, the following research questions are asked: How are adolescent mental illnesses defined and approached within and across social worlds? How do practitioners negotiate social processes of diagnosis? In what ways does the Diagnostic and Statistical Manual (DSM) as a technology, shape the diagnostic and treatment work of mental health practitioners? In what ways does Managed Care (MC) shape adolescent mental health care?

Social worlds define psychotherapy as an art and science, resist biomedicine and embrace eclectic theoretical orientations to treatment. Psychotherapists utilize Evidence Based Practices (EBPs) in their treatment plans but critique how EBPs privilege scientific evidence over patient subjectivity, social contexts and the therapeutic relationship.

Psychotherapists challenge the cultural authority of the DSM and downplay its significance for clinical work. While the DSM is a socially-scripted technology, its significance is interpretively flexible. Psychotherapists employ work-arounds to the problems posed by biomedical and bureaucratic standardization, and participate in processes of cribbing. Cribbing signifies the collective knowledge building and translation work necessary to learn the codes that facilitate therapeutic service authorizations and minimize denials. The DSM technology and MC privilege a therapeutic focus on surface level symptoms and behaviors whereas psychotherapists

focus on communication, relational and emotional issues. The assemblage of the DSM and MC creates diagnostic dissonance for psychotherapists—a conflict between their own theoretical orientations and the biomedical model. Biomedicalization processes are uneven and actively resisted.

MC governs the clinical practices of psychotherapists. For-profit MC companies have shifted care from intense psychodynamic therapy towards short-term surface level medications and behavioral programs. MC policies limit services, over-manage treatment and harm the therapeutic relationship. MC stratifies providers and patients by encouraging seasoned professionals to leave public forms of insurance. The least experienced practitioners care for those with the most intense mental illness while those with experience opt-out and treat the worried-well.

TECHNOSCIENTIFIC KNOWLEDGE-PRACTICES OF  
ADOLESCENT MENTAL HEALTH CARE WORK

By

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## DEDICATION

For my father, James A. Nelson, for always telling me and actually believing that I could accomplish anything I wanted to. Even after your passing, in my darkest moments of self doubt, the feeling of your unwavering confidence in me gives me strength. Your passion, charisma and work-ethic not only gave me my stubborn perfectionism and hopelessly emotional compass, but also taught me how to care deeply for important social issues. Your life and the experiences I shared with you offered me a rich understanding of the complexity of personhood. Your struggles with health and illness, with your own personal shortcomings and your social circumstances taught me as much about the sociology of health and illness as I learned working with youth in treatment centers or sitting in classrooms with brilliant colleagues and professors. While you never got to attend a graduation, I know how proud this accomplishment would have made you. In your honor I submit this work-in-progress of my studies in the sociology of health and illness.

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## **Chapter 1: Introduction and Review of the Literature**

This dissertation is an examination of the definitions of, and responses to, the Mental, Emotional and Behavioral (MEB) disturbances of adolescents in the United States (U.S.) in the 21<sup>st</sup> century. The scientific and clinical professions that take adolescent mental disorders as a key object of scientific study and clinical intervention are diverse in their disciplinary training, professional socialization, models of illness and therapeutic approaches. In addition, mental health care work is accomplished in diverse contexts situated within a larger political economy that is, itself, full of countervailing forces. This study examines the discursive and material practices that together co-constitute how society currently defines and intervenes in adolescent mental illness.

Four questions guide this study. First, how are adolescent mental illnesses defined and approached within and across interdisciplinary psychotherapeutic communities of practice (social worlds)? Second, how do psychotherapeutic practitioners negotiate social processes of diagnosis? Third, in what ways does the DSM as a biomedical technology, shape the everyday diagnostic and treatment work of mental health practitioners? Fourth, in what ways does the political economy, specifically, managed care, shape contemporary adolescent mental health care?

In this introductory chapter I provide a review of the historical background of the rise in the emergence of adolescent mental disorders as a significant object of scientific study and clinical intervention as well as a review of literatures relevant to understanding the contemporary mental health arena. In chapter two, I set up key theoretical frameworks, analytic concepts, and methodological procedures employed in chapters three, four and five of this study. Chapter three examines how adolescent mental

disorders are defined and approached within and across psychotherapeutic social worlds of practice. I examine how psychotherapy is understood as an art and a science through a set of knowledge-practice tensions that are salient in contemporary mental health care practice. Chapter four examines the social processes of diagnosis, including practitioner negotiations of the Diagnostic and Statistical Manual (DSM) and the ways in which the DSM as a biomedical technology shapes the diagnoses and therapeutic interventions adolescents receive. Chapter five examines the larger macro political economy of the adolescent mental health field and the meso level institutional forces shaping the conditions under which screening, diagnosis and treatment of adolescent disturbances occur. For instance, in out-patient expert mental health professional settings, managed care is a major social force that shapes the everyday care work of practitioners. Finally, in chapter six, I theorize what the empirical data and analysis from this study suggest about adolescent mental health and illness in contemporary U.S. society.

## **HISTORICAL BACKGROUND AND LITERATURE REVIEW**

This chapter begins with a historical telling of the emergence of Adolescent Medicine and the ascendance of adolescent mental disorders as an object of scientific knowledge and clinical practice intervention from 1980 to the present. In addition, I offer a brief background review of the social construction of adolescence, including a review of developmental and life course understandings of adolescence and adolescent health.

### ***Emergence of Adolescent Medicine and Mental Disorder***

In 1968, the Society for Adolescent Medicine (SAM) was founded along with other professional organizations and committees, demarcating adolescents as a social group deserving explicit and differential scientific study and medical intervention. While

it has been over four decades since advocates secured a professional organization, adolescent medicine is a fairly recent development in the history of medicine. In *A Doctor of Their Own: the History of Adolescent Medicine*, historian Heather Munro Prescott notes that it was not until 1991 that Adolescent Medicine's parent specialty – Pediatrics, formalized the sub-certification of Adolescent Medicine within Pediatric Medicine (1998).

Prescott's study demonstrates how the emergence of the specialty of Adolescent Medicine reflected larger developments of specialization in U.S. medicine at the time yet encountered unique professional resistance due to its scientific focus on a social group rather than a procedure or technological innovation (Prescott 1998). Due to its outright social component, there were problems of legitimacy for Adolescent Medicine as a specialty from the start. It was the first specialization to spotlight a social age category rather than a disease, new technology, or technique to distinguish itself from other specialties. The founders of Adolescent Medicine asserted a holistic model that examined the "whole" patient (as opposed to an organ or a particular part of the body and its functioning). This holistic model and its openness towards intervening in emotional, behavioral, psychosocial (as opposed to purely biomedical) as well as physical problems marked Adolescent Medicine as a soft or unsystematic specialty, leaving professional dilemmas for decades to come (Prescott 1998). This history is noteworthy because it highlights the social facets of the professionalization of scientific medicine in general, and Adolescent Medicine in particular. The consideration and inclusion of emotional, mental and behavioral components of health and illness and the focus on a social group rather than a disease, technology or procedure was revolutionary in the history of medical

specialization. This holistic approach to health and illness and the social construction of adolescent health issues as distinct from child and adult health, opened the door for the interdisciplinary emergence of scientific and professional knowledges and practices of that have developed across the past four decades.

Despite early professional disputes, in 1979 the Task Force on Pediatrics recommended that medical school educational programs in Pediatrics increase their emphasis on adolescent health. In the mid 1990s, the medical establishment began including Adolescent Medicine as a one-month requirement for residency education (Irwin 2004).<sup>1</sup> Intersecting social forces propelled the field of Adolescent Medicine forward throughout the 1990s:

During the 1990s, there was a major coming together of several sectors of society in the U.S.: private foundations began to pay attention to adolescents, the professional medical organizations demonstrated concern about their members' expertise in caring for teenagers, certifying organizations embraced Adolescent Medicine with subspecialty certification and the federal government issued a major report. (Irwin 2004:308)

This growing widespread concern for adolescents resulted in important publications on adolescent health and the development of subspecialty examination and certification process standards. The first certifying examination was given in 1994 to 465 medical students; by 1996 there were 39 training programs in Adolescent Medicine; and by 1998, the Accreditation Council on Graduate Medical Education accredited 16 new adolescent medicine fellowship training programs (Irwin 2004; Rieder, Alderman and

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<sup>1</sup> While the American Academy of Pediatrics (AAP) had formally recognized adolescence as a distinct social group in a policy paper published in 1938, it wasn't until 1978 that they established a professional section on Adolescent Health sometime during the 1980s that the Society of Adolescent Medicine created the Journal of Adolescent Health care along with several textbooks for medical education on adolescent health issues (Irwin 2004).

Cohen 2005). In 2002, Family Practice joined with Pediatrics and Internal Medicine specialties to offer sub-specialty training in Adolescent Medicine (Irwin 2004).

The historical emergence of Adolescent Medicine as its own specialty and sub-specialty of general medical training illustrates the inherent interdisciplinarity of the rise of adolescent health and illness as an object of scientific study and clinical intervention. The scientific ascendance of medicine tailored for adolescents reinforced parallel developments in other scientific and social fields interested in understanding or intervening in adolescence and/or emotional, behavioral and mental disturbances. Thus across the latter half of the twentieth century, adolescent health in general, and adolescent mental, emotional and behavioral health in particular, emerged as an object of social concern, scientific study and professional clinical intervention. By the 1980s, multiple scientific and professional disciplines viewed adolescent mental health and illness as an area of specialty under their jurisdiction. Each of these professional domains has relied on its own set of disciplinary expert knowledges to define the problems and provide solutions in the form of health care practices. I conducted a bibliometric exercise to demonstrate the drastic ascendance of adolescent mental disorder as an object of scientific knowledge.

Using the PubMed database with the search terms adolescent, mental and disorder, I charted its the significance as an object of scientific study from the 1950s to the present. Beginning in 1950, the Pub Med database reveals a steady rise in citations devoted to the scientific study of adolescent mental health and illness. From 1950 to 1959 only 59 studies mention adolescent mental disorder; across the 1960s the number of citations jumped to 7,113; from 1970 to 1979 there were 17,225 studies; across the 1980s



– 22,797 citations; in the 1990s there were 32,217 studies and finally from 2000 through 2009 there were over 50,000 studies on adolescent mental disorder.

**Table 1. Ascendance of Adolescent Mental Disorder as Scientific Object of Study**

<b>Decade</b>	<b>Number of Scientific Research Articles</b>
1950—1959	59
1960—1969	7,113
1970—1979	17,225
1980—1989	22,797
1990—1999	32,217
2000—2009	50,000+

This accelerating attention to adolescent mental illness signals a marked emergence and ascendance of a set of knowledges and practices specifically focused on the social age of adolescence and what medical fields term mental disorders. The contemporary result is a complex interdisciplinary assemblage of medical and mental health professions, professional societies, academic journals, theoretical orientations, and a vast industry organized around the treatment of mental, emotional and behavioral disturbances in adolescents.

In addition to the growing scientific and clinical focus on adolescent health, there has been a gradual increase in the focus on the intersections of health and the life course (also referred to in peer-reviewed literature as life-span or human development). Originally, Adolescent Medicine focused on the unique environments and experiences of adolescents and how those contributed to their health and illness status. Across the past decade, adolescence has increasingly been constructed as a period in the life course that is significant not only for the health of young people but for the influence it has on the health status of adults. Sociocultural definitions and assumptions about both adolescence

and adolescent health are embedded in conceptualizations of adolescent mental health and illness, and therefore shape how we as a society define and intervene in adolescent mental disorders. For this reason, the next section reviews the social construction of adolescence and developmental or life course health scholarship.

### ***The Social Construction of Adolescence***

The contemporary Western idea of adolescence as a period in the life cycle marked by conflicts and disturbances is viewed by many historians as a creation of the late nineteenth and early twentieth century. . . Hall's emphasis on the peculiarities of the emotional experiences of adolescents contributed to the picture of psychological storm and stress. (Fabrega and Miller 1995:883)

In the 21<sup>st</sup> century, the notion of Adolescence is embedded in the social fabric of our everyday lives, something we take for granted as a normative part of life experience. However, adolescence is a fairly modern social category that emerged in response to compound economic and cultural conditions across the 19<sup>th</sup> and 20<sup>th</sup> centuries. Multiple historical scholars have demonstrated the ways in which adolescence was a modernist product of the industrial revolution that in turn led to key social and cultural changes in the 20<sup>th</sup> century (Fabrega and Miller 1995; Kett 1977; Lesko 2001; Prescott 1998).

Industrialization brought about innovative social policies that created new contexts and opportunities for adolescent development. These new social policies, including compulsory education and child labor laws; a minimum school leaving age and limits on hours of employment for 14 to 16 year olds, established a social space for the category of adolescence within the legal institution (Kett 1977; Lesko 2001). In addition to the changing contexts and conditions in the legal and educational system, demographic transitions shifted the social structure and function of families.

New social trends of having fewer children and spacing childbirth closer together resulted in a novel family form where all children in a house were teenagers; thereby further distinguishing a teenage experience (Kett 1977), raising the salience of adolescent problems and creating more opportunity for intergenerational conflict (Fabrega and Miller 1995). Further, the industrial capitalist economy of this time period caused changes in American relationships of social class, race/ethnicity, gender and age that piloted increased stratification of youth experience across these social status characteristics (Prescott 1998). For example, the growing age segregation in schools and the concomitant rise in peer friendship and activity groups postponed societal expectations of adult responsibilities and therefore, the necessity of an adult identity (Fabrega and Miller 1995).

In *Act Your Age!: A Cultural Construction of Adolescence*, Lesko (2001) critically illustrates how the social construction of adolescence perspective emphasizes social contexts, institutional arrangements and differential experiences of youths from stratified class, race and gender backgrounds but fails to interrogate the physiological and biological paradigm underpinning the dominant view of adolescence. Similarly, Joseph Kett (1977) argues that while late 19<sup>th</sup> century middle class values universalized and democratized the concept of adolescence in the early 20<sup>th</sup> century, biological processes of maturation were (and still are) foundational for the social definition of this age group.

Multiple emerging academic disciplines had an influence on the early conceptualizations and governance of adolescence and adolescent health but early developmental psychology had an undeniably formative impact; as the definition of

adolescent personhood and adolescence as a distinct group became understood as a natural biological, emotional, and cognitive period of “storm and stress”.

In a survey of the published literature on adolescence in the first half of the 20<sup>th</sup> century, Sociologist A. B. Hollingshead (1949:5) showed that most prior studies had focused on physical and psychological aspects of adolescence, and argued “*of the millions of words written on the subject, most had a worried tone.*” This emphasis on adolescent problems can be traced back to G. Stanley Hall who published a comprehensive two volume study on *Adolescence* in 1904, popularizing the phrase “of storm and stress” to denote this stage of the life course. Throughout the first half of the 20<sup>th</sup> century, adolescence continued to be associated with “storm and stress” despite the lack of empirical evidence for a causal connection between physical manifestations of adolescence and social behavior (Hollingshead 1947). Psychologist Stanley Hall (1904) is best known for how he influentially defined adolescence in psychological, moral and developmental (life stage) terms. Halls’ seminal definition of adolescence as a biologically based stage of inevitable upheaval grounded future studies of adolescence and adolescent health in biological reductionism and a deficit paradigm (Lerner and Steinberg 2009). Similarly, Erik Erikson (1970, 1968) pathologized adolescence in psychological terms through his claims of a universal adolescent identity crisis and struggle for independence from parents.

A prominent figure in the parent education movement, Lawrence K. Frank (1953) echoed Hall’s anti-modernist fears about the future of American society by positioning adolescents as a focal point for the nation’s concerns about ills of modern society. Lerner and Steinberg (2009) characterize early scientific studies of adolescence as either grand,

essentializing theories about adolescent behavior and development or empirical studies that were descriptive rather than analytical. A. B. Hollingshead's (1949) sociological ethnography stands out as one of few early scientific studies that examined adolescence and adolescent behavior empirically in social context.

Hollingshead argued that, contrary to popular perception, adolescent behavior is transitional and wholly dependent upon socialization and the position the individual adolescent and his/her family occupies in the social structure, rather than upon biological phenomena such as puberty connected with this age (1949). While Hollingshead acknowledged anatomical, physiological and psychological facts have some bearing on behavior during adolescence, he asserted their importance as being shaped and defined by culture (1949). He hypothesized "*the social behavior of adolescents appears to be related functionally to the positions their families occupy in the social structure of the community,*" and his evidence demonstrated that class culture shapes the behavior patterns of adolescents (Hollingshead 1949:439). Thus, he argued that what is important about adolescence is the way that society, its institutions, and the social contexts surrounding the adolescent regard him/her, including the roles, expectations and opportunities for social action they provide.

While Hollingshead's (1949) ethnography stands out among early studies of the social aspects of adolescence, in the last half of the 20<sup>th</sup> century there was a significant increase in research on adolescence across a growing number of disciplines, and this increase has continued across the past few decades (Dornbusch 1989; Fursetenberg 2000). Sanford Dornbusch (1989) describes a great increase in scientific research on adolescence during the 1980s, when the Society for Research in Adolescence was

founded. He argues that there was a significant shift in the focus of scientific studies from examining individual adolescents and developmental tasks towards examining research on adolescents situated in social contexts. Frank Furstenberg (2000) notes that the scholarly culture set forth by Hall's (1904) seminal study was surprisingly persistent in psychological and sociological studies of adolescence throughout the 20<sup>th</sup> century. Scholars have continued to reproduce notions of adolescence as a time of "storm and stress" and as a "*problematic life stage in modern society*" (Furstenberg 2000:897). Thus while adolescence was increasingly studied in multiple ways, and increasingly situated within social contexts, there continued a theme of focusing on adolescence and youth as a problem:

As indicated earlier, the vast majority of articles and studies on youth are focused on the problematic features of adolescence and explicitly on problem behavior. A review of the leading journals on adolescence indicated that at least half of all articles were principally about youthful misbehavior and maladjustment; delinquency and violence, substance abuse, school problems, mental health, and the like. (Furstenberg 2000:900)

Jeffrey Arnett (1999) also examines the validity of the view of adolescence as "storm and stress." He examines three key aspects: (1) conflict with parents, (2) mood disruptions and (3) risk behavior (Arnett 1999). He concludes that in all three of these areas, scientific evidence supports a modified "storm and stress" view that accounts for individual and cultural variations.

The claim that that adolescent storm and stress is characteristic of all adolescents and that the source of it is purely biological is clearly false. However, evidence supports the existence of some degree of storm and stress—at least for adolescents in the middle-class American majority culture—with respect to conflict with parents, mood disruptions, and risk behavior. Not all adolescents experience storm and stress in these areas, but adolescence is the period when storm and stress is more likely to occur than at other ages. (Arnett 1999:317)

How adolescence is defined in the scientific literature is important for this study because these discursive practices shape larger societal definitions and responses to the emotions and behaviors of adolescents. Adolescent mental health and illness is coproduced by assumptions about adolescence itself.

Beyond persistent constructions of adolescence as problematic in modern society, there have been a number of other important developments in the literature that provide a fuller picture of how we think about adolescence in contemporary society. For example, scholars have continued focus on the way youth gain autonomy from their families and develop peer group relations (Furstenberg 2000). There also was a shift in attention from the social class of adolescents and their families to that of racial, ethnic and gender differences in experiences and outcomes (Furstenberg 2000). Finally, in looking forward to what sociological studies of adolescence and youth could do better in the 21<sup>st</sup> century, he urged scholars to begin exploring multiple rather than just single social contexts, in order to gain a fuller understanding of “*when, how and why different contexts shape the trajectories of development*” (Furstenberg 2000:904). Scientific scholars have largely used the developmental and/or life course theoretical frameworks to reach a better understanding not only of adolescence in general but of adolescent health and illness in particular.

## ***Developmental and Life Course Understandings of Health and Illness***

Normative benchmarks for adolescent moods and behaviors are still largely shaped by conceptualizations of developmental psychologists. However, the study of human development throughout the life course has become an even more interdisciplinary endeavor across the past half century, especially within studies on health and illness. *“The fastest growing research area in life course sociology and related fields, especially epidemiology, concerns the trajectories of health outcomes and the mechanisms responsible for age-specific exposures to health risks and the age-specific differentials in the impact of such risks”* (Mayer 2009:421). Within sociology, the life course framework is commonly used to study the way early life experiences and events impact future life conditions (health status, morbidity and mortality), and how life course trajectories vary based on one’s early and cumulative social class, education and income statuses (Mayer 2009).<sup>2</sup> For instance, adolescents have repeatedly been shown to have intersecting trajectories of poverty, mental, emotional and behavioral disorders, and education that have consequences for their future life experiences and pathways (McLeod and Fettes 2007; McLeod and Shanahan 1996, 1993; Wickrama et al. 2008). *“Early life course events and experiences are the seedbed for lifelong human development, and life course scholars are bringing fresh insights into how negative conditions during*

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<sup>2</sup> The term trajectories is a life course principle concerned with patterns of stability and change over time that are impacted by the duration, sequence and timing of various transitions or movements in and out of roles and statuses (George 2003; Pearlin et al. 2005). While movements in and out of roles and statuses occur throughout all phases of the life course, some research suggests that transitional events that are undesired or involuntary may be especially stressful or harmful to an individual and or family’s health (Thoits 1983).



*childhood and adolescence compromise adult well-being*” (Schafer, Ferraro and Mustillo 2011:1053).<sup>3</sup>

Sociological life course studies employ a set of perspectives that focus on the following four principles: (1) time and timing of patterns of stability and change (conceptualized as trajectories), (2) intersections of social context and personal biography or the connections between the macro social environment and micro personal situation, (3) linked lives or how individuals are interdependent on each other in various networks of social support and obligation across multiple domains of life such as family, school and work, and (4) human agency or the notion that although social and historical contexts shape individual lives, individuals can act to modify the relationships and institutions in their own lives (George 2003).

While there is a significant degree of overlap between developmental and life course frameworks, developmental psychological research focuses on measuring biological, psychological and social changes over time such as pubertal, cognitive, emotional and relational indicators, with explicit attention to standards of development. In comparison, examining adolescence within the life course requires an understanding of how *“adolescence is linked to developmental processes in the years before and after adolescence in ways that are shaped by broader patterns of social change”* (Johnson, Crosnoe and Elder 2011:273). Thus, contemporary studies of adolescence from a life course perspective also draw on lessons from the developmental perspective but attend more explicitly to social contexts and change over time.

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<sup>3</sup> For excellent reviews on research on adolescence and childhood and adolescent mental health in the 21<sup>st</sup> century using developmental and life course theoretical frameworks, see Crosnoe and Johnson 2011; Avison 2010.

One developmental research article on adolescent mental health argues “. . . *youth is not a tabula rasa on which new psychiatric disorders emerge. Rather, biological and psychosocial risk and resilience factors from childhood continue to interact to influence life events and outcomes throughout adolescence and youth into adulthood. This process begins in childhood*” (Birleson and Vance 2008:23). The utility of using a developmental perspective in understanding adolescent health and illness is that the adolescent stage of development “*is a critical period for the establishment of lifelong positive and risky health-related behaviors*” (Holmbeck 2002:409).

Therefore, both life course and developmental perspectives examine changes or trajectories across the life course, but sociological research emphasizes the ways in which social structures and stressors are stratified across different social groups within society and how these differences result in cumulative advantages or disadvantages. In comparison, developmental psychology focuses on defining and studying normal versus abnormal developmental processes and benchmarks across the life course.

In examining the scientific and clinical knowledges and practices of adolescent mental health and illness, it is important to deconstruct the ways that recent and historical context contribute to contemporary conditions and conceptualizations of “normative” emotional and behavioral standards. In addition to understanding constructions of adolescence and adolescent mental health through a life course perspective, it’s important to understand the manner in which adolescent mental health and illness is defined as a contemporary social problem.

### ***Adolescent Mental Health and Illness as a Contemporary Social Problem***

While there have been significant declines in most medical problems that afflict children and adolescents across the past century; mental, emotional and behavioral problems now comprise one of the most common disabilities of this population.<sup>4</sup> The majority of lifetime Mental, Emotional and Behavioral (MEB) disorders begin to develop during childhood and adolescence – over half of all persons who ever experience an MEB disorder report that onset occurred by age 14 (Kessler et al. 2005).

Given that the most seriously impairing and persistent adult mental disorders are associated with child-adolescent onsets and high comorbidity, increased efforts are needed to study the public health implications of early detection and treatment of initially mild and currently largely untreated child-adolescent disorders” (Kessler and Wang 2008:115).

National data show that 20-25 percent of youth have symptoms of emotional distress and one in ten has moderate to severe symptoms that indicate significant impairment (Knopf, Park and Mulye 2008). The National Comorbidity Survey Adolescent Supplement (NCS-A), a nationally representative face-to-face survey of 10,123 adolescents aged 13 to 18 years of age in the U.S., recently assessed lifetime prevalence of DSM-IV mental disorders with and without severe impairment, comorbidity and their sociodemographic correlates (Merikangas et al 2010). They found that anxiety disorders were the most prevalent (31.9%) but behavior disorders (19.1%),

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<sup>4</sup> Major increases in rates of psychosocial disorders among youth in many Western nations have been found in the past half century (Rutter and Smith 1995), raising serious questions about the cause of these increasing rates of mental health problems and the methodological challenges involved in accurately implementing and estimating accurate time trend data in child and adolescent mental health (Maughn, Lervolino and Collishaw 2005). The U.S. lacks a data registry that can account for time trend data across all of the different types of disorders. Therefore prevalence and incidence rates are difficult to interpret given there is confusion about the extent to which rising rates of disorder are due to increased public and professional awareness and outreach which have led to increases in referrals in diagnoses, or whether the increasing rates are the cause of a changing social environment.

mood disorders (14.3%) and substance use disorders (11.4%) were also common (Merikangas et al 2010). As expected, the NCS-A also revealed that comorbidity, the condition of experiencing symptoms that meet diagnostic criteria of more than one disorder, was common (40%).<sup>5</sup> Further, almost a quarter (22%) of adolescents surveyed had disorders with severe impairment and/or distress (Merikangas et al. 2010). The median age of onset for these disorder classes was surprisingly early: six years of age for anxiety, 11 years for behavior, 13 years for mood and 15 years for substance use disorders. This finding is important because early onset of mental, emotional and behavioral disorders is predictive of lower school achievement and increased burden on the child welfare and juvenile justice systems (IOM 2006).

While some scientific estimates suggest that between 20 to 45 percent of youth who need mental health services go without, others claim the problem is actually much worse; that four of five children and adolescents face unmet mental health care needs (Burns et al. 1995). Less than half of youth with mental health problems get professional treatment, services or support; and only one in five gets treatment from a mental health worker with special training to work with youth (American Psychological Association). Some researchers argue the high rates of unmet mental health treatment is a result of systematic defunding of specialized mental health services in the United States in the past

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<sup>5</sup> High rates of comorbidity have been found in both community (Bird, Gould & Staghezz 1993) and clinical samples (Jensen & Weisz 2002). Comorbidity is a significant concern in mental health research because it is one of the major differences between therapeutic interventions carried out in research (trials often have a singular disorder focus and exclude participants with co-occurring symptoms) and therapy carried out in everyday contexts (tend to be heterogeneous in patient and symptom type) (Doss and Weisz 2006; Weisz, Donenberg, Han & Weiss 1995; Westen, Novotny & Thompson-Brenner 2004). A frequent complaint of clinical practitioners is that therapeutic treatments listed as Evidence Based have not been studied or validated with heterogeneous populations that have co-occurring syndromes.

two decades (Appelbaum 2003). In fact, Appelbaum claims that while he is cautious in using the term crisis, financial cuts in public sector mental health services and the withdrawal of many private practitioners from managed care networks have resulted in a definite crisis in access to mental health services (Appelbaum 2003:110).

However, Appelbaum is not the only research practitioner to cry crisis. Jane Knitzer (1982) garnered the nation's attention with her book *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services* three decades ago. Tolan and Dodge (2005) argue the situation has gotten much worse since then. All one has to do is look at the numerous reports that demonstrate the gap between needs and services in childhood and adolescent mental health: the U.S. Public Health Service (2000), the President's New Freedom Commission on Mental Health (2003), the American Psychological Association's (APA) Working Group on Children's Mental Health (Tolan et al. 2001) and many more lay bare this gap. Cumulatively, these studies demonstrate that in the United States, childhood and adolescent mental health are severely neglected despite an abundance of evidence of the importance of mental health for childhood and adolescent development, the significance of early intervention in general and the efficacy of intervention with at-risk youth in particular (Tolan and Dodge 2005).

In addition to these governmental and professional society studies, a recent National Research Council (NRC) and Institute of Medicine (IOM) scientific consensus study titled *Preventing Mental, Emotional and Behavioral Disorders Among Young People: Progress and Possibilities* (2009) concluded that our nation devotes minimal attention to promoting positive mental health or preventing mental disorders in youth.

The report details the high psychosocial and economic costs of MEB disorders and how the normative national response is to wait for their emergence and then attempt to treat or limit the damage caused. The scientific consensus committee that produced this report argued that the current national response neglects efforts focused on preventing future disorders such as curtailing the environmental exposures that increase risk (NRC/IOM 2009).

This crisis in national response to youth mental health and illness, widespread lack of access to professional mental health services and evidence demonstrating that many children and adolescents with MEB disorders have their only mental health related service contact with non-specialty mental health providers begs important questions about childhood and adolescent mental health services research, the mental health workforce and institutional contexts within which care is provided.

### ***Contexts of Adolescent Mental Health Care***

Adolescents primarily receive mental health services in one of the following contexts: inpatient and outpatient specialty mental health settings (mental health experts such as psychologists, psychiatrists, counselors, social workers), school-based educational settings (school counselors, psychologists, social workers or special education teachers), and general medical settings (pediatricians or family practice providers) (SAMHSA 2009). The National Survey on Drug Use and Health (NSDUH) Report found that in 2007, one in eight (12.5%) adolescents aged 12 to 17 years received treatment or counseling in a specialty mental health setting, 11.5% received services in an educational setting and 2.8% received services in a general medical setting (SAMHSA 2009). The characteristics of the mental health providers and the contexts in which they

provide care will be explored in chapters three and five, respectively. Child and adolescent mental health services research has demonstrated significant flaws in the larger service delivery system:

The clinicians are resistant to change, agencies are avoiding accountability, governments are mired in their own bureaucracy and regulations, and the consumers haven't figured out they need to be demanding quality services not just more access. The researchers, well they are just happy publishing and winning grants. But the bottom line is what are we doing to make life better for children and their families who have mental health problems. (Bickman and Hoagwood 2010:4)

In a review of the state of childhood and adolescent mental health field across the past 25 years, Kimberly Hoagwood acknowledged that significant scientific progress had impacted science and practice communities working on diagnosis, treatment, prevention, early identification, education and support for families; but progress in the system of service delivery had lagged behind:

Similar advances in the system and delivery – in the conveyance infrastructure for getting better services (or for that matter any services) out into communities and to families – was foundationally flawed. The mechanisms, structure, organization and fiscal accountability of the public mental health system was antiquated and out of step with the changes in the broader world of healthcare. (Bickman and Hoagwood 2010:5)

The recognition of a scientific research-clinical practice gap isn't unique to the field of adolescent mental health but I suspect the research-practice gap may be particularly acute in adolescent mental health due to the complexities that arise from the sheer interdisciplinarity of both researchers and practitioners that take adolescent mental disorders as their object of scientific study and/or clinical practice intervention. Previous CEO of United Behavioral Health, Saul Feldman (2003), similarly agrees that the gap between what is known and what is done in the mental health field is perplexing given the proliferation of evidence-based guidelines intended to serve as vehicles of knowledge-to-practice translation.

In his book *Managed Behavioral Health Services: Perspectives and Practices*, Feldman (2003) argues that while there was a time when it was necessary and important for psychiatrists, psychologists, psychiatric social workers and nurses to have their own schools, disciplines, professional associations, journals, licensing and certification procedures and professional norms and identities, that time has long passed. He claims that disciplinary training promotes unhealthy rivalry between professions, discourages interdisciplinary learning and thus is a major barrier to positive change in the field of mental health (2003). Feldman calls for discipline-less, evidence-based curriculum in which professionals earn degrees in mental health care and yet can still specialize within it (2003). His book was one of few studies that even addressed the research-theory gap in science and practice on mental health and the role that the proliferation of separate disciplines, models and therapeutic approaches plays. My study also addresses the research-theory gap and interdisciplinarity of adolescent mental health services.

Some research has focused on how the field of childhood and adolescent mental health services can make quality improvements to the multiple existing service systems in order to tackle the gap between knowledge and practice. One recommendation is that in order to identify targets for change in mental health service systems, we need a better understanding of both effective and current routine clinical practices (Garland, Bickman and Chorpita 2010). They claim there is a dearth of research on routine or “usual care” of childhood and adolescent mental health providers, and that psychotherapeutic practice in particular is a “black box” (Garland, Bickman and Chorpita 2010).

Sexton and Kelley (2010) argue that the field of mental health can better transfer existing science into practice by developing: (1) a better understanding of clinical



relevance of different types of treatment evidence, (2) identification of the core mechanisms of change implicated in various therapeutic practices, and (3) a reconceptualization of what Evidence Based Practices (EBPs), means.

Like this research, my study examines the gaps between the scientific research and clinical practice communities (social worlds) in their definitions and approaches to adolescent mental health and illness. Also, my study focuses on gaining a better understanding of the current state of adolescent mental health services from practitioners themselves. Opening the “black box” of adolescent psychotherapeutic practice – the models or mechanisms of change and multiple approaches to intervention and contexts of routine care – is at the heart of this dissertation. My interview data speak to the perceptions practitioners have of Evidence Based Practices (EBPs) and reveals how practitioners’ real-world expertise with diverse therapeutic practices and populations has much to contribute to contemporary debates about problems of the mental health workforce, organizational contexts of care and the research-clinician gap in EBPs.

### ***Political Economy of Mental Health Care in the U.S., 1980-Present***

All health and illness is shaped by historical context and culture. In order to understand contemporary definitions and responses to adolescent mental health and illness, it is critical to understand the larger social currents that shape the systems and contexts in which mental health care is delivered and received. A growing set of contradictions and paradoxical social currents regarding the framing of and response to mental health and illness has developed within the U.S. across the past few decades. These discordant trends are interrelated and complex, but also serve as threads that tie multiple elements of this dissertation and the mental health system together.

There are a number of different but interrelated political, economic and social forces that colluded in the 1980s and since in shifting societal definitions and responses to mental health and illness. These forces have created the contemporary incommensurability between biomedical and psychosocial paradigms of mental health and illness. Noteworthy transformations in the United States health care system in the past few decades include the close of the deinstitutionalization movement, the rise of managed care organizations, the biomedicalization and commodification of health care, advances in technical and technological apparatuses and services, increasing disparities in access to and quality of health care services across the population, declining trust in and power of physicians, a consumer movement that has resulted in more active and knowledgeable health care patients and a blurring between public-private health distinctions (Cook and Wright 1995; Rosich and Hankin 2010; Stevens 2007).

I provide historical context through a review of the political economy from 1980 to the present in order to set the stage for my analysis of the contemporary arena of adolescent mental health care in the U.S. in the 21<sup>st</sup> century. My dissertation situates adolescent mental health and illness in historical context by focusing on the significant shifts that have occurred since 1980. First, the 1980s marked a major shift in the way mental health care was delivered from primarily institutional or in-patient contexts of care to ideals of assertive community treatment (out-patient care), and the ensuing emergence of managed care. Second, 1980 was the year the American Psychiatric Association published the DSM III, which dramatically changed the entire ethos of mental health and illness in society. Third, not only was there a paradigm shift in the mental health field from psychoanalytic to biological views of mental disorder, there was

a simultaneous paradigm shift in the larger political economy of society. This was an ideological shift from social welfare as a national and community obligation to neoliberal ideals of individualism. Other important societal shifts that occurred include the pharmaceutical revolution, insurance policies requiring diagnostic codes for reimbursement for mental health treatment, dramatic shifts in the funding policies of mental health research at major research sites such as the National Institute of Mental Health, and finally, the increasing attention paid to adolescent mental disorders in the DSM and across the larger scientific, governmental and industry communities.

### ***Paradigms of Mental Health and Illness: The Rise of Biopsychiatry***

There has been a dramatic shift in attitudes towards and culture of mental health and illness in this country. It is now common sense or taken for granted knowledge that mental illness is caused by a chemical imbalance or brain disease. Only a few decades ago, it was common sense that mental illness was a psychosocial phenomena rooted in family origin, childhood and adolescent experiences, dysfunctional relationships and/or unconscious repression. Medical historian Matthew Smith received a call for papers for a conference billed as the first ever conference in the U.S. on the “Social Determinants of Mental Health,” scheduled for June 3-4, 2010 in Chicago. In a paper published later on the impact medical historians can make in which he details his experience of the conference he writes:

I re-read the blurb again, and the phrase about the conference being the first such convened in the United States. Hold on, I thought, that’s not right. Maybe it was the first such conference convened in years, decades even, but it was certainly not the first in any historical sense. Social psychiatry had been a major force in inter- and post-war American psychiatry, threatening to supersede both psychoanalysis and biological psychiatry if President Kennedy’s 1963 ‘Message to Congress on Mental Illness and Mental Retardation’ was to be believed. . . . Many other influential, though apparently

forgotten, monographs had been written about social psychiatry. . . Perhaps no psychiatrist had uttered the phrase social psychiatry in 30 years, but that didn't mean that its history should be forgotten, particularly now, given its apparent resurgence. (Smith 2011:144)<sup>6</sup>

Smith's (2011) account shows that even among contemporary professionals committed to hosting a conference with the intention of facilitating action on the social determinants of mental health, the not too distant history of psychosocial and psychodynamic professional dominance has receded from view. Smith's narrative meaningfully demonstrates that historical context is more important than ever during a time of discordant paradigms of mental illness, especially because "*perhaps the history of how social psychiatry fared in the past could help its advocates be more successful today*" (Smith 2011:145).

While the first biological theory of psychiatric disorder was published in 1965, it wasn't until the 1980s that a consolidation of several forces led to the triumph of biological and displacement of psychoanalytic and psychosocial explanations of mental health and illness. "*Biological psychiatry's dominance of the profession today belies the interdisciplinary competition that raged during the 1960s between it, social psychiatry and psychoanalysis*" (Smith 2008:544).

Prior to WWII, several different models of mental illness were influential but following WWII, psychoanalytic and psychosocial models preeminently guided social and professional definitions and responses to mental health and illness (Menninger 1948; Pearlin, Avison & Fazio 2007; Wilson 1993). In fact, WWII is commonly cited as a key historical event that sparked the integration of disparate theories and approaches to mental illness into a larger psychosocial paradigm (Wilson 1993). "*The fundamental*

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<sup>6</sup> President Kennedy's 1963 Message to the United States Congress on Mental Illness focused on eradicating social-environmental causes of mental illness such as poverty.

*assumptions of the psychosocial model were given compelling legitimacy by American psychiatric experience in WWII. Human exposure to combat situation was the clearest and most telling instance of what Karl Menninger called the “personality-environmental struggle” (Wilson 1993:400). The 1950s and 1960s represent a time of theoretical and empirical pluralism with regards to scientific studies of mental health and illness. During the 1960s, psychoanalysis was beginning to be questioned, yet at the time, the majority of journal editors, department chairs and professional leaders were psychoanalytically trained (Smith 2008). “By the 1970s, psychoanalysis seemed anachronistic in an American society that consistently looked to technology to solve its problems” (Smith 2008:551).*

Each paradigm or model of mental health and illness has its own definition, attribution and approach to diagnosis and therapeutic intervention. In addition, every theoretical model or paradigm of thinking comes with its own set of tenets and assumptions that may shift based on context of use, but are discernible from contrasting models and paradigms. Models of illness are a defining feature not only of approach to diagnosis and goals of therapeutic treatment, but of the different types of mental health professionals and their diverse educational and training backgrounds (Luhmann 2000).

A psychoanalytic model of illness largely follows theoretical insights of Sigmund Freud. However, psychoanalysis, like most sub-disciplines of thought, is eclectic and while significantly shaped by Freud and depth or psychodynamic psychology, is equally shaped by early theorists who deviated from Freud such as Jung, Adler and Reich (Rogers and Pilgrim 2005).

Biological models of mental health and illness are dominant today, but several disciplinary backgrounds of the mental health professions continue to be psychoanalytical, psychosocial and psychotherapeutic in focus. The following assumptions are embedded in a psychosocial framework of mental health and illness (1) mental health and illness is a fluid boundary – individuals who are healthy mentally can become ill if exposed to enough negative life events or a trauma; (2) mental illness is a continuous phenomena – there exist a wide range of experiences of mental health and illness, from mild disturbance to extreme psychosis; (3) multicausality – mental illness is caused by an interaction of a noxious environment and psychic conflict; and (4) manifestation of mental illness is personally mediated – the mechanisms through which mental illness presents itself is mediated psychologically (Wilson 1993: 400). Evidence of the dominance of the psychosocial model is found in the first publication of the DSM-I in 1951, “in which all “functional” psychiatric diagnoses were characterized as “reactions”” (Wilson 1993:401).

Whereas psychoanalytic orientations focus on the connections between one’s past and current psychological problems, biopsychiatry locates the cause of mental illness within the biological substrata of the body, specifically, the brain (Pearlin, Avison & Fazio 2007). Less than 50 years ago, psychosocial etiologies of mental health and illness were dominant and biological theories of mental illness hadn’t even emerged in the professional literature yet. In the 1940s and 1950s, the demand for psychoanalytic psychiatric treatment in the U.S. expanded and the term psychiatrist became synonymous with psychoanalyst in the public imaginary (Barber 2008). In 1961, the *Atlantic* did a special issue focused on the significant impact the psychoanalytic revolution had not only

on medicine and academic departments but the arts, entertainment, family, child socialization and other normative spheres of daily interaction (see Barber 2008:74).

Dynamic psychiatry found common sources for both neurotic and normal traits in the persisting unconscious influences of repressed childhood emotions and experiences. This blurred the boundary between ordinary and pathological conditions, greatly expanding the range of behaviors the mental health professions might treat. (Horwitz 2002:1)

In the 1960s and 1970s, psychodynamic or psychoanalytic psychiatry continued to dominate the mental health profession. Charles Barber (2008) argues that the fall of psychoanalytic and triumph of biopsychiatric theories can be boiled down to two major developments: the discovery of drugs that work (for some people), and brain imaging. Similarly, neuropsychiatrist Nancy Andreasen argues that the “*scientific study of mental illnesses is now occurring in the era of the genome and the golden age of neuroscience. The powerful tools of molecular genetics, molecular biology, neurobiology, and Neuroimaging have only been used to understand the causes of mental illnesses for a few years*” (Andreasen 2001:x-xi).

While Andreasen frames her book *Brave New Brain: Conquering Mental Illness in the Era of the Genome* in the spirit of both a warning and a hope; she warns that society should not lose the human face of psychiatry and must recognize the perils of false dichotomies such as mind vs. body and gene vs. environment, she also frames her book out of hope. She hopes that in the near future, with the tools of molecular biology, genetics, neuroscience and neuroimaging, our society will be able to build a brave new brain (2001:4). Andreasen was and is not alone in her spirit of hope for the capability that biological, genetic, neurological fields of sciences and technologies will be able to bring us better understanding and responses to mental illness in society. In fact, Congress

and the former President George Bush labeled the 1990s as “The Decade of the Brain.” This proclamation was in response to a larger political and economic effort of the Library of Congress, the National Institutes of Mental Health, National Institutes of Health “to enhance public awareness of the benefits to be derived from brain research” (Goldstein 1994; Jones 1999).

The biopsychiatric paradigm of mental illness posits that mental disorders are the cause of biochemical imbalance or dysfunction in the brain and its circuits. *“Biological models seek the primary causes of mental diseases in genetic and biochemical factors and so locate the pathological qualities of psychological conditions in the physical properties of brains, not in the symbolic systems of minds”* (Horwitz 2002:3). Attempts to find the biological basis of mental processes in the brain is now widely understood as the biopsychiatric understanding of mental illness.

The emergence of U.S. biopsychiatry in the last decades of the twentieth century signals the consolidation of one particular mass approach to problems of psychic distress. . . . biopsychiatry had become all but inseparable from the funding and financial structures, research agendas, advertising and marketing campaigns, globalizing ambitions of the transnational pharmaceutical industry. (Orr 2010:354)

In the next few sections, I focus on contextualizing how the larger political and economic environment in U.S. society, social processes of professionalization, the publication of the DSM-III in 1980, the pharmaceutical revolution, the rise of neoliberal ideologies and governance, and research and insurance company financing have each played and continue to play a dynamic role in the dominance of biopsychiatric definitions and responses to mental health and illness in the U.S. across the past few decades.



### ***The Diagnostic and Statistical Manual of Disorders (DSM)***

The DSM-III published in 1980 largely solidified a turn to biological psychiatry that has taken off and become legitimated in the institutional knowledges and practices of scientific professions, government and research agencies, and the consciousness of public communities in the U.S. After an anti-psychiatry backlash during the 1960s and 1970s wherein psychiatric asylums and treatments were exposed as inhumane and unscientific, the profession of psychiatry needed to re-establish itself as a medical specialty based on science. The development of the DSM-III was an attempted solution to the intensifying crisis of legitimacy suffered by the profession of psychiatry in the 1970s.

In order to understand why psychiatry repositioned its' professional boundaries along a medical axis it's important to understand the criticisms lodged during the 60s and 70s. The psychosocial and psychodynamic models of psychiatry increasingly became a focus of attacks from within and outside the profession throughout the 60s. Within the profession, biologically oriented psychiatrists critiqued the lack of research progress generated by the psychosocial model and called for a return to a medical model of psychopathology (Wilson 1993). Psychiatry was attacked by professional outsiders on the basis that if mental illness is psychosocial, than psychiatric problems are social, political and legal rather than psychiatric (Wilson 1993). Thus, across the 1970s, jurisdictional disputes within the psychiatric profession occurred over a rising struggle to redefine their work activities and expertise as based in medical science.

In addition to professional boundary-work, in the 1970s, psychiatry was practicing in a context of decreased funding for research and clinical practice via federal agencies such as NIMH and reimbursement rates of insurance companies (Wilson 1993).

As a response, the profession of American Psychiatry increasingly became interested in issues of diagnostic reliability, reimbursement for clinical services and treatment outcomes (Wilson 1993). The DSM-III became a strategic technological apparatus of professional jurisdiction for the American Psychiatric Association (APA) that transformed not only the profession of psychiatry, but the entire field of mental health (Kutchins and Kirk 1997).

The psychiatric profession presented the DSM-III as a neutral guide based on scientific evidence rather than social values. However, in two different books that examine the social processes involved in the making and remaking of versions of the DSM across time, Kutchins and Kirk show that political and personal negotiation, advocacy and interest play equally significant roles as do the fragility of the science that informs these processes (1992; 1997). While American Psychiatry was transformed because of multiple internal and external forces, and through several on-going political negotiations, much of the transformation can be traced back to one man, the elite group of colleagues he handpicked for the DSM-III task force, and the first meeting convened by this small group of like-minded biomedical research analysts in which a set of guiding principles for the DSM-III and the future of psychiatry (and unfortunately, the entire field of mental health) was decided (see Wilson 1993).

Robert Spitzer was a leading character in transforming the DSM manual in the 1970s from a spiral notebook of about 150 pages to the almost 500 page DSM-III in 1980. The DSM-III became regarded as a scientific instrument carrying a significant degree of cultural authority (Spiegel 2005). Spitzer had devoted his career to the standardization of psychiatric assessment and played a significant role in the

development of the Research Diagnostic Criteria (RDC) (Wilson 1993). Since a primary goal of those in the ranks of the psychiatric profession was to improve diagnostic reliability through the DSM-III, Spitzer was chosen as task force chairman. While during the 60s the majority of psychiatric research and writing focused on clinical work, psychoanalysis and social psychiatry, a research group at Washington University had been developing descriptive, rational rule-driven diagnostic criteria with the goal of inventing a reliable assessment tool (Wilson 1993). This group published what became known as the “Feighner criteria.” Their paper was the most cited in the psychiatric literature through the 70s and 80s (Wilson 1993). The fact that this paper was so popular is, in itself, evidence of the fall of the psychodynamic model of illness as the dominant model because psychodynamic and psychosocial approaches to mental illness exclusively focused on the meaning behind symptoms and disregarded diagnostic criteria and the diagnostic label itself as a key aspect of therapeutic practice.

Spitzer collaborated with this Washington research group on the RDC that was published in 1975. As the chairman of the DSM-III task force, Spitzer handpicked other psychiatrists that like him, embraced biomedical research and rejected the psychodynamic model. Half of the psychiatrists he appointed to the task-force had current or past affiliation with the Washington University research group (Wilson 1993). By the close of their first task force meeting, this small group of like-minded psychiatrists traded the psychodynamic clinical couch for a biomedical laboratory. During the first meeting, these scientists came to consensus on three guiding principles: 1) that etiology would be removed from a classificatory principle since it was unknown; 2) that the DSM-III would be a medical manual applied to psychiatric problems; and that 3) in order to

enhance reliability, the manual would be descriptive and emphasize visible symptoms (Wilson 1993).

Each of these guiding principles would become the focus of social controversy during the revision process, but Spitzer was adept at quelling protestors and criticism from the start.<sup>7</sup> After hearing several criticisms of the significant transformations the small group of psychiatrists on the task-force were single-handedly making for the profession, the APA appointed a Liaison Committee, who proceeded to attack each of the guiding principles of the task force (Wilson 1993). For example, the Liaison Committee questioned the removal of etiological understandings of illness, claimed the task force had been ignoring evidence presented in the literature regarding clinical practice, and noted the key distinction between a classification system and diagnostic manual.

A classification system is used for research purposes and the gathering of aggregate data; a diagnostic manual should aid in the understanding of psychiatric disorders and their treatment. Because DSM-III would have a strictly behavioral orientation and make little attempt to relate the syndromes it described to etiology or treatment, its relevance to clinical work would be minimal. (Wilson 1993:406)

The underlying goal of Spitzer and the 25 committees he established to create descriptions of mental disorders was to turn the DSM into a manual that followed scientific evidence and addressed problems of reliability. Reliability refers to the likelihood that different practitioners using the same manual and seeing the same patient

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<sup>7</sup> While Spitzer would often make recommendations under a veil of compromise in order to silence protestors, several of the recommendations were never adopted. One such example is the companion manual to the DSM that was to focus on models of illness and approaches to treatment. This manual called Project Flower; was supposed to include chapters about each of the major types of psychiatric models or therapeutics. This planned manual was the result of conflict between research and clinical interests, especially between psychoanalysts and the rising biomedical investigators that championed the new DSM-III. While the dedicated work on the manual had started by 1978, it was never finished, and Spitzer claims it was due to a number of complicated reasons (for a full description of this history, see Wilson 1993:407).

will arrive at a similar diagnosis. The problem, argues Spiegel (2005), is that the scientific studies hadn't been conducted yet. Further, while the introduction of the DSM-III made claims of being more scientific in comparison to earlier versions – i.e., that it enhanced diagnostic reliability, it also included the following disclaimer:

It should be understood, however, that for most of the categories the diagnostic criteria are based on clinical judgment, and have not yet been fully validated by data about such important correlates as clinical course, outcome, family history, and treatment response. Undoubtedly, with further study the criteria for many of the categories will be revised. (DSM-III: 8)

However, in the DSM-IV, the admonition that the diagnostic criteria were largely based on clinical judgment and had yet to be validated by scientific evidence was removed, instead adding a “cautionary statement” that claimed the diagnostic criteria were based on knowledge and consensus in their evolving field (Kutchins and Kirk 1997). This seems problematic because studies have shown that neither the DSM-III nor more recent editions have greatly improved and by no means solved issues of reliability. Further, while the makers of the DSM-III took an approach of inclusivity- including any set of symptoms (as disorder) that had been observed by psychiatric professionals, DSM-IV makers adopted the approach that nothing gets changed, added or deleted unless strong scientific basis existed for doing so, thereby solidifying what had made it in to the DSM-III as the scientific foundation (Kutchins and Kirk 1997).

So what are the key elements that made the DSM-III revolutionary for scientific and professional social worlds as well as the larger societal culture of health and illness? A quick laundry list of key changes include the ways in which the DSM-III refashioned the language of psychiatry (from psychosocial and psychoanalytic to a medical taxonomy), explicitly defined mental disorder for the first time, solidified a medical or

biological approach towards diagnosis, added several disorder categories, expanded every section of the manual with the greatest expansion among childhood and adolescent disorders, removed homosexuality as a disorder from the manual, made claims for being scientific and increasing diagnostic reliability and added a list of necessary criteria (symptom checklist) required for diagnosis (Kutchins and Kirk 1997). Each of these changes has made a significant, lasting impact not only on the mental health profession, but on the social framing and response to mental health in general and adolescent mental health in particular.

Thus, American Psychiatry was a profession in crisis that sought to strategically reposition themselves as a medical science through the standardization and operationalization of symptom-based diagnostic categories (Orr 2010; Whooley 2010).

They imported a medicalized framework organized around specific disease entities to formulate the basic nature, causes and treatment of disturbed behaviors. The fundamental premise of the DSM-III was that different clusters of symptoms indicated distinct underlying diseases such as schizophrenia, depression, panic disorder or substance abuse. (Horwitz 2002: 2)

In effect, the new framework of the DSM-III introduced an epistemic order of diagnosis that posited mental disorders are discrete, biological phenomena (Orr 2010). This new order transformed diagnostic practice from professional interpretation and experienced judgment to a formulaic performance of matching symptoms to descriptive checklists, thereby devaluing the therapeutic relationship (Orr 2010). Orr labels this reformulation work the *informatics of diagnosis* and explains that based on the inclusion and exclusion criteria institutionalized in the DSM-III; professional background training, treatment orientations and clinical experience are replaced with performances that mirror computer simulation (Orr 2010:367).

In addition to refashioning the epistemic language and structure of diagnostic practice, the DSM-III created a manual of codes that were soon adopted by managed care insurance companies and lists of symptoms that later were used by pharmaceutical companies to advertise medications for potential disorders.

The widespread adoption of the DSM by researchers, insurance companies, pharmaceutical manufacturers and other mental health professions represents a validation of psychiatry's claim to expertise. DSM codes organize the institutional infrastructure of the mental health field as they are required for insurance reimbursement, hospital admittance, psychiatric research and professional exams. The ascendancy of the DSM has facilitated the proliferation of pharmaceuticals in the treatment of mental illness (Rose 2004), the new big business of these drugs (Healy 1997) and the increased presence of managed care. (Whooley 2010: 453).<sup>8</sup>

Whooley demonstrates the negative unintended consequences the DSM has had for psychiatric professionals' clinical practice through the adoption of the DSM by the for-profit industries of managed care insurance and pharmaceutical companies alike.

In addition to the profession of psychiatry, the pharmaceutical profession had and continues to have a significant stake in the language and structure of diagnosis and treatment of mental illness. The emergence and increased popularity of biological psychiatry and its reliance on pharmaceutical therapy has benefited both professions, but their allegiance has been rightly interpreted as one of a number of adaptations to the changing political economy, namely, the requirement by the managed care enterprise that

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<sup>8</sup> Whooley (2010) demonstrates that the institutionalization of the DSM has actually led to negative unintended consequences for psychiatrists in clinical practice, especially their professional autonomy, and as a result, psychiatrists employ strategies to retain discretion in their daily work practices. As Whooley (2010) argues, in previous research the DSM has too often been presented as a monolithic artifact rather than a tool used in a variety of ways by clinical practitioners. This dissertation examines the ways in which non-psychiatric mental health professionals, those least likely professionally socialized and trained through the dominant biomedical approach to therapeutic intervention to reveal the ways the DSM as technological apparatus factors as an important player in social processes of diagnosis.

treatment for mental illness and its compensation depend on diagnostically specific ailments (Pearlin, Avison & Fazio 2007).

### ***The Pharmaceutical Revolution and the Rise of Corporate Psychiatry***

While the first antipsychotic drug, Chlorpromazine, was discovered in 1952 and the first antidepressant drug, Imipramine, in 1957, the psychotropic medication boom began in the 1980s with the development of the “new” antidepressants known as Selective Serotonin Reuptake Inhibitors (SSRIs) (Horwitz 2002:187). *“The initial tremors of Corporate Psychiatry were felt in the late 1960s and into the 1970s, when Valium became the top-selling drug in America, but this was just a flirtation compared to what was to come later. Corporate Psychiatry began in earnest in 1988 with the introduction of Prozac”* (Barber 2008:61). In his investigation of the history of psychiatry and psychiatric drugs, Barber describes how the effects of Valium were historic because earlier drugs like Haldol, Thorazine and Lithium were taken exclusively in asylums or hospitals, but Valium was prescribed for all sorts of people to enhance their productivity and ability to function occupationally and socially (Barber 2008:26-27). You didn’t have to be severely mentally ill to take Valium, marking a major cognitive shift in professional and public thinking about both mental illness and psychiatric drugs.

This shift in the ideal user of pharmaceuticals for mental problems from the severely ill to anyone suffering any number of broadly defined symptoms of depression or anxiety massively expanded the market for psychiatric drugs. While some of this shift had to do with the rise in biological psychiatry and the compulsion by managed care for psychiatrists to demonstrate specific disorders, symptoms and treatment for reimbursement; pharmaceutical advertising and governmental (de)regulation also



colluded in expanding pharmaceutical markets. Whatever the direct and indirect cause, there is no denying the revolutionary impact the pharmaceutical industry had on healthcare in society in less than a decade. In the transition from the 20<sup>th</sup> into the 21<sup>st</sup> century, Big Pharma did more than climb to the top of the fortune 500 – they reaped profit margins higher than all of the other companies combined (Barber 2008). “. . . *antidepressants have been the most profitable product in the most profitable industry in the most profitable country in the world*” (Barber 2008:24).

Within specialized psychiatric practice alone, between 1985 and 1994 the number of visits where an antidepressant was prescribed nearly tripled, from 4.2 million to 11 million visits (see Olfson et al. 1998). These antidepressants penetrated not only psychiatric and medical practice but also popular culture and everyday discourse, most notably through Peter Kramer’s best-selling *Listening to Prozac* (Kramer 1993) (Horwitz 2002:187).

According to national estimates, antidepressant use increased 73.4 percent between 1990 and 1995, with the majority of this increase coming from prescriptions of SSRI’s (Sleath and Shih 2003).<sup>9</sup> On average, between 1998 and 2002, antidepressant prescription among children increased 9.2 percent each year and even more importantly, the largest year-to-year increase was from 2001 to 2002 at 16 percent (Delate et al. 2004).

The pharmaceutical revolution refers to how increases in pharmaceutical advertising and prescription rates has significantly impacted cultural understandings of where mental illness comes from and how the “problem” can be fixed. Biological, genetic and pharmaceutical framings of mental health and illness are evidenced in “*t-shirts and greeting cards and one-liners about medication for a psychiatric disorder (e.g.*

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<sup>9</sup> A similar estimate found that between 1990 and 1996, the total number of SSRI prescriptions for children and adolescents increased by 69 percent (Shiremen, Olson & Dewan 2002). Finally, a study that evaluated almost a million Medicaid and HMO youths concluded that child and adolescent psychotropic prescription rates nearly tripled since the pre-1990s levels (Zito et al., 2003).

*“Don’ Worry, Take Prozac”*) all suggest that the biological revolution has become entrenched” (Schwartz and Corcoran 2010:65). Mental health and illness in contemporary U.S. society are culturally defined in biological and genetic terms, mental illness is socially framed as a brain disease and pharmaceutical medication is slotted as the right treatment for the job.

The sharp rise in pharmaceutical prescriptions and antidepressants treatment coincides with political and economic trends of neoliberalism. Neoliberal policies in the late 1970s were designed to facilitate corporate expansion, privatization of social services and deregulation of markets (Moncrieff 2006). The model of distress underlying the promotion of psychiatric drugs is useful to neoliberal policies and the languages and practices (discourse) of neoliberal ideology encourages U.S. citizens to see ourselves in biomedical, genetic, neurological or even molecular terms (Pitts-Taylor 2010). Thus, the transitioning biopolitical economy in the late 70s and across the 80s and 90s not only restructured the political and economic institutions such as the government and the U.S. workforce (wages and employment), but all social institutions, knowledges and practices, including those shaping and shaped by health care.

### ***Neoliberalism***

Beginning in the late 1970s and strengthening throughout the presidency of Ronald Reagan, a new pro-business activism and ethic seized the primary institutions within the U.S. (Duggan 2003).

This pro-business activism became the foundation for late 20<sup>th</sup> century neoliberalism, and it was built on earlier conservative activism. Neoliberalism developed over many decades as a mode of polemic aimed at dismantling the limited US welfare state, in order to enhance corporate profit rates. The rising of profit rates required money be diverted from other social uses, thus increasing overall economic inequality. Such diversion required a

supporting political culture, compliant constituencies and amenable social relations. Pro-business activism in the 1970s was built on and further developed a wide-ranging political and cultural project – the reconstruction of the everyday life of capitalism, in ways supportive of upward redistribution of a range of resources, and tolerant of widening inequalities of many kinds. (Duggan 2003:xi)

Neoliberalism refers to a theory of political economic practices and thinking that posits that social well-being is best advanced by liberating individual entrepreneurial freedoms and skills (Harvey 2005). Neoliberal policies and practices have deceptively constructed economic policy as a matter of neutral, technical expertise that has nothing to do with politics or culture, thereby shielding its policies and practices from political accountability or cultural critique (Duggan 2003; Moncrieff 2006). However, any good analysis will show that the political economy does not operate separately from other social institutions in society. Economic goals are embedded in and formulated through political and cultural meanings that shape social organization and cultural context (Duggan 2003).

There has everywhere been an emphatic turn towards neoliberalism in political-economic practices and thinking since the 1970s. Deregulation, privatization and withdrawal of the state from many areas of social provision has become the norm. Almost all states have embraced some version of neoliberal theory and adjusted at least some policies and practices accordingly. It has pervasive effects on ways of thought to the point where it has become incorporated into the common-sense way many of us interpret, live in and understand the world. The process of neoliberalization has entailed much creative destruction of prior institutional frameworks and powers and has challenged divisions of labor, social relations, welfare provisions, technological mixes, ways of life and thought, reproductive activities, attachments to the land and habits of the heart. (Harvey 2005:3).

Within healthcare in general, and mental health care in particular, neoliberalism meant privatization of health care, a shift to mental health policies being driven by fiscal rather than social goals, and rising profitable industries such as the insurance and pharmaceutical regimes.

### ***National Governance of Mental Health Research Funding***

In alignment with the rise in a neoliberal ethic of individualism throughout the 1970s and 1980s, sources of research funding for mental health and illness such as the National Institutes of Health (NIH) and National Institutes of Mental Health (NIMH) increasingly shut out investigations of the social conditions and causes of mental health and illness and instead, increasingly embraced the disciplines and methods of biology, neuroscience and genetic mapping as the right way to investigate mental illnesses (Orr 2010; Pilecki et al. 2011; Schooler 2007). In a chapter dedicated to the history of the Laboratory of Socioenvironmental Studies (LSES) of the Intramural Research Program (IRP) at NIMH, Carmi Schooler (2007) provides evidence of how the changing currents of scientific and medical knowledges and practices significantly restructured government financing of mental health research.

Several classic sociological studies of mental health were researched and written during the 1950s and 1960s and a noticeable proportion of the sociologists were at one time associated with the LSES at the NIMH, including John Clausen, Melvin Kohn, Morris Rosenberg, Leonard Pearlin and Erving Goffman. However, after Melvin Kohn left LSES in 1985, the laboratory was reduced to section status with a significantly reduced budget and labor force (Schooler 2007). Further, Schooler (2007) fears his own departure (retirement), will bring a presence of social science in NIMH intramural program to a close. Not only have sociologists suffered dramatic reductions in funding and number of appointments within the NIH and NIMH across the past few decades, but anthropologists and psychologists that are not biomedically oriented are also near NIMH extinction (Schooler 2007).

In the early days of the intramural research program – from the mid 1950s to mid 1970s – the Laboratory of Psychology, which was dedicated to studying both normal and abnormal adult human psychology, was notably larger than the Laboratory of Socioenvironmental Studies and contained a similar proportion of quite notable researchers. Its remnants are also pretty much reduced to one researcher and supporting staff. The Laboratory of Developmental Psychology, which can be said to have played an equally illustrious role in the study of the psychological development of children, is gone, without leaving a trace. Today the Intramural Program can be fairly characterized as highly disease oriented, biologized, and reductionist- in the sense of seeing human behavior – both healthy and non-healthy—as essentially being determined by interrelated biological, biochemical and genetic processes. (Schooler 2007:57)

Following Schooler's (Schooler 2007) recommendations, one easy way to understand the contemporary scientific financial and social value structure is to examine the listing of research units listed on the public website. Even a quick glance at the list of IRP research program titles demonstrates the disinterest or even disdain the NIMH has towards investigations of how the social environment affects mental health and illness. Another researcher found evidence for a medical model bias of the NIMH by examining the information they provide for the public on various mental disorders and their possible treatments.

For Obsessive Compulsive Disorders (OCD), one common mental illness, the treatment recommendations that were published in early 2009 focused on various psychopharmacological medicines and only mentioned therapy as a secondary suggestion. . . . Several prominent OCD researchers, including one author of this article, submitted a response to NIMH stating that such treatment recommendations are misleading and not based on a totality of relevant evidence. Essentially, medication was emphasized over cognitive-behavioral interventions, which have been shown to be at least as efficacious. . . . It is hard to explain why a drug-based model of OCD is being favored despite clear evidence that other models of explanation and treatment may do just as well, or even better, in predicting treatment outcomes. . . . This oversight by the NIMH is not out of character with the organization's general preference for a biological model of mental illness, to the exclusion of other ways of conceptualizing psychiatric disorders. (Pilecki et al 2011:198).

In contrast to the past few decades in which governmental organizations and funding have increasingly supported biological explanations of health and illness,

Schooler (2007) argues that in the 1960s and 1970s the NIH and NIMH was not only open to social science research programs, but even appointed directors with sociological and social psychological backgrounds. Schooler (2007:60) points to multiple causes for the decline in funding and valuing social science within the NIMH the past few decades: 1) the value system that underlies the prestige hierarchy within the sciences such that the more micro the phenomena under investigation, the higher level of esteem attributed; 2) the perceived successes of methodologies of studying micro level phenomena such as brain imaging; and 3) the increasing influence of corporations and lobbying groups that steer funding towards research on finding cures for specific diseases.

### ***Deinstitutionalization***

Massive deinstitutionalization occurred during the 1960s and 70s as a result of sociological, pharmacological, administrative and legal factors (Thornicroft and Tansella 2009). In the decades that have passed since deinstitutionalization, health analysts have largely come to agree it was one of the worst implemented policies of health care in the history of the U.S. Deinstitutionalization was in fact largely motivated by the critiques of the ill effects institutions had on patient residents such as from Erving Goffman's study *Asylums* (1959). Inappropriate mental hospital admissions were another significant concern with researchers such as Wing and Brown (1970) demonstrating the strong association between the poverty of patients and their likelihood of being institutionalized. However, in addition to these critiques, innovations in patient care such as day hospitals, half way houses, therapeutic communities and antipsychotic drugs enabled communities to care for patients with mental illness (Thornicroft and Tansella 2009). The problem with the deinstitutionalization of mental health care in the U.S. is that the primary goal –

community support systems – was not fully established or maintained to the degree necessary, especially for persons suffering from severe mental illness (Thornicroft and Tansella 2009).

### ***The Rise of Managed Care and Complex Health Corporations***

The emergence, rise and dominance of managed care structures and strategies designed to reform the financing of health care has drastically altered the U.S. health landscape.

Managed Care (MC) emerged in the 1980s as a response to declining government support for public sector health care and the soaring costs of psychosocial and substance abuse treatments in the private sector (Frank, Salkever, and Sharfstein 1991; Scheid 2003).

Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and other group insurance entities were established and have multiplied as have their strategies of external and internal reviews that dictate the type and intensity of treatment services (Manderscheid and Henderson 1996; Manderscheid, Henderson, Witkin, and Atay 2000).

In addition to controlling costs by limiting access to services, MC companies changed the financial structure from the traditional fee-for-service payments to one in which providers are paid a set capitation fee based on a specified range of services (treatments deemed most effective) for a predetermined length of time (Mechanic 1999). Capitation fees are significantly lower in comparison to traditional fee-for-service (30% lower according to one estimate) (Moffic 1997).

Other predominant strategies of cost-containment include: gatekeeping, precertification, case management, and measureable outcomes. Gatekeeping requires patients to get referrals from primary care providers. Precertification or utilization review

requires that services be authorized before they can be provided to clients. Concurrent review or case management involves insurance companies scrutinizing client cases, documentation of treatment services and evaluation of treatment outcomes of providers on a regular or on-going basis. Further, managed care corporations emphasize measureable outcomes and require patients fulfill a criteria of ‘medical necessity,’ which facilitates denials of reimbursement claims. Often these denials are for therapies that have yet to be proven efficacious or are for some reason, devalued Diagnostic and Statistical Manual (DSM) disorder diagnoses (Mechanic 1999; Scheid 2000).

While MC organizations started out primarily in the private health insurance market, over time, they have moved to the public, state and federal market sectors, including Medicaid and Medicare. The effects of MC on the quality and quantity of mental health services is just beginning to be studied for different types of services and populations, but the hallmark change is a decline of inpatient care and increase in outpatient care.

Before reviewing some of the key critiques of managed care, it’s important to note that the prior mental health system had its own flaws.

Patients often lacked access to needed services and commonly received inappropriate care. Patients were put into long term therapies without a clear treatment plan or focused objectives. There were few clear treatment standards and therapy was commonly determined more by clinicians’ preferences than by evidence. . . The overall system was characterized by fragmentation, important gaps in services and little coordination. (Mechanic 1997:45)

In comparison to the previous health landscape, advocates argued MC would improve mental health services by increasing effective use of economic resources and holding mental health providers accountable to high standards of care and improved treatment outcomes. However, past Deputy Executive Director for public policy at the National



Alliance for the Mentally Ill (NAMI) E. Clarke Ross, examined the application of managed mental health care in the public sector and concluded:

. . . other than constraining costs, most managed behavioral health programs have not lived up to their promises. . . In poorly performing public managed care systems, often the managed care vendor lacks a social commitment because of primary obligations to private shareholders or the bottom line [which contributes to the] problems faced by consumers, families and enrollees. (Ross 2000:9)

Thus, the primary criticism of MC is that it undermines social justice through its commodification of health and in the process, demoralizes professional ethics (Scheid 2004). In two articles and a book titled *Tie a Knot and Hang On: Providing Mental Health Care in a Turbulent Environment*, medical sociologist Teresa L. Scheid illuminates the ways in which managed care practices threaten professional logics of health care, autonomy and ethics (Scheid 2004, 2003, 2000). Scheid conducted qualitative interviews and survey questionnaires with mental health providers who worked in both private and public sectors for a decade. She argues that managed care significantly altered the paradigm operating in the health landscape from one based on professional ethics and commitment to community care to one of technical rationality and bureaucratic control (Scheid 2004, 2003, 2000). “*Providers at CARE felt they were not able to provide the treatment or services they believed their clients needed, and they have raised serious concerns about the quality of care*” (Scheid 2003:158).

Rather than adhering to a social or biopsychosocial model of mental illness, managed care imposes a medical model of illness on its providers via privileging treatment goals that focus on short-term improvements at the expense of deeper changes that would provide longer-term stability (Scheid 2003). In addition, a critical

*“consequence of MC is the greater reliance upon psychiatric medication as opposed to more intensive forms of therapy or skills training” (Scheid 2000:709).*

In Scheid’s analysis of interviews with providers in the private sector, she found MC significantly affected the everyday therapeutic work practices, to the extent that some therapists were considering leaving private practice (2000). Providers in the private sector were working longer hours to augment their incomes due to the significant decline in reimbursement fees and yet had increases in administrative duties such as paperwork and phone calls for treatment authorizations (Scheid 2000). However, it wasn’t just the intensity of administrative labor that providers resented; it was that these duties took focus away from patient care, proper supervision, continuing education and the quality of the therapeutic relationship (Scheid 2000). MC is a coercive system because if providers spoke out against a managed care insurance company, they could be (and were) dropped from mental health panels, or put on a provider excluded list (Scheid 2000).

In summary, managed care subjects the treatment decisions of providers and provider-client relationships to increased managerial, financial and bureaucratic scrutiny to the point where both the quality and quantity of interaction between provider and patient are compromised. In addition to harming therapeutic relationships, managed care threatens professional autonomy over their own work.

### ***The Role of the Professions in Transformations of Health Care***

In the past few decades the organization and delivery of health care has undergone significant interconnecting social, political, economic and cultural transformations (Hafferty and Light 1995). These transformations have led to questioning whether or not health care is best organized through the professions (Feldman 2003;

Martin, Currie and Finn 2009; Timmermans and Oh 2010). Opening up the role of the professions in the organization and delivery of health care services is in part based on the fear that professional norms and clinical decision making have been corrupted by the logic of the market and increased consumerism. Several scholars have examined the features of changing organizational contexts and their impact on the normative orientations of health professionals and the social processes of clinical decision making.

Increased attention to the role of organizational contexts and professional norms in shaping the terms and conditions of health care delivery have led to the realization that the professions' relations to capital are complex. It is easy to both over and under estimate the role of the professions in the organization and delivery of health care, and in order to better understand the paradox of the expansion the medical sovereignty and decline of professional autonomy, professionalism needs examined within the larger macro context of the political economy (its relations with the state, economy, other professions, all external actors) and within the micro politics of interaction in day to day work within and across varying organizational settings (see Light 2009; Timmermans and Oh 2010).

The combination of a tightening of revenue streams, rising costs, competitive markets and patterns of variation in both availability and quality of health care situate the role of professions in the center of the contemporary health care controversy. While the government, (federal, state and local) is the biggest purchaser of health care, it is only one among corporate purchasers (insurance and managed care companies), corporate sellers (manufacturers of medical technologies and drugs such as pharmaceutical companies), consumers (including special interest and other consumer groups) and other providers

that have been designated as external forces of power and interest within the Medical-Industrial Complex (Hafferty and Light 1995). In addition to the forces external to professions, the internal dynamics of professions such as increasing specialization, differentiation and substitution, the degree of inter-professional competition and changing demographics within professions have been studied as internal forces within the health care arena (see Abbott 1988; Hafferty and Light 1995; Nancarrow and Borthwick 2005).

## **CONCLUSION**

In this introductory chapter I provided a review of the historical background of the rise in the emergence of adolescent mental disorders as a significant object of scientific study and clinical intervention as well as a review of literatures relevant to understanding the contemporary mental health arena. Following this in chapter two, I set up key theoretical frameworks, analytic concepts, and methodological procedures employed in chapters three, four and five of this study.

## Chapter 2: Theory/Methods Analytical Framework

This study analyzes the technoscientific knowledge-practices of psychotherapy provided to adolescents with mental disorders in the contemporary U.S. Four questions guide this study: (1) how are adolescent mental illnesses defined within and across psychotherapeutic communities of adolescent mental health practice? (2) How do psychotherapeutic practitioners negotiate social processes of diagnosis? (3) In what ways does the Diagnostic and Statistical Manual (DSM), as a biomedical technology, shape the everyday diagnostic and treatment work of mental health practitioners? (4) In what ways does the political economy, specifically, managed care, shape contemporary adolescent mental health care?

In what follows, I lay out my core theoretical and methodological frameworks. First, I provide an overview of the modified grounded theory I employ to analyze 40 semi-structured qualitative interviews conducted with psychotherapeutic clinicians across a Midwestern state and an east coast metropolitan area. Social worlds analysis is a Theory/Methods package that facilitates simultaneous data collection and analysis through two step coding and memo writing processes. This approach utilizes techniques of method based on material social interpretive and feminist standpoint orientations to qualitative research. Second, I describe the procedures of method I used to analyze my qualitative interviews. Third, I provide detailed descriptions of my data. Finally, I review the theoretical frameworks, debates and concepts of Science and Technology Studies (STS), Medical Sociology and the Sociology of Mental Health and Illness. This study builds on the theoretical frameworks and concepts of SI studies of medical practices and

feminist STS that examine science as a shared activity that is accomplished through relationships within and across communities (social worlds). I bridge these theoretical frameworks and empirical studies with the sociology of mental health and illness to make a unique contribution to the literature.

### **THEORY/METHODS PACKAGE: FEMINIST POSTMODERN SOCIAL WORLDS THEORY**

The theory/methods approach of social worlds analysis was designed to expose conflicting interests and commitments in the social aspects of accomplishing work. I deploy social worlds analysis to examine how mental health practitioners grapple with definitions of adolescent mental, emotional and behavioral disorder as a scientific and clinical boundary object and the messiness of the social and political values embedded in biomedical and bureaucratic standardization.

#### ***Feminist Grounded Theory after the Postmodern Turn: Social Worlds Theory***

Glaser and Strauss (1965) developed grounded theory through their research in hospitals on how the medical system and clinical care providers managed dying patients.

Following the tenets of Symbolic Interactionism (SI) and the lessons they had learned through research, they explicated the complex processes of qualitative data collection in the medical setting by emphasizing how the symbolic and social aspects of patients' lives outside of the hospital played a key role in reaching an in-depth understanding of the clinical management of death. Later, they formalized these processes in *The Discovery of Grounded Theory: Strategies for Qualitative Research* (Glaser and Strauss 1967).

The premise of a grounded theory approach to social research is that theoretical explanations of social phenomena are grounded in and emerge through empirical research. Although it was originally developed as a single research approach by both

Glaser and Strauss, they later disagreed, causing grounded theory to develop in multiple directions. Barney Glaser, originating what came to be the Glaserian tradition of grounded theory, holds to a more positivist and structuralist orientation toward perceiving the outside world as waiting to be discovered.

On the other hand, Anselm Strauss and his student, Juliet Corbin (see 1998), developed a grounded theory tradition built on a more social constructivist epistemological framework – one that grapples with the way that researchers and research participants, or even the observed, make meaning together and how there are multiple levels of interpretation. This theoretical difference has become known as the interpretive turn – and points to the notion that there is no complete objective standpoint or empirical truth that is waiting to be observed by a neutral observer (see Charmaz 2006; Denzin and Lincoln 2000). In this study, I use a modified version of grounded theory – one that has followed Anselm Strauss’s turn to social worlds analysis and feminist and postmodern turns in social theory.

The different approaches to “doing” grounded theory can be simplified in terms of their standpoint in relation to a more or less positivist or social constructivist approach in their work (Clarke 2005:2). The grounded theory employed in this study utilizes techniques of method based on material; social interpretive and feminist standpoint orientations to qualitative research (see Clarke 2005; Charmaz 2000; Casper & Clarke 1998; Clarke & Montini 1993; Clarke 1990; Naples 2003).<sup>10</sup> My approach to using

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<sup>10</sup> See Denzin and Lincoln (1998: 27) for a table, typology and explanation of interpretive paradigms of qualitative methods.

grounded theory follows the poststructuralist turn to discourse theoretically, which facilitates explicit attention to discourse as it is produced and enacted.

Strauss (1978) introduced the notion of “social worlds” to identify a research situation of a group committed to or oriented around a key set of activities. In the case of this dissertation, social worlds involve mental health practitioners who diagnose and/or intervene in adolescent mental, emotional or behavioral disturbances. There is a long tradition within SI medical or science studies of examining science as a shared activity that is accomplished through relationships within and across social worlds. In this sense, the science and clinical intervention of adolescent mental disorders are a scientific and technological activity.

Within this version of grounded theory (situational or social worlds analysis), the goal is to understand the elements of a situation or the social worlds involved in an arena of action and their relations within it. Also, subjects and objects are decentered, meaning that methodological attention is paid to actors and actants, including cultural objects, technologies, media and non-human entities. The social worlds theory/methods package approach prioritizes examination of the relationships of animate and inanimate things as they work together in constituting situations. Thus modified grounded theory is an empirical approach to studying social life via qualitative research and analysis.

In her book *Situational Analysis*, Adele Clarke (2005) argues that in many ways, grounded theory has always been (theoretically) beyond the postmodern turn due to its symbolic interactionist roots. For instance, foregrounding deconstructive analytic interpretations such as open coding and multiple interpretations and attending to multiplicities are core tenets of SI that have influenced grounded theory. Also, Mead’s



(1934) notion of perspective and the social self influence grounded theory principles of attending to negotiations and relational forms of analysis.

Following these core SI properties, Clarke (2005) modifies grounded theory to take up theoretical turns toward feminist postmodern epistemologies. Her work illustrates core feminist postmodern assumptions such as the situatedness of all knowledge producers, recognizing heterogeneities and the importance of discourses. This study is theoretically and empirically situated in feminist STS literatures and goals. Therefore, modified grounded theory of social worlds that has SI and constructivist roots but attends to postmodern feminist concerns facilitates the analysis of the definitions, practices and relationships at the heart of my study.

#### **PROCEDURES OF METHOD**

Grounded theory is an analytic process that assumes that data collection and analysis are carried out simultaneously and are consciously (by the researcher) put into conversation with one another by conducting a two-step data coding process, comparing sections of data to one another and by writing memos. These procedures of method are carried out with the goal of working through conceptual issues, emergent themes, patterns and gaps between the data and what is understood about the relationships that are being examined (see Charmaz 2000:510-11). Following these strategies, I employed the method procedures of two-step coding and memo writing processes.

These procedures are the concrete techniques which facilitated the analysis of emerging patterns of adolescent mental disorder definition, diagnosis and treatment across disciplinary psychotherapeutic social worlds. Relationships between contexts of care of different mental health professionals, their theoretical orientations, the work-

around them they employ in negotiations of the DSM, and diagnostic standardization emerged by engaging the discourses of my data sources.

### ***Coding and Memo Writing***

I followed two-step coding procedures. I started by performing line-by-line coding of single documents. As particular themes or “codes” emerged repeatedly or in relation to one another throughout the line-by-line coding of documents and interview transcripts, I authored memos which put my research questions into dialogue with these emerging thematic codes.

Memos are reflections that tracked my theoretical understandings of the disciplinary social worlds and the discourses they produced about adolescent mental disorder. I continuously moved back and forth between coding documents, interview transcripts, reading the literature, and writing memos until I began reaching theme saturation. Theme saturation occurred when new coding categories ceased emerging and the codes already emerged repeatedly accounted for “what was going on” in the discursive renderings about definitions of adolescent mental disorder, diagnostic processes, the DSM as a technological actant, EBPs, interdisciplinarity and MC. In this iterative process, I produced some memos which focused on particular disciplinary social worlds—and compared how the discourses of the published disciplinary documents mapped onto or diverged from the interviews with professionals from similar disciplinary backgrounds. I sought out patterns both within and across these disciplinary worlds, and wrote memos that focused on content, context, convergence/consensus and divergence/contestations. Thus, throughout the iterative deconstruction and analytic process, I produced some written memos about singular documents or particular

theoretical orientations and some about constellations of documents from particular professional worlds or about particular emerging issues that crossed over multiple worlds (issues with MC).

Early memos were more explorative and asked questions of the data, and put the research questions in dialogue with the discourses studied. As analytic work continued, memos became more refined and explicitly set out to answer research questions and move towards coherent data chapters. Through the employment of these techniques of analysis, discursive themes emerged that rendered the relations across multiple mental health professionals, their knowledges and practices surrounding adolescent mental disorder diagnosis and treatment, visible.

#### ***Descriptive Information on Data Source***

This dissertation analysis is based on social worlds analysis of 40 in-depth semi-structured interviews with mental health professionals. The interviews were conducted from the winter of 2009 through the fall of 2010 in a Midwestern state and a large east coast metropolitan area. Respondents were recruited using a snowball sampling methods, starting with contacts I had from previous work experience in the field.

When I began my study I reached out to professional contacts I had acquired from working as a paraprofessional in the adolescent mental health field for six years before going to graduate school. Some of my previous contacts connected me with other mental health professionals and four of them participated in the study themselves. Each of these four respondents had worked with me in some capacity at a Residential Treatment Center (RTC) for a large non-profit mental health care organization in a mid-sized city (population around 300,000) in a Midwestern state.

In addition to professional contacts I already had in the field, I reached out through my informal loose tie network of acquaintances to find out who they knew working in adolescent mental health care. I had people send me the email addresses of mental health professionals. I sent emails to these loose ties explaining the project and only continued contact if they expressed interest in taking part in the study. Once I conducted an interview with a mental health professional I used snowball sampling methods to acquire new interview respondents.

The sample consists of mental health professionals who worked in some capacity with adolescents diagnosed with mental, emotional or behavioral disturbances. Initially I intended to only interview mental health professionals who worked in out-patient clinical office settings. However, as the study progressed, discussions of schools and school therapy repeatedly came up during my interviews. Some of the out-patient clinicians I interviewed worked in schools one day or afternoon a week in addition to their work in out-patient clinics. Schools emerged as an important site of study from processes of conducting and transcribing interviews and writing memos, and thus my original conception of the desired respondent characteristics were broadened to include psychoeducators and counselors, social workers and psychologists who worked in schools.

As is true in the general population, the majority of mental health professionals I interviewed were white women: 35 women, 5 men; 35 white, 3 African American, 1 non-white Hispanic and 1 Native American. See Appendix A for information on sample characteristics. The mental health professionals I interviewed had diverse disciplinary and professional backgrounds, degrees and theoretical orientations. While I had originally

set out with the orienting framework that practitioners from different disciplines or professional backgrounds were likely to approach adolescent mental health and illness from uniquely different theoretical models or orientations, I struggled to find concrete patterns across disciplines. See Appendix B for information on disciplinary backgrounds and theoretical orientations and their overlap. I refer to the mental health professionals who comprise the communities of practice or social worlds in my study as psychotherapists and MHPs because what they all had in common was that their everyday work was structured around some form of psychotherapy (although the form it took varied by context of care). In addition to a diverse set of professional backgrounds and theoretical orientations, MHPs varied widely in years of experience as an adolescent mental health professional. The range was 2 to 43 years of experience in the field, with the 14 years mean average, 13 years median average. Ten practitioners (25%) of my sample had less than 10 years experience while 15 practitioners (almost 38%) had 15 or more years of experience.

Interviews were semi-structured and conducted in various public, school and office settings. Interviews lasted anywhere from 40 minutes to two hours. Two interviewees that had each been in the field as clinicians for over 15 years were interviewed twice. These two interview respondents were among a group of four interviewees whom were extremely knowledgeable and articulate about their field and their everyday clinical work, and thus heavily shaped the analysis. Prior to starting the interviews, research participants were asked to read informed consent documents which asked permission to record the interview. Every participant received a copy of the informed consent form while I acquired a copy with their signature. See Appendix C for a

copy of the consent form. Each interview was conducted using the same semi-structured interview guide (see Appendix D for a copy of the interview guide).

Interviews were recorded, and started with a general section about the professional background of the research participant. An important aspect of this study was to understand the ways in which disciplinary training and professional socialization shaped the definitions of adolescent mental health and illness. The beginning of the interview guide entailed questions about duration in the mental health profession, background professional education and training and how their discipline and approach to providing adolescent mental health services had changed since they entered the field. The second section of the interview guide asked about their definitions and approaches to adolescent mental illness, their professional and disciplinary memberships and interdisciplinarity. This section allowed me to successfully tap into mental health professionals' theoretical orientations towards adolescent mental illness and the significance with which their professional background shaped these orientations and approaches to treatment. Further, this section yielded information about the costs and benefits of the interdisciplinarity of the field.

The third and fourth sections of the interview guide focused on diagnostic and treatment practices, including the ways in which the DSM was understood and utilized in diagnostic processes. As themes emerged through the interviews, I added a few questions to these sections of the interview guide. For example, after almost half of my interviews were completed and V codes had emerged as a significant contentious issue for practitioners, I added a question about them on the interview guide. V Codes are diagnostic codes that cannot be given as legitimate diagnoses, but are often used as

secondary diagnoses to provide clinicians and other professionals with information about the social contexts of mental illness. V codes encompass relational and other social environmental disturbances such as parent-child or sibling conflict, neglect, abuse, school problems and more. Several practitioners thought V codes should be legitimate (reimbursable) diagnoses, and thus I followed the data by asking other professionals if and when they used them and the role they played in processes of clinical diagnosis and treatment.

The final section of the interview guide focused on professionals' evaluations of the larger field of adolescent mental disorder services. While the third question in this section was about Managed Care (MC), there were very few interviews where MC had not already emerged as a significant theme in the interview. MC emerged as the thematic code of analysis that was connected to everything else including the ways in which the field had changed, how treatment plans are written and had changed over time and how the DSM has been utilized to standardize diagnostic practices.

#### **DATA ANALYSIS: FEMINIST POSTMODERN GROUNDED THEORY**

In this study, theory and research are a package approach that shape data analysis. Theory and methods are intimately intertwined in this study through interpretive, postmodern and feminist standpoint turns in social theory. Thus, this study takes a constructivist SI approach that follows these theoretical turns in focusing on deconstructive analytical interpretation, (open coding and enabling multiple interpretations), orientation towards social actions such as negotiations, discourse, and the ways in which discourses are produced and enacted (see Clarke 2005). Discourse is defined as knowledges and practices that are forms of social action (Clarke 2005). This dissertation analysis builds

on a long tradition of SI constructivist, medical and STS studies that examine science as a shared action that is accomplished through relationships within and across social worlds of psychotherapeutic mental health professionals. Next, I review key theoretical frameworks of constructivist, SI, feminist STS and medical sociology studies that facilitate examination of adolescent mental disorder knowledge-practices as scientific and technological activities. My unique contribution is to apply this SI, feminist STS approach to the sociology of mental health and illness.

### **SOCIAL STUDIES OF SCIENCE, MEDICINE AND TECHNOLOGY: THEORETICAL REVIEW**

The sociology of health and illness and STS both have distinct intellectual histories yet can be considered sister sub-disciplines due to their overlapping research questions and methods of inquiry. This is where I situate my dissertation. Rather than a thorough review of each of these fields and the ways they overlap, I lay out theoretical concepts relevant to my study and develop the analytic framework for the empirical chapters that follow.

#### ***Social Constructivism***

Social Constructivism refers to the notion that knowledge is created through human interaction. Social reality is accomplished rather than given by humans collectively defining and acting in social situations (Berger and Luckman 1966). Studies of how science, medicine, medical technologies, health and illness are constructed offer a lens into the dialectical relationship between them and the social-historical forces with which they interact. A social constructionist framework examines the historical and social shaping of ‘truths’ and ‘common-sense knowledge’ which comprise contemporary culture at any given time. Social constructionist studies start with the contention that all



knowledge, including health and illness or disease categories, are not natural products of objective science but instead are created out of particular historical and political circumstances (Clarke 2001).

In *Science Studies: An Advanced Introduction*, David Hess (1997) argues that a large majority of science studies scholars posit a moderate constructivist stance, or the balanced view that both the social and the material shape knowledge production. Scientific theories are both representations of the material world and operate as vehicles through which social values and local culture are transmitted (Hess 1997:35-36). Most moderate social constructionists do not question the material reality of disease or illness but focus on the way these experiences are known and interpreted through social meanings and practices (Lupton 2003; Conrad and Barker 2010).

An early theoretical move by social scholars of health and illness was to distinguish illness from disease precisely because the expert medical categories did not capture the subjective experiences of illness (Kleinman et al. 1978; 1988). Following pragmatism and the tenets of Symbolic Interactionism (SI) (Mead 1934; Goffman 1959, 1961), Anselm Strauss and his colleagues (1963, 1965, 1967, 1978) began examining how people who were ill made sense of, embodied and managed their illness in conjunction with other aspects of their lives. Over time, social constructivism was used to understand how subjective illness experiences, presumed “objective” diseases and other medical facts were shaped by social values and processes. This is closely aligned with STS because the object of study is how biomedical categories of disease and methods of intervention are socially created, negotiated and interpreted (Conrad and Barker 2010; Joyce 2008; Timmermans 2007).

In contemporary STS, the term “construction” is worn-out to such an extent that new terms have arisen up to restore some value and specificity to the theoretical and methodological frameworks used (see Aronowitz 2008; Jutel 2010; Sismondo 2007). Sismondo (2007) notes that terminology such as framing, constitution, organization, production, and manufacture have all been used to convey the social construction of facts and artifacts. Despite the particular term used, the main tenets of contemporary social constructionist studies of science and technology include a questioning of taken-for-granted realities and objectivity; an understanding that the concepts we use to interpret the world are historically and culturally specific; and that science, medicine and technology are inherently social and active, and rather than being natural, are made (Clarke 2001; Sismondo 2007).

Social constructivist studies have contributed to STS in several ways, but important for this study is how science has been conceived of and studied as a form of culture as opposed to a special form of truth that exists outside of social practices (see Law 2008:626). Social constructivist studies of scientific knowledge take the content of science, including the theories, methods and more recently, the practices and tools involved in its production, as the focus of examination. Thus, constructivist researchers study science, medicine and technology in the same ways as they examine other areas of culture because the underlying assumption is that all knowledge, even scientific knowledge and technologies, are created through collective social processes, or social relationships.

### ***Symbolic Interactionism (SI)***

Considered both a theoretical and methodological approach to knowledge, the self, and human interaction, Symbolic Interactionism emerged out of American Pragmatism.

Building on the ideas of William James (1879), Charles Horton Cooley (1918) and George Herbert Mead (1934) theorized how the mind, self, and society arise out of and are sustained through human interactions. Mead (1934) posited both the mind and the self as social processes capable of using symbols, rehearsing lines of action and choosing among the possibilities. Thus, individuals perceive and interpret gestures and the self arises as individuals symbolically represent themselves as objects, while at the same time society emerges out of organized and coordinated activities.

After Mead's death, Herbert Blumer took over his social psychology course and coined the phrase "Symbolic Interactionism," becoming as influential to the frame as Mead had been. His three premises of SI are: 1) humans act toward things on the basis of the meanings that the things have for them; 2) meanings of things are social products created through human interaction; and 3) meaning occurs through a process of interpretation used to guide actions within situations (Blumer 1969). Blumer (1969) advocated for exploration and inspection as preferred SI methodologies and was primarily concerned with linking social behavior to elements of social structure.

The SI frame has often been conceived in a polarized fashion as the Chicago versus the Iowa schools of thought. However, according to Jonathan Turner (2006), all Symbolic Interaction frames converge on the following four premises: 1) humans create and use symbols; 2) humans use symbols and gestures to give common meanings to things; 3) the generalized other mediates social control and change by individuals taking on the roles of "others;" and 4) interaction, humans and society all emerge and become

defined through each other. Individuals can assess and sort out various lines of conduct based on the definitions of the situation which are continuously created over time through on-going interactions. Symbols and meanings of particular situations ultimately evolve into taken-for-granted and routinized practices (Blumer 1969; Fine 1992; Stryker 1980; 1988).

### ***Constructivist, Symbolic Interactionist Framework***

For the past four decades constructivist SI scholars have analyzed the social processes involved in medical practices, including the role of technologies within medical practices (see Glaser and Strauss 1965; Charmaz 1991; Timmermans 1999) (Casper and Morrison 2010). My study follows this intellectual tradition in examining the medical practices of mental health care work, and the role the DSM as technology plays in that work. At the intersection of symbolic interactionist medical sociology and STS, scholars have developed key concepts such as negotiated order (Strauss 1978), work-arounds (Clarke and Casper 1998), boundary objects (Star and Griesemer 1989), infrastructures (Bowker and Star 1999), bandwagons (Fujimura 1988, 1996), and the right tool for the job (Clarke & Fujimura 1992) in order to help shed light on the social aspects of medical practices (Casper and Morrison 2010). In this section, I briefly explain a few of the key concepts and foci of this theoretical tradition on which my work builds.

A social constructivist SI framework examines science, medicine and technology as work and work activities organized in particular cultural spaces, using particular materials and techniques (Fujimura 1988). Monica Casper reviews how SI studies commonly focus on the diverse aspects of science and medicine related to work tasks, tools and other materials, thereby situating scientific and medical work as accomplished

through social processes and actions (1998:30). She identifies two crucial interactionist concepts: (1) Mead's (1934) notion that people live and work within contexts of meaningful objects, and therefore objects are social products that are created via definitional processes of social interaction; and (2) Strauss and colleagues' (1964:176) concept of negotiated order which describes the way that social order continually emerges or is negotiated and renegotiated through human actions that become patterned or routinized across time (1998:31). In following these highly developed interactionist concepts, Casper (1998) developed the notion of work objects and theorized the ways in which multiple consequences flow from the diverse meanings attributed to work objects in medical practice.

Clarke and Casper (1996) developed the term "work-arounds" to denote the emergent local solutions to problems that are posed by standardization. In his award winning article that examines how psychiatrists negotiate diagnostic standardization, Owen Whooley (2010) uses the concept of work-arounds to demonstrate the strategies employed by psychiatrists to respond to and alleviate their ambivalence for the bureaucratization and biomedicalization of the DSM. I discuss Whooley's (2010) work in chapter four and build on his analysis of work-arounds to show the ways that non-psychiatrist mental health practitioners negotiate the DSM as a biomedical technology.

I utilize the concepts of negotiated order and work-arounds in analyzing how mental health practitioners accomplish the work of defining, diagnosing and intervening in the mental, emotional and behavioral disturbances of youth. The concept of negotiated order refers to the capacities of different actors to protect their own interests and to achieve their goals while acknowledging and acceding to others' interests (Strauss 1978).

Thus, a negotiated order is a set of working arrangements within an arena (Strauss 1978), which does not mean that the actors have reached consensus or are free from competition or conflict. I use the concept of negotiated order in examining the way that mental health practitioners have conflicting interests and commitments in their negotiations of diagnostic practices in general and the DSM in particular. Even though most practitioners must operate under diagnostic standardization, there is interpretive flexibility within and across sites of practice.

Another key area of work for interactionist STS studies of medical practices is the focus on classification systems, standards, protocols and contingencies of practice. Susan Leigh Star and Geoffrey Bowker (1999) examine how every single standard, category or classification valorizes one particular point of view while silencing others, yet in everyday real life practice, whether inside or outside the clinic, we commonly struggle with things that do not fit. The problem with things not fitting is that social and moral values are embedded within classification systems and thus both classification work and standards have material consequences.

While standards are similar to classification systems, Bowker and Star (1999) define them as distinct entities. They define standards as: (1) agreed upon rules for production of textual and material objects; (2) span more than one community of practice or site of activity, have temporal reach and persist over time; (3) are deployed in making things work together over distance and heterogeneous metrics; (4) legal bodies often enforce standards, be these mandated by professional organizations, manufacturers' organizations or the state; (5) there is no natural law and the best standard shall win and (6) have significant inertia and can be very difficult and expensive to change.

Standards embody goals of practice and production and are never perfectly realized . . . Classifications may or may not become standardized. . . Every successful standard imposes a classification scheme, at very least between good and bad ways of organizing actions or things. The work-arounds involved in practical use of standards frequently entail use of ad hoc nonstandard categories. (Bowker and Star 1999:15-23)

The classification system of the DSM and the formalized standard of requiring a DSM code for a legitimate diagnosis and thus for reimbursement for care are at the heart of my examination of mental health care practices. Following this intellectual tradition, I examine the DSM classification system as a biomedical technology and the way that practitioners employ work-arounds in negotiating the order of diagnostic practices and the biomedical infrastructure in which it is embedded. Only examinations of how practitioners tame, unleash, or work-around contemporary diagnostic standards in their particular setting of practice reveals the messiness and complexity of their work.

In summary, my work builds on the following five major assumptions of interactionist science studies: (1) scientific facts, findings and theories are socially constructed; (2) knowledge represents and embodies work or particular ways of organizing the world and STS is concerned with the processes by which scientists develop standard procedures and patterns of commitments; (3) science is a matter of work, organizations and institutions; (4) scientific work is like other social activities; and (5) there is an insistence on multiple perspectives and a concern for silenced and deleted perspectives, thereby making itself compatible with feminist approaches that are inherently concerned with marginalized outsiders (see Van House 2004:25-27).

### ***Feminist Epistemologies***

While there is no distinctive feminist theory or method of inquiry, there are a few distinctive characteristics of feminist analyses (Harding 1987). First, feminist

theory/methods are studies done by and/or about women – they begin with something that appears problematic from the perspective of women’s experiences. Second, feminist analyses connect the purpose of their research to their research subjects and thus their research questions and research subjects are guided by a purpose of furthering knowledge by or about women or gendered experiences. Third, feminist analyses explicitly locate themselves in relation to their subject matter. Feminist analysis is an approach to studying the social world, not a unitary method (Reinharz 1992).

Underneath a feminist framework there are multiple research methods that are guided by different lines of feminist theorizing. However, there are general trends within feminist research towards interdisciplinary and transdisciplinary scholarship, aims to create social change, attention to difference and diversity in representations and researcher reflexivity (Reinharz 1992). Feminist analyses attend to local settings, multiple social worlds, and deconstruct the assumption of a single society, culture or even, woman or feminism. Further, feminist analyses focus on both multiple and partial knowledges, including an explicit attention to relations of power or dominant versus subjugated knowledges.

Feminist epistemology, also known as standpoint theory, is a problematization of how knowledge and truth are bound by relations of power that operate in all knowledge contexts. Dorothy Smith (1974) was one of the first feminist sociologists to identify how traditional theories and methods of sociology was built on and within a male social universe, thereby discarding women’s experiences and how they might be different, indeed how sociology would be different if modes of inquiry emanated from a woman’s standpoint.



Smith's (1987) project in *The Everyday World as Problematic: a Feminist Sociology*, was to create the space necessary for there to be a different kind of epistemology operating in the field of sociology and among feminist scholars. Smith (1987) revealed how the principles of universality (rationality) and neutrality (impersonal) that operated in the field of sociology and in the wider public sphere were gendered – i.e. the rulers of academia and the public sphere's social relations were men; and thus women had become confined to the subjective. Smith's concept of bifurcated consciousness refers to how the professional sociological vision of ordinary reality was a mode of consciousness controlled by men; the actual experiences of women were repressed and experienced as some "other" form of consciousness. The organized practices of society bring into relation particular forms of understanding between the knowers and the known, and Smith (1987) challenged this traditional way of knowing in order to create a space where the experiences of women, as located inside their body, in particular places in the everyday world, could be expressed and validated as "knowledge." Smith (1990) extended Gouldner's (1970) concept of reflexivity by making the everyday world of women as the problematic of sociology, allowing for the material-social relations of women to be explored as an area where knowledge exists, thereby reconfiguring the traditional object/subject of study as a place in which searching for knowledge and understanding began from within women.

Patricia Hill Collins is one of the most influential standpoint and intersectionality theorists. The term intersectionality refers to the way in which each social identity such as gender, race, age, sexuality, social class, and others, intersect to confer advantages and disadvantages. In theoretical and empirical analyses, the focus can be on individuals,

groups, institutions, policies or discourses and practices, but the goal is to understand how social structures organize relations of inequality and how diverse groups and positions within those structures produce uneven experiences. For examples of theoretical and empirical intersectional analyses, see Collins 2000; Dill 2009; McCall 2005.

Collins' (1990) standpoint theory is about the project of furthering critical social thought on group formation and power relations within the social structure of society. Collins' takes Smith's reconfiguration a step further by claiming that sociology was still excluding black women and their standpoints. Collins set out to show how *Black Feminist Thought* as oppositional and subjugated knowledge, could inform a critical social theory (Collins 1990).

What both Smith and Collins are concerned with is how to create a space within social theory where the subject/object divide disappears and the reflections and experiences of those researched do not. Collins's standpoint epistemology is based on the notion that social groups are situated within unjust power relations; and although each member of a social group may not experience the same thing or have a similar standpoint on any given issue, it is the position within the overall structural relations of domination and subordination that gives any social group a "standpoint." Collins demonstrated that intersectional thinking is a useful heuristic device for describing the patterns of social organization (for making structural power dynamics visible). Standpoint theory connects the previously invisible subjectivities of Black women at the meso level of power relations through their shared experiences of subjectivity. As such, Collins theoretically mediated between the micro and macro contexts of subordination, domination and all of the complexities of personal and group identities when dealing with relations of power in

society. Her concept of “outsider-within” explicated the ways in which black women were situated yet treated as outsiders subjugated within their own communities (1998).

Donna Haraway’s influential feminist epistemology is widely known as “situated knowledges” – a concept she utilizes to convey that all knowledge is partial and socially situated (2004). To Haraway, objectivity and feminist standpoint theory is about situating our knowledge from within ourselves. Situated knowledges offer partial perspectives that are more accurate and that demand the investigator to become accountable for her claims.

Key questions of feminist epistemology include: Who can know and by what means? Who can be the knower? What can be known? Feminist epistemologies have created strategies for justifying knowledge claims that include triangulating multiple data sources, methods and tools; collaborative research projects, researcher reflexivity, integration and examination of the connections between the personal and social; and an engagement, responsiveness and accountability to the people studied. Thus feminist epistemological studies tend to be transparent in their presentation of data and analysis, focus on disenfranchised groups, are accountable to their subject matter and the implications of the knowledge claims their work produces. At the forefront of feminist epistemological concerns are the worlds that are produced by scholarship, due to the explicit recognition that all knowledge has material consequences.

The theory/praxis of Haraway, Smith and Collins re-configures the material relations of knowledge production such that the credibility of all constructions of reality are regarded as needful of explanation (Hernstein-Smith 2006). This reconfiguring is not about reordering knowledge producers in an attempt to create a new hierarchy of ideas, but instead, is about democratizing the process of how knowledge is produced (by whom,

and in what knowledge contexts). Feminist epistemology assumes that theory and practice are bound together and thus produce situated knowledges. This reconfiguring of knowledge as a socially-situated process allows for sociologists to investigate how beliefs about the world are socially shaped, constrained and stabilized (situated) (Hernstein-Smith 2006: 101).

### ***Key Concepts of Feminist Social Studies of Science, Medicine and Technology***

Given that social studies of science, medicine and technology are interdisciplinary and draw from multiple traditions of theory/methods, there is no unitary origin story or easy way to characterize the entire field. In this section I review key aspects of STS that shape my data analysis.

From the earliest development of the field, STS scholars have been committed to studying the social content of science. Charis Thompson (2005) describes how a large majority of STS scholarship has examined the interdependence of knowledge production with the classification and evaluation of persons and things in various naturecultures.<sup>11</sup> Early studies of STS interrogated the social aspects of the content of science, but in more recent decades, STS theory/methods has turned toward examining science in the making, or how scientists arrive at “facts” (Thompson 2005). As already discussed in detail, one such theory/methods approach is social worlds theory, which traces the flows of people, practices and knowledge claims as they occur around a shared object or arena of concern (Thompson 2005). Examinations of science in the making are labeled the ontology of science. This strain of STS scholarship focuses on how technoscience matters for our

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<sup>11</sup> For a more in-depth review of STS scholarship that examines naturecultures, see Haraway 2004, 1997, 1991, 1989; Law 2004).

everyday living in the world. A different theory/method approach that is also popular is Actor Network Theory (ANT).

ANT is well known for being concerned with science in the making and attending to the ways in which science and nature are interdependent (Thompson 2005).<sup>12</sup> Actors, or more commonly referred to as actants (actors may be human or nonhuman), coordinate or work together in heterogeneous networks to resist and accomplish scientific knowledge production. Within this kind of STS scholarship and the ANT tradition, there has been a turn towards laboratory studies or following the practices of scientists and practitioners to understand how particular versions of the world are made. A key concept taken up across STS studies is the notion of black-boxing – the process by which knowledge comes to be accepted or taken-for-granted even though many do not understand how it came to be that way, and even more importantly, often, it could have been otherwise. In other words, within STS, scholars examine how it is that one technology, protocol or model came to be accepted and how others have become hidden from view. Bruno Latour (1999) argues that ANT is not a theory at all, rather it is a heuristic that is part of a larger materialist turn within social theory that recognizes the critical role that material objects play in the production of facts and social order (Harbers 2005:26-28). This aspect of STS is intimately connected to standards and routines of practice, including the processes through which social networks play a role in constituting the particularities of how knowledge is made. A feminist STS version of scholarship focused on science in the making is Donna Haraway's (1990) development of

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<sup>12</sup> Latour, Callon and Law are the originators of ANT (see Callon 1986; Callon, Law & Rip 1986; Latour 1987; Latour & Woolgar 1986; Law 1986, 1990, 1992, 2001; Law & Hassard 1999).

the concept of the cyborg. The cyborg is a great example of the way feminist technoscience scholars explore the ontology of science – by examining the intersections of gender, race, and naturecultures. Even further, an early articulation of the ontology of science is found in Haraway's theory of situated knowledges where she explicates that partial perspectives are actually better versions because they are truths which are situated in particular naturecultures, and thus have accountability.

Haraway proposes an alternative form of modest witnessing – one that is partial, can be located in specific cultural context and is accountable. Feminist versions of STS, in their poststructural and cultural turns (and ontological politics of technoscience), argue that both material realities and discursive representations of those realities are enacted or performed simultaneously (Law 2008; Mol 2002).

The basic proposition that comes from STS and its cognate disciplines is this. Since the real is relationally enacted in practices, if those practices were to change the real would also be done differently. Foucault tells us this. He talks of the conditions of possibility set by an episteme, and then of heterotopic spaces that lie at or beyond the margins . . . more or less different realities are being done, moment by moment, in those different practices. (Law 2008:635-36)

While Haraway (1997, 1999) and Mol (1999, 2002) have different vocabulary and to some extent, politics, both are feminist STS scholars whose attention to multiplicities of and differences within social practices are important. Haraway (1997) and Mol (2002) both position themselves as modest witnesses that interfere so that perhaps the more humane versions of reality or practices with less subjugation have a better chance of being reproduced.

A more recent concern within STS scholarship is the interrogation of how various scientific truths co-constitute particular versions of nature, politics and identity (Thompson 2005). This strain is associated with the label “coproduction” to point out

how knowledge is always political, and this strain of scholarship deconstructs how coproduction plays out in various sites of scientific practice and standardization. This strain of STS takes seriously the claim that every scientific production, story, routine set of standards and practices privilege some version of reality and silence or minimize others. The notion of coproduction of science, technology and society conveys that social, political and moral relations are embedded in scientific knowledge and technological systems – they are constituted in one and the same historical process (Harbers 2005:257, see Fishman 2004; Taylor 1995).

In addition to analytic attention to coproduction, STS has taken a turn towards examining the social construction of technologies. Thus, scholars increasingly use their interactionist constructivist theory/methods to examine the content and making of technologies (see MacKenzie and Wajcman 1999; Star 2002; Williams and Edge 1996; Van House 2004). Information and biomedical technologies have restructured contemporary medical practices (Casper and Morrison 2010). Information technologies have become central to health care practices, financing, politics of reform and outcomes (Casper and Morrison 2010:S121). At the intersection of sociology of health and illness and STS studies, biomedical technologies have been examined for how they reshape medical practices, reconfigure human bodies and personhood and our understandings of them, and have contributed significantly to newer health social movements (See Balsamo 1996; Casper and Morrison 2010; Dumit 2004; Joyce 2008; Loe 2004; Saetan et al 2000). Casper and Morrison (2010) illustrate that empirical findings about medicine and medical technologies are as much about *how we know* – or the diverse array of theories,

concepts, and methods that have been used to understand medicine, medical technologies, health and illness, as *what we know* (Casper and Morrison 2010).

Social studies of technology, including SCOT approaches, argue that technology is mutually co-constituted with the social. The SCOT approach, developed by Pinch and Bijker (1987), focuses on the producers and users of technological artifacts in order to show how the meanings of artifacts vary across groups. The concept interpretive flexibility (Pinch and Bijker 1987) was coined to explain how technologies can be used and understood differently – i.e. that different users attribute different functions, abilities and properties to them (Brey 2005).

Within STS, both SCOT and ANT approaches have been criticized for attending more to the development of technologies and less to the appropriation and usage of technologies or the users, including the differential power dynamics involved in who uses the technology and under what circumstances (Wajcman 2000; Van House 2004).

Feminist STS scholars have examined the ways in which the users of technologies are active agents who convey their interpretations of a technology within specific situational contexts and have extended the script approach to understand how masculinity and femininity are inscribed in technological devices (Balsamo 1996; Clarke & Fujimura 1992; Cowan 1987; Wajcman 1991).

Oudshoorn, Brouns and Van Oost (2005) stress the importance of situating medical technologies, arguing that both different contexts of use and different types of users are part of larger heterogeneous network of actors that co-constitute clinical practices, including the meanings assigned to technologies within those practices. Within these heterogeneous networks, agency is distributed among diverse actors and actants that



together form a collective actor (Oudshoorn, Brouns & Van Oost 2005). Their concept of distributed agency is used to interrogate the way technologies distribute agency among people and things, often in uneven ways across user groups (Oudshoorn, Brouns & Van Oost 2005). The feminist criticism that ANT and SCOT approaches tend to focus too much on powerful experts and too little on women's voices are taken seriously in this study. *"Feminist scholars argue it is important to include the "silent" and "silenced" voices of less-powerful actors than experts and producers in technology studies"* (See Star 1999; Clarke & Montini 1993; Clarke 1998; Saetnan et al. 2000) (Oudshoorn, Brouns & Van Oost 2005:87).

My dissertation takes these criticisms seriously. Within the mental health field, the profession of psychiatry is the dominant professional group with authority to codify diagnostic criteria and to transform a distressed person, into a biomedical identity, through the application of its diagnostic categories. The legally and socially institutionalized DSM, created by the American Psychiatric Association, is a technological actant (non-human actor) that shapes processes of diagnosis. I acknowledge this by investigating other mental health practitioners – psychologists, social workers, counselors and paraprofessionals whose daily work activities are significantly shaped by biological psychiatry and the DSM, but whose use of the DSM emerge from their own material-semiotic meanings and locations. Thus, in chapter four, I examine the ways in which the DSM is socially scripted and interpretively flexible, and how meanings of the DSM emerge from practice (for other STS studies that take this approach, see Mamo 2007; Oudshoorn 1994; Petryna 2002).

## **THE BIOPOLITICAL ECONOMY: THE MEDICAL PROFESSIONS AND BIOMEDICALIZATION**

### *Medical Sociology of the Professions*

The notion of the professional project was one of the first theoretical concepts to explore the relations between how professions used their specialist knowledge to monopolize a set of services and thus an exclusive share of the market (see Freidson 1970, 1986; Larson 1977). The two main features of the concept are (1) autonomy – the degree to which a profession controls the content and application of their technical knowledge and (2) dominance- the degree to which a profession is able to exclude other professions from their market share and/or control the work of other health care occupations (Evans 2003). Keith Macdonald (1995) argues the professional project concept was important in that rather than focusing on professions as static structures, it led the way for the examination of the strategies professionals used such as exclusion and social closure, to achieve and maintain their special elevated social status and power (over other professionals). Further, Macdonald notes that studies of collective professional strategies or the move toward examining the actions and interactions of professionals was heavily influenced by the Chicago School of American Sociology and the theoretical orientation of Symbolic Interactionism (see Glaser and Strauss 1965). He (1995) argues that it was the Symbolic Interactionist attention to the actions and interactions of the professions as they negotiated their everyday work and acted to maintain their positions of status that led Larson (1977) to actively investigate how technical, cultural and ideological authority were achieved by professions. In addition, Macdonald (1995) argues Larson's (1977) explication of a professional project employed Weber's view of stratification in that her study emphasized the ways in which social mobility and market control were the outcomes of a professional project. Future studies

followed the lessons learned from interactionist and professional-state (or producer-economy) relations (Cooper et al. 1988; Macdonald 1995). David Evans (2003) argues the professional project was a useful explanatory framework for the professions before the mid 1990s; but it is unable to account for complex political processes as they play out in contemporary health care governance regimes.

A similar concept that developed in explorations of professionalism and is still used today is jurisdiction (Abbott 1988). MacDonald (1995) critiques Abbott's view of professionalism as a system, claiming that he places too much significance on the structure and function of professions as a systematic entity, thereby leaving meanings, negotiations or interactions of professionals in everyday work unsettled; yet he praises the way in which Abbott's theme of jurisdiction attends to occupational divisions and conflicts among professions. In recent sociological studies of the professions, jurisdiction is often paired with the medicalization thesis, or the notion that increasingly more areas of social life have become defined by medical professions as medical problems (Conrad 2005, 1980; Clarke et al. 2010, 2003; Zola 1972). Jurisdiction is used to refer not only to the encroachment of one profession's area of knowledge, expertise and intervention into another but also to the process of taking control over and/or erasing conceptual models and practices previously used to understand or intervene in a particular problem or process (see Garry 2001). Thus a significant mark of the concept of jurisdiction is the focus on the relations between professions and/or occupational organizations and their competition for control over the definitions, practice and assessment of an area of work, often referred to as jurisdictional disputes.

Jurisdictional disputes occur over professional boundaries of specific work activities, including techniques and technologies that best accomplish said work. Abbott (1988) discusses how the cultural work that maintains or accomplishes distinct professional activities and areas of expertise is professional boundary maintenance in attempt to gain or maintain professional dominance. Further, jurisdictional boundaries are perpetually in dispute. Abbott (1988) attended to three important sites of jurisdictional struggle: the workplace, legislation and public opinion and emphasized the importance of understanding jurisdictional disputes within contexts of internal and external forces. Thus following (Freidson 1970, 1986; Larson 1977; Johnson 1972 and Abbott 1988), medical sociology of the professions began to recognize and examine the ways in which professional dominance and professional boundaries are contested spheres of knowledge and practice, and boundary maintenance requires cultural work.

***Technoscientific Knowledge-Practices: Biomedicalization and the Professions***

The concepts of medicalization and biomedicalization “*have significantly reconfigured what “technology” means, under what conditions, and for whom*” (Casper and Morrison 2010:S121). Medicalization refers to the ever-expanding jurisdiction of the medical establishment, including the reframing of social, moral or legal problems in medical terms (Zola 1972). Much like what the term is used to describe, the definition and implications of medicalization have also expanded since the social constructionist SI studies of American medical sociologists in the 1960s and 1970s. Early sociological studies of medicalization focused largely on the creation of new medical categories and the resulting expansion of medical jurisdiction (Conrad 2005).

Peter Conrad, one of the foremost American scholars of medicalization theory, argues that prior to the 1980s, three foci comprised the majority of medicalization studies: (1) the power and authority of the medical profession; (2) how medicalization occurred through the activities of social movements and interest groups; and (3) the concrete inter- and intra-professional activities (professionalization) (Conrad 2005). Thus, before the 1980s, the primary agents of medicalization were the powerful medical professions, social movements and interest groups, whereas other agents such as the media, consumers, the pharmaceutical and insurance companies, remained secondary (Conrad 2005; Conrad and Leiter 2004).

Changes within the organization of medicine and between the establishment and the political economy in the early to mid 1980s, transformed the character of medicalization. Within the institution of medicine, there was an erosion of medical authority (Star 1982), and the aforementioned secondary actors (pharmaceutical and insurance companies) entered front and center, exercising what Light (1993) theorized as countervailing powers against the sway of medical professionals and professional organizations. *“As a sociological concept, countervailing powers is not confined to buyers and sellers; it includes a handful of major political, social, and other economic groups that contend with each other for legitimacy, prestige and power, as well as for markets and money (Light 2009:241).* The sociology of the professions work today starts from the assumption that a profession is one of several countervailing powers in society invested and interested in health care. In addition to the awareness of multiple interested stakeholders, contemporary analyses attend to how these relations change in response to social, political and economic values and priorities.

Conrad (2005) argues that by the 1990s, changes in the organization of health care, medical knowledges and marketing had shifted medicalization in a systemic way. He examines how major changes in medical knowledge and organization created a shift towards biotechnology, consumers and managed care as key drivers of medicalization: *“In a culture of increasingly market-driven medicine, consumers, biotechnological corporations and medical services interact in complex ways that affect social norms in changing definitions of behaviors and interventions. The relationships between normative changes and medicalization run in both directions”* (Conrad 2005:11). Following these shifts in the agents of medicalization and the growing countervailing powers in the political economy, Conrad (2005) urges medical sociologists to go beyond social constructivist analyses of medicalization by including political economic perspectives.

One such group of medical sociologists has been examining what they see largely as technoscientific changes in biomedicine since the mid 1980s (Clarke et al 2010, 2003). If medicalization was the first major transformation of the organization and properties of health care in the U.S. (Bauer 1998; Clarke and Olesen 1999; Conrad 1992, 2007), biomedicalization is the second major transformation (Clarke et al 2010, 2003).

Biomedicalization is our term for the increasingly complex, multisited, multidirectional processes of medicalization that today are being both extended and reconstituted through the emergent social forms and practices of a highly and increasingly technoscientific biomedicine. We signal with the “bio-” in biomedicalization the transformations of both the human and nonhuman made possible by technoscientific innovations such as molecular biology, biotechnologies, genomization, transplant medicine, and new medical technologies. That is, medicalization is intensifying, but in new and complex, usually technoscientifically enmeshed ways. (Clarke et al 2010:47)

The designation of this transformation alludes not only to technoscientific innovations of molecular biology and biotechnologies, but to Foucauldian theories of biopower and biopolitics (Clarke et al 2010). Biopower and biopolitics refers to the

emergence of political knowledges, techniques and technologies that enable analysis of processes and forms of life, and thus also, health and illness. For Foucault (1977), biopower and biopolitics signaled a major historical break in the ideas and practices of politics, leading to the reformulation of political sovereignty through the emergence of new forms of political knowledge. Prior to the 17<sup>th</sup> century, a sovereign repressive control over death reigned, whereas contemporary forms of power now make regulative calculations to maximize life and the surplus value it produces or will produce for the economy.<sup>13</sup> Thus, biopolitics refers to the ideas and practices of government and state institutions that attempt to administer and regulate life processes.

Thomas Lemke (2011) follows Foucault's oeuvre and proposes a relational and historical notion of biopolitics as an analytic lens for understanding how new disciplinary knowledges and techniques are applied to life. Lemke distinguishes between three different uses of biopolitics in Foucault's work: (1) biopolitics as a rupture in political thinking and practice that reformulated sovereign power; (2) the role of biopolitical mechanisms in the rise of modern racism and; (3) an emergent art of government focused on regulating both the individual and social body (Lemke 2011:34). Foucauldian theories of biopower and biopolitics have been taken up as analytics that reveal relationships among government and state institutions, power, knowledges and individual subjectivity

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<sup>13</sup> For detailed theoretical and empirical studies of the contemporary bioeconomy and human life as surplus value, see Cooper 2008; Franklin 2006; Harrington et al. 2006; Rajan 2006; Waldby and Mitchell 2006. Although life emerged as a focus of politics in the 17<sup>th</sup> century, the life of a social body, or population, and its economic value – or the political economy of life, emerged later in the 18<sup>th</sup> century (see Foucault 1973; Lemke 2011:45; Rajan 2006:13).

and collective well-being. Foucault uses the term biopower to refer to two types of power over life (and by extension, health and illness): (1) a power that disciplines individual bodies, and (2) a regulatory control over the population (Foucault 1977; Lemke 2011). Foucault demonstrates how history is rooted in forms of power and emergent forms of disciplinary power operate through social discourses and practices in acting on individuals and populations (Foucault 1977). *“Michel Foucault’s notion of biopolitics is an account of the ways in which, through techniques of normalization, standardization, visualization, and enumeration, populations get included, and thereby accounted for, within “state rationality” in its broadest sense”* (Rajan 2006:99). Thus, Foucault’s theoretical constructs of the disciplines, disciplinary society, the life sciences, biopower, the individual and social body (population), and normalization, produce a theoretical frame from which social theorists examine how new technoscientific knowledges intervene in processes of life such as health and illness.

In hopes that biomedicalization theory will be used as an analytic framework for future studies, Clarke et al. (2010, 2003) delineate five key interactive processes of this major transformation in American medicine. (1) The first interactive process describes the biopolitical economy of health and illness. This process encompasses how the health care organization is increasingly profit oriented, corporatized, and how new biomedical knowledges, technologies, services and capital are co-constituted. *“Biocapital is the study of the systems of exchange and circulation involved in the contemporary workings of the life sciences, but is also the study of those life sciences as they become increasingly foundational epistemologies for our time”* (Rajan 2006:12). In his seminal book titled *Biocapital: The Constitution of Postgenomic Life* (2006), Kaushik Sunder Rajan argues



that epistemic and technological assemblages such as genomics (and therefore biomedicine and neuropsychiatry) are impossible to understand without attending to the political and economic frameworks within which they emerge (Rajan 2006:280).

Following Foucault's concept of the biopolitical frame, the manner in which Rajan (2006) explicates it in his analysis and biomedicalization theory, my study considers how youth populations are accounted for and governed through techniques of normalization and standardization (Foucault 1977; Rajan 2006:99). I employ the biopolitical economy of health and illness as an analytic lens in the fifth chapter where I examine how the larger assemblage of managed care, the DSM and state governance structures the organization of mental health care work.

(2) Clarke et al's (2010) second interactive process is the intensified focus on health in addition to illness and disease. An important consequence associated with an increased focus on health is the elaboration of risk calculations of and surveillance over individuals, target groups and populations. Steven Epstein (2007) examined the ways in which the biopolitical paradigm is built into contemporary medical and nation-state research, policies and practices. He defines a biopolitical paradigm as a framework of ideas, standards, formal procedures and unarticulated understandings that structure how concerns about health, medicine, the body and personhood are made a focus of medical and state research and practice (Epstein 2007). Especially relevant to the increasing elaboration of risk calculations and surveillance over individuals, target groups and populations, is Epstein's concept of niche standardization. Niche standardization is a type of categorization that is concerned with social groups as opposed to the individual on the one hand, or the standard/universal human, on the other. Epstein examines how the

categorization of groups based on social differences such as gender, race and age contribute to the conflation of social with biological differences. In my study, adolescents constitute a niche standardization that shapes the societal and clinical definitions and responses to their mental, emotional and behavioral disturbances. While no one specific chapter is devoted entirely to adolescents as a social group, the analysis in chapter three speaks to how practitioners' negotiations, work-arounds and cribbing processes are all heavily shaped by the unique aspects of caring for adolescent as opposed to childhood or adult disturbances. Further, I build on what my entire data analysis has to say about adolescents as a niche target group in my theoretical conclusion.

(3) The third interactive process of biomedicalization is the technoscientization of biomedical practices, which describes how increasingly, medical interventions are reliant on new sciences and technologies and how therapeutic remedies themselves are increasingly technoscientific applications (Clarke et al 2010; 2003). The technoscientization of biomedical practices is central to my empirical analysis because in chapter four I analyze the DSM as a key scientific technology that shapes mental health care diagnosis and treatment.

(4) The fourth biomedicalization process describes the continual transformation of knowledges, including constantly changing information management, distribution and consumption needs. In chapter four I demonstrate that a significant aspect of negotiating social processes of diagnosis depends on collective knowledge building or crib sheets that guide mental health professionals in passing insurance company utilization of DSM diagnoses in their reimbursement and treatment plan policies. Further, in connection to the constant transformation of knowledges and information management, my study

reveals important connections across organizational settings and the types of information technologies or computer software programs used for diagnosis and documentation.

While not a central focus of this analysis, emergent computer software programs such as Shrinkrapt and Therascribe used by practitioners in their everyday clinical work is revealed as a primary focus for future research on interactions between the technoscientization of biomedical practices and on-going transformation of knowledges within mental health care work settings.

(5) Finally, the fifth interactive biomedicalization process is the transformation of bodies and selves. New individual and collective identities are formed, such as those on the basis of normalizing biopolitical risk groups. In my analysis of the social processes of diagnosis, I found mental health practitioners were painfully aware of the material consequences of labeling adolescents with mental disorders. Several diagnostic work-arounds were employed by mental health practitioners in order to acquire authorization from insurers to provide psychotherapeutic services without having to severely label an adolescent with depression or anxiety. Adjustment disorders were the go-to disorders and the fact that V codes (relationship and social environmental problems) are not recognized as legitimate diagnoses were found to be a contentious issue for contemporary psychotherapists. It is clear that the transformation of adolescent selves through DSM diagnostic labels, and the degree to which adolescents adopt technoscientific identities based on DSM disorder labels is an important area for future work, although an area for which an IRB approval may prove to be near unattainable (are you still awake)?

These five biomedicalization processes occur at multiple levels of the social and are taken up in multiple ways across practices and settings, often accompanied by

ambivalences, negotiations and countertrends (Clarke et al 2010). I employ biomedicalization theory in my analysis and examine the ways in which these processes are actively negotiated, resisted and/or transformed in different ways through mental health practitioners' theoretical orientations and approaches to treatment (chapter three); negotiate diagnostic processes, biomedical and bureaucratic standardization (chapter four), and are governed by assemblages of insurance and state power (chapter five).

Contemporary biopolitics and biomedicalization necessitate scholarship which examines concrete practices and sites of action within situated political and economic contexts (Clarke et al 2010; Haraway 2004; Raman and Tutton 2010). Raman and Tutton (2010) challenge Rabinow and Rose's body of work on biopolitics and the assumption that in interactions of medical technoscience and society, biopower operates only through the life sciences and at the molecular level (Rabinow 2002, 1996; Rabinow and Rose 2004; Rose 2001). Further, they critique the notion that contemporary biosocieties and their discursive practices of life, health and illness, are post-disciplinary (Raman and Tutton 2010). While citizens of U.S. society increasingly participate in individual self-techniques to optimize, enhance and self-govern their own health, they also continue to be shaped by institutional authorities and disciplinary knowledges. State population and subpopulation categories, statistics and interventions, niche standardizations as well as self-identified sociopolitical categories; continue to be crucial to contemporary biopower and biomedical knowledge production. Finally, Raman and Tutton (2010) importantly critique how too many analyses of biopolitics have ignored the issue of resource allocation and potential uneven access to the opportunistic self-enhancement and optimization envisioned by Rose (2001).

Contemporary studies of the biopolitical economy and the medical professions have begun to demonstrate the ways that biomedical, genetic and neurological technologies serve to further stratify health care within the United States and globally between wealthy and poor nations (Clarke et al 2010; Scheper-Hughes 2004; Shim 2010, 2005, 2002). Following Casper and Morrison (2010), Clark et al (2010), Raman and Tutton (2010) and other key Science and Technology Studies (STS) scholars (Braun et al 2010; Fujimura, Duster and Rajagopalan 2008; Harbers 2005; Rosoff 2010), I investigate concrete sites of action situated within the contemporary adolescent mental health care arena in order to reveal the contours of contemporary biopower and biomedicalization in-practice.

Following the theory/methods that have been reviewed thus far, this study bridges the gulf between STS of medical practices and the sociology of mental health and illness. Since the beginning of my graduate education, I have been interested in studying the social aspects of mental health and illness, but have found social constructivist SI approaches to be marginalized in this field, at best. I argue STS theory/methods such as grounded theory, and the empirical work on the medical professions and medical practices has much to contribute to understanding the debates within the sociology of mental health and illness, especially regarding its definition and measurement. In the final section of this chapter, I review these debates.

### **THE SOCIOLOGY OF MENTAL HEALTH AND ILLNESS**

Sociologists who examine mental health and illness focus on social circumstances, how the organization of society and the medical establishment shapes the proportion of the population who suffer from mental illness, and how we as how societies define and react

to mental illness (Horwitz 2010). In studying social processes of everyday life, sociological studies of mental health and illness might examine (1) how social processes influence the definition of mental illness or the classificatory boundaries of what constitutes mental illness or mental health; (2) the role social processes play in the aetiology or causation of mental illness; and/or (3) the social processes of mental health practice such as diagnosis and therapeutic intervention (Busfield 2001, 2000).

While there are several sociological perspectives of mental health and illness and the field is inherently interdisciplinary, sociological studies are generally focused on examining mental health and illness from the standpoint that social arrangements and processes are integral to understanding both the causes of mental illness and its consequences (Aneshensel and Phelan 1999).

This assertion rests first and foremost on a foundation of empirical research demonstrating repeatedly and convincingly that mental disorders are not randomly distributed throughout society, but tend to cluster more densely within some social strata than others . . . a person's chance of developing and maintaining a healthy mental state throughout the life course is influenced by his or her social status, for example, by gender, race or ethnicity, and socioeconomic status (SES). These characteristics also influence the ways in which disorder is likely to be experienced and expressed. (Aneshensel and Phelan 1999:4)

Further, the social circumstances of a person's life, including his/her social status characteristics, influence interactions with mental health professionals including the likelihood of particular diagnoses or treatment in particular settings (Aneshensel and Phelan 1999). The theoretical and empirical lessons of the sociology of mental health and illness have much to contribute to this study, but in addition to the basic assumptions and empirical lessons just described, I particularly build on the critical debates over the definition and measurement of mental illness.

***Defining "It": Mental Health, Disorder and Distress***

Sociologists' attention to definitional issues surrounding mental health and illness is important in that popular, practitioner and/or scientific understandings of what "it" is socially shapes how we talk about, experience, intervene and respond to "it". Several sociological scholars working in the sociology of mental health and illness subfield have weighed in on the debate over whether or not mental illness is better conceptualized as distress or disorder. For instance, there have been two special journal issues in which researchers were invited to grapple specifically with the question of how best to define and measure mental illness: *The Journal of Health and Social Behavior* (2002:43) and *health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine* (2007:11). Each demonstrated the integral role the definition of mental health and illness plays in this arena of sociological scholarship. One good place to start is the social stress paradigm.

The stress process paradigm has dominated the sociology of mental health for the past 30 years (Aneshensel 2005; Horwitz 2007b; Pearlin 1989). The paradigm investigates how social arrangements and resources contribute to mental illness.<sup>14</sup> Stress process researchers have investigated a variety of different social sources or conditions of mental illness, but over time, three key contexts or fundamental causes have been demonstrated: (1) inequalities in income, power and/or prestige, (2) loss of or absence of

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<sup>14</sup> While Allan Horwitz (2007b) views the stress paradigm as investigating the ways in which social arrangements and social resources are major determinants of generalized states of psychological distress, Schwartz (2007) argues this is only one (and perhaps a narrow) view of stress process research.

close attachments (i.e., divorce, death of a loved one, social isolation), and (3) the inability to attain important life goals (Horwitz 2007b).<sup>15</sup>

While sociologists generally focus on the consequences social structures or social arrangements have on mental health and illness, Sharon Schwartz critiques the tendency for scholars to reduce sociological phenomena into psychological constructs such as mastery and self-esteem (Schwartz 2002:224). The critique that sociologists of mental health and illness too often measure mental illness at the level of the individual largely holds today, although there are a growing number of exceptions (see Scheid 2004, 2003, 2000). Schwartz (2002) argues sociologists should seek to understand the variety of consequences of social organization rather than the etiology of specific disorders. “*We should examine whatever outcomes fit with our theories of how the social world impacts our minds and bodies*” (Schwartz 2002:233).

John Mirowsky and Catherine Ross (2002) also argue we should study a broader range of symptoms, especially the material connections between how our epistemological constructs (distress or disorder) align with particular kinds of understandings and experiences of mental health and illness. They claim that mental illness scholars should be more mindful of how our measurements shape and reflect how people actually experience mental illness (Mirowsky and Ross 2002). Measuring mental illness as

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<sup>15</sup> Horwitz claims that similar to social stress research, evolutionary psychology research demonstrates that humans become distressed in contexts of subordination, attachment loss and inability to achieve valued goals, and thus both of these fields of research lead to the conclusion that distress is a natural response to stressful situations (2007b). Thus, Horwitz (2007b) argues that both the sociology of stress and evolutionary psychology research demonstrate that *distress* is a natural response to social circumstances that are stressful.



discrete diagnostic categories rather than as a broader range of symptoms makes it more difficult to understand the problem because it discards important information (or fails to consider social context) (Mirowsky and Ross 2002):<sup>16</sup>

Psychological problems are not discrete. Diagnostic categories do not reflect the reality of psychological problems. Indexes are scientifically superior to diagnostic categories, but continuums are not as useful in convincing the public, other physicians, insurance companies, or government agencies that psychiatric problems are real, serious problems that deserve insurance coverage and funding (Wilson 1993). (Mirowsky and Ross 2002:160)

Expanding upon Schwartz's (2002) call for sociologists to examine a broader range of social rather than psychological variables, Aneshensel (2005) demonstrates empirically that mental health effects of social organization are nonspecific. She differentiates a social etiology from a social consequences model of research; for her, social etiology identifies social antecedents of one particular disorder whereas the social consequences model is concerned with overall mental health consequences of social arrangements (Aneshensel 2005). In showing the multiple ways that we can examine the social consequences of social institutions and arrangements (including families, schools, relationships and social status characteristics), Aneshensel reiterates that social conditions frequently affect more than one domain of functioning. When sociologists examine specific disorders rather than a broad array of social consequences, the impact of social conditions is underestimated (Aneshensel 2005). She argues that sociological methods of

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<sup>16</sup> Mental illness can be defined and measured in both discrete (presence/absence) and continuous (a range – minor to major, low to high number or low to high intensity, of symptoms). See Aneshensel 2002, 2005; Kessler 2002, Mirowsky and Ross; Wheaton 2001 for more discussion of the discrete versus continua debate.

research should reveal the broad impact of social organization on health outcomes, not conceal it.

Horwitz (2007a) argues that social arrangements produce two different types of psychological outcomes – mental disorders and mental distress, and that it's important to distinguish between the two. For both Horwitz (2007a) and Wakefield (1992), the difference is that a mental disorder exists when a psychological mechanism is broken down, regardless of whether its cause was social, psychological or biological. Horwitz argues that distress occurs as the result of stressful circumstances; and sociologists can tell it is distress and not disorder because when the stressor disappears, the distress subsides. The definitional distinction is that distress is a normal human emotion and a reaction to social circumstance whereas disorder is not (Horwitz 2007a).

Horwitz (2007a) argues that sociologists do more harm than good when they assume that stressors necessarily produce mental disorders, rather than distinguishing between the outcomes of distress and disorder that often, kinds of social circumstances might give rise to. He claims this does not mean that distress is less severe or a more transient version of disorder, since stressful circumstances can lead to very serious but non-disordered and long-lasting distressing symptoms that are not disorders (see Turner et al 1995). Thus, it is not the severity of psychological symptoms that distinguishes distress from disorder, but rather the presence or absence of social stressors, i.e. when the stressors are removed and the psychological symptoms continue, then it's disorder, if they get better, it's distress:

Finally, when both levels of stressfulness and symptoms stay high over time, the issue of whether conditions are distressed or disordered remains unresolved. Longstanding symptoms in the face of chronic stressors could indicate that the stressors have produced

a disorder; alternatively, persistent symptoms could reflect a natural response to the continuing stressfulness of social circumstances. (Horwitz 2007a:283)

Horwitz's (2007a) analysis challenges sociologists to reconceptualize mental illness by developing clear definitions and measurements for both distress and disorder, including the kinds of factors most likely to lead to each. He believes that by labeling outcome variables as distress rather than disorder, sociologists can help resist the inappropriate medicalization of human emotions and life conditions (see Conrad 2005; Horwitz 2007a).<sup>17</sup>

In response, Schwartz (2007) claims that Horwitz's (2007a) definition of mental disorder is based on Jerome Wakefield's 'harmful dysfunction' criterion. She notes that disorder as individual dysfunction is the key criterion that distinguishes Horwitz's (2007a) definition of disorder from distress. In the theory of the harmful dysfunction model, dysfunction refers to an organ or mechanism that is not performing its intended function, as can be inferred from evolutionary psychology (Wakefield 1992). Following this notion of functionality of bodily organs and mental processes as they have evolved across time, Wakefield (1992) defines a mental disorder as a condition that arises when an internal mechanism fails to perform its intended or 'natural' function, and causes some harm to the person.

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<sup>17</sup> In the field of psychiatry as well as in the pharmaceutical industry, there is currently a recognition that any intense emotion as mental disorder. Medicalization justifies social policies that define and allocate resources to conditions that are viewed as pathologies of individuals rather than stressful social arrangements (Conrad 2005; Horwitz 2007a). Social policies that improve child and elder care, family leave, unemployment benefits, health care coverage, etc should provide better solutions for preventing and dealing with distress (Horwitz 2007a).

Schwartz (2007) takes issue with the ambiguity of the dysfunction criterion when it comes to determining the intended or natural functions of cognitive, linguistic, affective or motivational mechanisms. Further, she argues that scientific advances have rebuked simple one gene, one neurotransmitter models by showing that most evidence demonstrates that mental disorders arise from complex interactions at multiple levels of organization (Schwartz 2007). Her critique is that the harmful dysfunction criterion presupposes that minds operate like the biology of bodies – that they have natural mental functions first and when they dysfunction, then it may be social *or* internal (biological): *“While this notion of dysfunction may eventually prove useful in separating disorder from non-disorder, as a conceptual framework for the categorization of any particular condition it is a hypothesis to be tested”* (Schwartz 2007:294).

Schwartz (2007) critiques the definition of mental disorder, and thus the distinction Horwitz (2007a) makes between disorder and distress, on the basis of the dysfunction criterion because of (1) a lack of scientific consensus on what mental functions are and therefore, when they are dysfunctional and (2) the value criterion – i.e. that symptoms are expectable or not is based on social judgment and thus strips the concept of dysfunction from its objective character.

Schwartz (2007) also questions the feasibility of operationalizing internal dysfunction (i.e. expectability of psychological symptoms) in sociological studies. While Horwitz (2007a) suggests we rate responses in proportion to their context to determine normality or pathology (normality indicated when the severity and duration of symptoms are proportionate to the stressor), Schwartz (2007) notes that the establishment of levels of symptoms that are proportionate to circumstances would require a reliance on

statistical averages, that require local definitions of symptom severity. Also, the duration of symptoms or response to a stressor will be determined based on social norms of expectable response to a given social circumstance (Schwartz 2007). Further, she argues:

But the most fundamental problem is the assumption that an outcome that substantially outlasts the stressor or is disproportional in severity is a sign of an internal dysfunction that says something is broken. Why do we assume the body works in a way that things are broken or not? There may be weaknesses, inefficiencies and liabilities that interact with contexts large and small to determine responses. (Schwartz 2007:296)

Yet, Schwartz (2007) leaves open the possibility that the expectability of symptom response may be a conceptual and operational improvement over current discrete disorder measurements in which symptoms are completely decontextualized from the social environment. Horwitz (2007a) argues that sociologists of mental health and illness in general, and social stress research in particular, have failed to distinguish between distress and disorder, and further, that distress, not disorder, is the proper outcome for social stress research focusing on social arrangements such as life events, chronic strains and conflicting roles (see Pearlin 1989; Aneshensel 2005). Schwartz (2007) on the other hand, argues that the social stress paradigm is more general and is focused on examining all of the consequences of social structures; if Horwitz (2007a) is right, then empirical inquiry will, demonstrate stressful events to be highly associated with distress and less associated with disorder, but this remains an empirical question.

Wheaton (2007) argues that the distinction Horwitz (2007a) makes between distress and disorder defines distress as transient, expectable, natural and less consequential for outcomes compared to disorder. While only some of this is true—Horwitz goes out of his way to say that distress is not always transient and can be chronic

and lead to internal dysfunctions or disorder – (2007a)— Wheaton’s (2007) problem with this binary definition is that it positions the sociology of mental illness or distress research as less important and excludes major stressors as key social causes, thereby privileging biological explanations of mental disorders. Wheaton (2007) focuses on how the two definitions and measures overlap, and whether or not distress and disorder are indicators of a single underlying construct, leading to his own definition.

Wheaton (2007) defines distress as an affect-based impairment in social functioning. This is a more specific definition of distress in that it is tied to two forms of disorder (depression and anxiety). In comparison, Dohrenwend et al. (1980) define distress independently from disorder as a non-specific form of demoralization and Mirowsky and Ross (1989) define it in terms of subjectively uncomfortable states. In contrast to Horwitz’s definition of distress, Wheaton’s (2007) is not transient, moderate or normal (Wheaton 2007). He critiques Horwitz’s (2007a) assumption that distress is an expectable or proportionate response to stress, claiming that research on stress doesn’t show a clear pattern of normative or expectable response (Wheaton 2007). While Horwitz (2007a) draws on the work of Wakefield (1992) and his harmful dysfunction model in his definitional criteria, Wheaton draws on the history of stress research and Kessler’s (1979) differential vulnerability model.

The history of stress research and the differential vulnerability model both focus on the wide variability in individual responses to the same social stressors (Kessler 1979; Thoits 1995; Wheaton 1999, 2007). Wheaton (2007) argues that to be an expectable response, it should be not just the average but the prevalent response. Further, he argues that while there has been a tendency in the literature to assume that distress is a transient

response to stress, the empirical evidence shows a number of life events that produce chronic strains (e.g., divorce) (Eccles 2005; Sweeney and Horwitz 2001; Wheaton 1990; 2007). Third, he rebukes the common assumption that disorder (but not distress) produces impaired functioning, arguing that distress is more stable than is widely assumed and has patterns of life consequences that mirror the evidence of redirection in life trajectories reported in studies of disorder (Wheaton 2007). Finally, he argues that the DSM-IV definition of disorder similarly sets up distress and not disorder as related to social causation. Wheaton claims that this is problematic because these are theoretic models, no internal dysfunction has been located within individuals with mental disorder and the manifestation of dysfunction is heterogeneous. Rather than continuing to use distress as a screening device and considering disorder as closer to the gold standard (which doesn't exist yet for mental illness diagnosis), he suggests scholars take a less bounded approach that might lead to a better understanding of the correspondence between distress and disorder (Wheaton 2007). In summary, Wheaton (2007) argues that when talking about stress, variability is the rule, and distress demonstrates many of the same characteristics of what is known in the larger scientific literature as disorder.

### ***DSM and ICD Classification Systems' Definitions and Criteria of Mental Illness***

Sociology is not the only field grappling with how to reach consensus about how best to define and measure mental illness. Contemporary classification systems such as the DSM and ICD strongly shape mental health and illness practice and research, but even such seemingly coherent systems resist conceptual clarity about the definition and diagnostic criterion of mental illness.

Unlike many sociologists who critique the DSM definition of mental illness, Allan Horwitz argues that the DSM's definition of mental disorder appropriately distinguishes between disordered and nondisordered conditions that are the result of social stressors (Horwitz 2007b; Horwitz and Wakefield 2007). However, in their book *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow Into Depressive Disorder* (2007), Horwitz and Wakefield carefully demonstrate that several sets of criterion for DSM disorders contradict its own definition (Horwitz 2007b; Horwitz and Wakefield 2007). The problem, they argue, began with the DSM-III when the APA set out to erase theoretical, especially psychodynamic, assumptions from the manual (Horwitz 2007b; Horwitz and Wakefield 2007). With the publication of the DSM-III, the field of psychiatry tried to purge all theoretical assumptions of etiology from the manual and adopt symptom based definitions. In doing so they also took out terms such as "excessive." This led to all symptoms, whether "normal and proportionate" responses to social stressors or "inappropriate and pathological" signs of dysfunction, to become treated as indicators of mental illness (Horwitz 2007b; Horwitz and Wakefield 2007). Thus, Horwitz and Wakefield (2007) critique the DSM for inconsistent disorder diagnosis criterion and for going too far in ridding (some) theoretical language from the taxonomy.



In response, they provide their own definitions: disorder as pathological internal dysfunction, distress as normal sadness.

Rather than critique the DSM's definition and criterion of mental disorder, Michael Phillips (2009) examines the operationalization of distress both within and across the dominant classification systems. He argues that despite being vague and unclearly defined, the concept of distress is widely used in both the DSM and to some extent, the ICD systems of classification (Phillips 2009). Phillips (2009) questions whether distress is a symptom of mental disorders, a marker of functional impairment, or both, and examines what he notes as substantial differences and inconsistencies both across and within the two diagnostic systems' use of distress:

. . . both diagnostic systems use distress as a stand-alone symptom, as a qualifier of other symptoms and as a general measure of severity, but neither the DSM-IV nor the ICD-10 provides a definition of the term, so there can be a wide range of interpretations of the corresponding diagnostic criteria. The frequent use of various qualifiers for distress in the diagnostic criteria (clinically significant, marked, excessive, etc) suggests that distress is construed as a dimensional construct that is being truncated to be employed as a categorical diagnostic criterion, but the diagnostic systems do not assess the degree of distress and do not provide further clarification about the cut off between distress that is and is not diagnostically important. (Phillips 2009:92)

Given the lack of consensus in the literature on the definition of distress, Phillips (2009) argues that the makers of both diagnostic classification systems have two options. First, if they can't find a suitable operational definition for distress, then it should be dropped entirely from the diagnostic criteria and from the assessment of functional impairment. Otherwise, if it is possible to develop an operational definition of distress, it should be used as one of the dimensional components of the functional impairment assessment for

all disorders, and be considered as a symptom for some specific disorders (Phillips 2009:92).<sup>18</sup>

### ***Multiple Models and Measurements of Mental Illness***

In response to this ongoing source of conflict in the sociology of mental health and illness, Andrew Payton (2009) empirically assesses three competing frameworks regarding the relationships between the concepts mental disorder, mental distress and mental health. First, he tests what he terms the modal perspective, the historical tendency of mental health researchers to view mental illness or disorder as the larger concept and assume mental health exists in the absence of mental illness (Payton 2009). In contrast to this modal perspective, the positive psychology perspective argues that mental health is not the same thing as absence of mental disorder, but instead, is its own concept. In fact, Marie Jahoda's (1958) classic piece demonstrates the necessity of specificity and distinction with regards to the differential content between negative and positive affect. Yet, the norm in studies of health and illness tends to be to focus on mental illness at the expense of mental health as a unique concept in itself.

Second, Payton (2009) tests what he calls the Mirowsky and Ross (1989, 2002) perspective which treats distress as the larger umbrella concept and defines it as negative emotional affect, commonly manifested as depression or anxiety. Third, he tests the positive psychology perspective that mental health is a separate and unique construct that is not simply the presence or absence of mental disorder (Payton 2009). The results of his

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<sup>18</sup> Related to the debate surrounding the definition and measurement of mental illness as disorder or distress, is whether mental illness is better conceptualized and measured as continuous or discrete (see Aneshensel 2002; Horwitz 2002; Kessler 2002; Mirowsky and Ross 1989, 2002; Wheaton 2001 for in-depth discussion of these issues).

analyses demonstrate that mental disorder, distress and health are all distinct concepts and should be studied both separately and in interaction. His results provide support for the positive psychology perspective because mental health and disorder do not appear to exist on a continuum, yet this perspective and his tests neglect the relationship between mental distress and mental health. Payton (2009) argues that his results suggest we think of mental health, distress and disorder through a discontinuous lens – that while these concepts may be correlated, they do not underlie a continuum. *“In fact, the moderate-to-strong correlations among the concepts suggest that the substantive relationships among the concepts are likely more important than the mere fact that they are conceptually distinct phenomena”* (Payton 2009:223).

### ***Social Meanings of Health and Illness***

In theorizing the potential relationships between the unique constructs of mental health, distress and disorder, Payton states: *“It is likely that how the individual, her or his significant others, professionals, and corporations view these phenomena plays a part in how these phenomena relate to one another in the actual experience of them”* (Payton 2009:225). Thus, social meanings of health and illness— epistemological knowledges of— shape their materiality (social practices of intervention, individual and collective experiences, etc.). In this last section, I focus on the consequences of the contemporary dominant definition of mental illness as mental disorder.

As a result of the third revision of the DSM in 1980, biological psychiatry undergirds the dominant contemporary definition and understanding of mental illness. The biological revolution in thinking has displaced social, environmental and dimensional models of illness. One way of taking stock of these changes is to examine

the consequences the contemporary dominant perspective has for larger societal understandings and responses to mental illness.

Since the third edition, the DSM fails to distinguish symptoms that are responses to stressful circumstances from those that are individual pathology and represent true mental disorders (Horwitz 2007b; Horwitz and Wakefield 2007). Horwitz and Wakefield (2007) argue that while the conflation of normal versus pathological symptoms can easily be corrected in clinical practice settings where practitioners use their own judgment, three other major consequences have resulted: (1) inflation of rates of mental illness in community populations, (2) public policy towards mental illness focused on unmet need for treatment and (3) shifting societal norms surrounding mental illness, mainly, expanding the social space of pathology (Horwitz 2007b; Horwitz and Wakefield 2007).

Horwitz and Wakefield, among others, argue that the field of psychiatry created the atheoretical DSM-III to enhance their scientific status as a profession, but once the APA's DSM-III popularized symptom based definitions, several groups such as the pharmaceutical and insurance industries, found they benefited from them (Horwitz 2007b; Horwitz and Wakefield 2007). That a number of constituencies benefit from the atheoretical symptom based definitions popularized by the DSM-III is the reason why they haven't changed (Horwitz and Wakefield 2007). Both the profession of medicine in general and the profession of psychiatry in particular, are rewarded with the primary claim to jurisdiction over an expanding range of conditions that are redefined as medical problems (Horwitz and Wakefield 2007).

Symptom-based conceptions of medical disorder thus expand the range of conditions that can be the legitimate objects of psychiatric management. Piggybacked on justifiable exercises of psychiatric power aimed at mental disorder, normal human emotions, once they have been classified as disorders, are generally subjected to technologies such as

psychotropic medications or psychotherapy. These technologies have spread from the mental hospital or psychiatric clinic to the doctor's office, the school classroom, and the Internet self-help site. (Horwitz and Wakefield 2007:213)

However, psychiatrists are not the only mental health professionals who benefit from symptom-based definitions of mental disorder. Symptom based definitions of mental disorders help clinicians receive insurance reimbursement for rendering therapeutic services, largely because insurance companies will pay for conditions for which treatment is medically necessary but not for "problems of living" (Horwitz and Wakefield 2007). Further, researchers, public policy, government and family organizations all benefit from symptom-based definitions in that their research is easier, less expensive, better funded, estimates of the social and economic costs of mental illness are bigger, and mental illness becomes less stigmatized as larger percentages of the population are recognized as afflicted (Horwitz and Wakefield 2007). Research funding has facilitated biological, neurological and genetic understandings of mental illness, impacting all scientific disciplines that take mental health and/or mental illness as their object of study. It is no surprise that pharmaceutical companies reap enormous profits from their reliance on symptom based definitions of disorders in their advertisements (Horwitz and Wakefield 2007).

While Horwitz and Wakefield (2007) adeptly cover the range of consequences of the medicalization of unpleasant emotions, Schwartz (2007) questions why their critique only pertains to distress and not disorder. She points out that there are several physical disorders for which a wide variety of treatment regimens exist that include behavioral, social and pharmaceutical solutions (Schwartz 2007). For example, diabetes may be treated and prevented from behavioral or lifestyle changes or the use of blood glucose

monitors and insulin (Schwartz 2007). The assumption in Horwitz and Wakefield's (2007) argument is that medicine is appropriate to treat dysfunctions but not for treating distress, yet Schwartz argues that there are consequences or side effects of any intervention and questions whether it is necessarily more fruitful to treat disorder rather than serious chronic distress with medication. Further, Horwitz (2007b) claims that by distinguishing distress from disorder, sociologists can help redress the hyperfocus on the individual as the site for intervention because distress, since it is clearly caused by social stressors, should be solved by social policy. Yet again, Schwartz (2007) questions why this would be true for distress but not disorder and cites evidence from the field of social epidemiology that has repeatedly demonstrated how social policies are often the most or only effective way of preventing or ameliorating disease and or dysfunctions.

Dysfunctions while located within the body are not of the body alone. In the effort to demarcate dysfunction from normal response, the boundaries are translated into gaps that are far too wide. The body and its functions and dysfunctions cannot be separated from the social and physical environments in which it resides. Ultimately, these considerations make me hesitant about this approach to our outcome variables. My fear is that attempts to make sharp distinctions between disorders and distress, between the normal and the abnormal, may lead to more harm than benefit. It may do harm to our understanding of disease formation if the conceptualization of dysfunction does not reflect our physiology. It may do harm to the hard-fought movement to consider the role of the social in both the cause and the cure of frank medical conditions. It may deflect the recognition that our bodies are socialized bodies that have no existence independent of the social context in which we carry out our biologic functions. The disorder/distress boundary may be inherently fuzzy and value laden. I am not yet convinced that an objective dysfunction criterion can provide a distinct or useful marker. (Schwartz 2007:298)

Horwitz (2007b) urges sociologists to focus on distress rather than disorder because he believes distress but not disorder is caused by social arrangements. The problem with this distinction is that it leaves out the role of social conditions and stressors in causing, mediating or alleviating mental disorders. However, it is now considered common knowledge that the brain and biology of bodies interact with the

social environment and are changed by it. Contemporary genetic diathesis models and findings about brain plasticity bear witness to a much more intricate interaction between our biological and social mechanisms. As argued by Schwartz (2002, 2007), sociologists who study mental health and illness should be envisioning theoretical models of our minds and bodies as interconnected. Sociologists of mental health and illness should explore the relationships between the social and biological, distress and disorder and health, and not just mental or physical health, but the too often ignored relationship between them.

### **ORGANIZATION OF THE STUDY**

Chapter three examines how adolescent mental disorders are defined and approached within and across psychotherapeutic communities of practice, or social worlds. I examine how psychotherapy is understood as an art and a science through a set of knowledge-practice tensions that are salient in contemporary mental health care practice. Chapter four examines the social processes of diagnosis, including practitioner negotiations of the Diagnostic and Statistical Manual (DSM) and the ways in which the DSM as a biomedical technology shapes the diagnoses and therapeutic interventions adolescents receive. Chapter five examines the larger macro political economy of the adolescent mental health field and the meso level institutional forces shaping the conditions under which screening, diagnosis and treatment of adolescent disturbances occur. For instance, in out-patient expert mental health professional settings, managed care is a major social force that shapes the everyday care work of practitioners. Finally, in chapter six, I theorize what the empirical data and analysis from this study suggest about adolescent mental health and illness in contemporary U.S. society.

### **Chapter 3: The Art of Psychotherapy: Therapeutic Eclecticism, Interdisciplinarity & Clinical Expertise**

The clinical professions that take adolescent mental disorders as a key object of study and or intervention are diverse in their background disciplinary training, professional socialization, theoretical orientations and approaches to therapeutic intervention. This chapter examines how adolescent mental illnesses are defined and approached within and across multiple psychotherapeutic social worlds. I examine these relationships through the following three knowledge-practice tensions that are salient in contemporary mental health care practice: (1) Biomedicalization vs. eclectic theoretical orientations to mental health and illness; (2) Increasing specialization and interdisciplinarity; and (3) a simultaneous push for standardization (Evidence Based Practices) and individualized treatment plans and care.

First, I examine how practitioners negotiate the knowledge-practice tensions between the dominant biomedical model and their own theoretical orientations and approaches to treatment. Building on Luhrmann's (2000) concept of models of illness and Scheid's (2004) concept of treatment ideologies, I deploy the concept of theoretical orientation to understand how contemporary psychotherapeutic clinicians define and intervene in adolescent mental illness. Theoretical orientation refers to how their epistemology of mental health and illness, their disciplinary and professional socialization, and their current institutional work settings all influence their understandings and approaches to psychotherapy. My analysis reveals three ways that MHPs resist the biomedical model of illness and, instead, embrace eclectic and more holistic theoretical orientations and approaches to treatment. First, MHPs situate their



theoretical orientations as eclectic and/or in opposition to the biomedical paradigm. Second, their theoretical orientations and approaches to treatment focus on the strengths of adolescents and their families with a turn towards constructivism. Third, their theoretical orientations value the social aspects of mental health and illness, including the central role of relationships and understanding the complex personhood of adolescents in approaching psychotherapy interventions.

Second, I explore the knowledge-practice tension between the increasing specialization within the mental health professions and growing interdisciplinarity of psychotherapeutic social worlds. I examine the costs and benefits of the diversification of the field of mental health care from the standpoint of psychotherapeutic social worlds. Does it matter that mental health professionals enter therapeutic practice from a diverse set of disciplines, specialties (i.e. social worlds)? My analysis reveals that the interdisciplinarity of the mental health professions has become black-boxed, or a taken for granted aspect of mental health care. MHPs perceive the interdisciplinarity of the field as necessary to fulfill different types of health care coverage needs. Interdisciplinarity at its best is described as facilitating professional collaboration and more comprehensive care and at its worst, encouraging jurisdictional disputes and the devaluing of some of the professions' perspectives and contributions.

Third, I examine how practitioners negotiate the tensions between the simultaneous push for standardization and personalized medicine. To what extent do mental health practitioners embrace Evidence Based Medicine (EBM) and Evidence Based Practices (EBPs) in their every day clinical work and to what extent do they focus more on tailoring their treatment plans (or Individualized Educational Plans IEPs) to their

patients (students)? Largely in response to concerns about variability, EBPs have developed and are defined as an integration of the best research evidence, clinical expertise and patient values (IOM 2001). My analysis reveals that psychotherapeutic social worlds value EBPs as a good place to start in their treatment plans, but claim it is important to maintain clinical freedom (professional autonomy) and flexibility with regards to theoretical orientations and treatment techniques. MHPs critique the way in which EBPs privilege scientific evidence over patient subjectivity, social context and the therapeutic relationship. Further, MHPs take issue with the way managed care policies have implemented EBPs in ways that have shifted the field of mental health care from psychodynamic towards more Cognitive Behavioral focused theoretical orientations and therapies. At the heart of this criticism is a tension over how best to define and measure mental health and illness. MHPs struggle with the EBP standardization and how it privileges discrete, quantitative understanding and measurement of emotional well-being.

### **CONTEMPORARY KNOWLEDGE-PRACTICE TENSIONS OF MENTAL HEALTH CARE**

While biological psychiatry has reigned as the dominant paradigm of mental health and illness in the U.S since the 1980s, biomedicalization isn't a hegemonic process. Biological psychiatry is entrenched in scientific, legal, and popular discourses and clinical practices of mental health and illness, yet there are also on-going active negotiations, resistances and countertrends to biomedicine.<sup>19</sup> Contemporary knowledge-

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<sup>19</sup> As discussed in the literature review in chapter one and the theoretical review in chapter two, biomedicalization refers to the increasingly complex, multi-sited, multidirectional and interactive processes of emergent and transforming technoscience within medical and mental health care (see Clarke et al 2010, 2003).

practices of health and illness in U.S. society have been characterized as suffering from competing paradigms (Gergen 1997) and problematic interactions between two kinds of medical knowledge—experiential and experimental (May et al 2005). Kenneth Gergen (1997) points out that at the crux of the controversy over definitions and orientations toward treatment of mental illness lies incommensurable conceptualizations of personhood. He, like Saul Feldman (2003) calls for the democratization of the mental health project— for the healthcare institution to move beyond silos of distinct professions and practitioners, and the totalitarian logic of biomedicine (Gergen 1997). Gergen argues that multiple worlds of clinical practice are doing just that – that there is a “*rapidly growing movement of therapists, social workers, counselors and other professionals who reject the essentializing and objectifying predilections of both the psychological and biological professions. They are deeply cognizant of the socially constructed character of these realities*” (Gergen 1997:26). Within several disciplinary and professional worlds, the biomedical approach to mental health has been critiqued for its epistemological assumptions of universal truths, objectivity, rationality and moral principles (Gergen, Lightfoot & Sydow 2004). These challenges can be located in multiple disciplines and professional social worlds.

In a study on the technological changes and solutions in medicine, May et. al (2005) demonstrate that there is a fundamental tension between two different kinds of medical knowledge that are actively negotiated in the heterogeneity of clinical encounters (for specific study exemplars, see Clarke et al. 2003; Franklin 2001; Nettleton 2004; Waldby 2000). These two kinds of knowledge emerge from different ways of organizing ideas about and goals of clinical practice. Tensions occur between patient-centered

medicine (or individualized treatment plans) and the push for statistical evidence about large populations, i.e. Evidence Based Medicine (EBM) or Evidence Based Practices (EBPs). These kinds of knowledges can be characterized as (1) experiential qualitative knowledge rooted in clinical experience and worked out in the everyday encounter versus the (2) experimental quantitative knowledge derived from population studies, Randomized Control Trials (RCTs), and meta-analyses (May et al. 2005). Thus multiple kinds of medical knowledges coexist and inform conceptualizations of health and illness, patient personhood and orientations toward therapeutic practice. While contemporary assemblages of scientific research funding, insurance and pharmaceutical companies, media and popular sentiment favor a biomedical view of health and illness; the interdisciplinary arena of the health professions democratizes and diversifies theoretical orientation and approaches to therapeutic intervention. Thus, there exists a simultaneous push for EBM/EBPs and individualized treatment plans; for objective scientific guidelines and professional expertise and discretion; for professional specialization and interdisciplinarity. All of these technoscientific knowledge tensions are at work in contemporary clinical practices.

In what follows, I examine the relationships between these different social worlds of psychotherapeutic practice and their definitions and approaches to adolescent mental illness through three knowledge-practice tensions salient in contemporary mental health care practice. First, I examine how practitioners negotiate the knowledge-practice tensions between the dominant biomedical model and their own theoretical orientations to treatment. Second, I explore the costs and benefits of the diversification (simultaneous specialization and interdisciplinarity) of mental health care. Does it matter that mental

health professionals enter therapeutic practice from a diverse set of disciplines and specialties? Third, I examine how practitioners negotiate the tensions between the simultaneous push for standardization and personalized medicine. To what extent do mental health practitioners embrace Evidence Based Medicine (EBM) and Evidence Based Practices (EBPs) in their every day clinical work and to what extent do they focus more on tailoring their treatment plans (or Individualized Educational Plans IEPs) to their patients (students)?

### **CONTEMPORARY SOCIAL WORLDS OF PSYCHOTHERAPEUTIC PRACTICE**

Social worlds are defined by their collective meanings, shared activities and ideological commitments. A recent study describes the difficulty of distinguishing each mental health profession as a unique and distinctive entity:

The heterogeneity of disciplines' training programs, practitioners, clinical emphases, scope of practice, professional organizations, regulatory mechanisms, and other factors within and between disciplines confound comparisons among them. . . Their respective scopes of practice are overlapping and complementary, appearing to be increasingly fluid in response to changes in the healthcare system. (Robiner 2006:606)

Thus, we cannot assume that all mental health professionals with a social work background will define or approach adolescent mental illness completely differently than professionals with counseling or psychology educational backgrounds. The mental health professionals that comprised the multiple social worlds in my study, while coming from multiple disciplinary backgrounds, having various forms of formal and informal training and working across diverse contexts of care, are all united as they all advocate for youth mental health and practice psychotherapy.

While United States federal law only recognizes social workers, psychologists, psychiatrists and psychiatric nurses as comprising the core mental health professions

(AAMFT 2012), current analyses demonstrate that community counselors, marriage and family therapists, educational specialists trained in teaching children and adolescents with Emotional and Behavioral Disturbances EBDs (psychoeducators), primary care and pediatric physicians contribute significantly to the deliverance of mental health services (Ivey 1998; Walter 2006; (BLS) 2010-2011; BLS 2010-2011).<sup>20</sup>

The mental health professions encompass a diverse array of disciplinary and professional training socialization processes. As the Mental Health Workforce operates in an increasingly complex and competitive health market, it has become more important to understand the total universe of MHPs and how their knowledges and practices, experience and expertise shape their increasingly interdisciplinary professional activities (Robiner 2006). Analyses of the mental health services demonstrate a multiplicity of existing theoretical or epistemological models and overall fragmentation of services (Robiner 2006).

The assemblage of the mental health professions continues to expand and diversify, as do the contexts of care in which they deliver their services. A growing number of youth receive mental health services in school and primary care (pediatrician and family doctor) settings. Social workers, counselors and psychologists increasingly work in and are specially trained for, school settings.<sup>21</sup>

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<sup>20</sup> A recent study that examined the six mental health professions of psychiatric nurses, licensed professional counselors, marriage and family therapists, psychiatrists, psychologists and social workers calculated that there were 353,398 clinically active providers (Ellis, Konrad et al. 2009). A different study using broader parameters estimated that 537,857 persons comprise the core Mental Health Professionals (MHPs) (Duffy 2004).

<sup>21</sup> A specialist degree or its equivalent is required in most states for professionals to work as school psychologists although some states credential school psychologists with master's degrees. An Education

## FRAMEWORKS: MODELS, IDEOLOGIES AND THEORETICAL ORIENTATIONS

Medical Anthropologist T. M. Luhrmann (2000) argues that each mental health practitioner has a personal model of illness, or their own epistemology of or answer to the question of why a patient is sick, disturbed or struggling. She argues that each professional's answer to that question shapes their approach to treatment, their goals of treatment, their interactions with the patient, and the culture of the work place.

Like the interpretive patterns that lead psychiatrists who are thinking therapeutically or biomedically to evaluate patients in different ways and to anticipate different kinds of emotional responsibilities and responses to them, the psychotherapeutic interaction model of illness has a different impact on the life of a hospital unit than the biomedical disease model of illness. Working with these different models changes the way staff joke, the way doctors relate to nurses, and even the sense of the unit's ultimate goal. Ultimately these differences help to produce different moral sensibilities about mental illness. (Luhrmann 2000:119)

T. M. Luhrmann's (2000) ethnography of psychiatric residents in training illustrates how professional models of illness develop from disciplinary and professional socialization. She examined how psychodynamic and biomedical perspectives and training led to different therapeutic and pharmacological approaches and tools of intervention (Luhrmann 2000).<sup>22</sup> Yet, medical sociologist Teresa Scheid (2004) found that mental

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Specialist (EdS) degree in school psychology requires a minimum of two years of full time graduate study and a one year internship during the third year. The training for EdS requires coursework in both education and psychology since their professional practice addresses both educational and mental health components of students' development.

<sup>22</sup> Biomedical and pharmaceutical approaches tend to be more heavily relied upon in in-patient settings, whereas various forms of psychotherapy are more prevalent in out-patient settings. The majority of adolescents who receive some form of intervention for mental, emotional and behavioral disturbances are seen in out-patient clinical care and/or school settings. This chapter focuses on interviews with mental health care providers who work in out-patient and/or school settings.

health practitioners leave their disciplinary and clinical training behind to some extent in their switch from the institution of schooling to that of the workplace.

Scheid's (2004; 1998) work has largely investigated how institutional environments and professionally generated norms shape interactions and approaches to treatment and care at the collective level. She argues that occupational identification is more important to understanding the work experiences of providers than their unique disciplinary backgrounds (Scheid 1998). That is, she argues that the types of organizational work places that mental health providers practice in matter just as much as their disciplinary and professional socialization in shaping their everyday work practices. Rather than investigating individual professional's models of illness, Scheid analyzed treatment ideologies; defined by her as the complex set of beliefs providers hold about mental illness and treatment (Scheid 2004, 1994). She argues that treatment ideologies convey the individual theories providers hold about etiology, the way they view the provider-client relationship and what they consider the "best" treatment or approach (Scheid 2004). Rather than examining professional's individual models of illness and how they were shaped by their disciplinary training and socialization, Scheid examined treatment ideologies and argued that they arise from a combination of their past training and on-going work experiences.

Following the work of Luhmann (2000) and Scheid (2004), I analyze practitioner's theoretical orientations – a combination of their individual models of and beliefs about etiology, as well as their treatment ideologies – or the complex set of orientations toward treatment that have been formed by both their past professional training and their current collective work arrangements. In examining the theoretical



orientations of mental health practitioners, I demonstrate that while biological psychiatry is the contemporary dominant paradigm, alternative mental health professionals, i.e. those who are not biological psychiatrists, resist biomedicalization of mental health and illness. The diverse interdisciplinary field of alternative mental health professionals did not ascribe to biomedicine or biological psychiatry as their acting theoretical orientation or the collective ideology of their workplace. Instead, practitioners articulated numerous ways that their own theoretical orientations and approaches were alternative to and/or actively resisted the biomedical paradigm.

#### **DATA FINDINGS: THEORETICAL ORIENTATIONS IN CONTEMPORARY PSYCHOTHERAPY**

While biological psychiatry continues to be the dominant model of health and illness in U.S. society and the managed care organization of the mental health field, none of my practitioners identified it as their theoretical orientation.<sup>23</sup> Several models of illness and therapeutic approaches were presented as important alternatives to the biomedical paradigm, but often practitioners were resistant to name just one that was the most important and more often described the multiple models they used and how their therapeutic approach is eclectic. Theoretical orientations that were described most often include family systems, strength based, Cognitive Behavioral Therapy (CBT), biopsychosocial, psychoeducational, psychoanalytical, solution focused, constructivism and relationship based. Rather than describe the ways in which their orientation, approach

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<sup>23</sup> One mental health practitioner I interviewed did identify the medical model as the collective treatment approach of her organization, but clarified that this was only because they had restructured their treatment plans and practice to fall more in-line with the biomedical DSM and the bureaucratic requirements of managed care (each of these issues will be discussed in detail in the next chapter). While her organization had brought their diagnoses and treatment plans into correspondence with the biomedical paradigm, it was clear she herself did not ascribe to it as her own theoretical orientation or treatment approach.

or goals of treatment built on or contributed to the biomedical model, practitioners frequently located their therapeutic approach far away from it. Practitioners discussed aspects of psychotherapy, diagnosis and treatment that have not been valued and/or legitimated by the psychiatric profession's DSM, insurance companies and the majority of mental health care research funding. My analysis revealed practitioners resisted the biomedical model of illness in the following three ways: (1) by describing their theoretical orientation and approach as eclectic, as different from, or actively in opposition to, the biomedical model, (2) by (re)focusing on strengths of adolescents and their families and possible positive linguistic constructions of them and their futures rather than pathologizing them with labels, negative language, or focusing on their weaknesses or bad behaviors, and (3) by valuing the importance of the social aspects of mental health including relationships, the family and reaching an understanding of the adolescent as a whole complex person.

### ***Resistance toward the Dominant Biomedical Model***

While the majority of the mental health practitioners I interviewed were hesitant to identify with just one theoretical model or approach, several identified biopsychosocial, family systems and psychoeducational orientations as having a significant influence on how they saw patients and developed therapeutic goals. These orientations are eclectic in and of themselves in that they pull from diverse theories and modes of thinking about health, illness and personhood. For example, the following practitioner, who holds an MSW and works full time in a school setting, acknowledges all components of the biopsychosocial model: *“With a lot of the work I do here, I’m bound to be more crisis management, putting out fires, but, I’ve always went on the basis of looking at the whole*

*person, the biopsychosocial aspects. You know, biologically, what's going on, socially, what's going on, mentally, what's going on, and then kind of just pulling pieces. It's more eclectic."* A counseling psychologist who works in a large out-patient group practice gave a similar definition. She rejects the biomedical paradigm by characterizing her approach as holistic:

I'm pretty eclectic. I'm holistic in my approach, and definitely always respectful of culture. I believe it's very important to see what-- when a client comes in and presents with concerns-- its 'What are these concerns telling you? What needs are not being met in this client's life to where this solution, adaptation of behaviors has now become a problem, a problem in their daily functioning? . . . These children may have special gifts but they are so different then what we see as normal that we pathologize their behaviors because we can't control those. They are not what we see as normal so we reject them. That is something that I think a lot about in my work with adolescents and children.

While some practitioners defined their theoretical orientation and approach as opposite from or in resistance to the medical model, this Licensed Mental Health Practitioner (LMHP), with a Psychology background, attributes some of her theoretical orientation to her current institutional care setting:

I never think of it as a model. That seems so formal. When I think of model I always want to put the term medical in front of it. I would be almost the opposite end of that. I don't, in outpatient therapy, there's very little major mental illness. I don't have to do a lot of medical model stuff. A lot of people come in with what would be considered adjustment disorders. Most of what I would work with are kind of depressive or anxiety symptoms, things that would also be on the V codes--the systemic stuff: family, relationships, those kinds of things. That term, model, mine would be much less medical than maybe somebody who was in an acute care facility like at the regional center they would probably have to function much more along those lines, I know even at RTC [Residential Treatment Center] we did. Now I feel like its much less medical model based. I don't spend so much time thinking about the diagnostic codes, and what symptoms I'm going to be able to pick out to justify them being there. I mean really kind of meeting that model's needs; outpatient therapy is gloriously removed from that. As far as my interventions or approaches I suppose it would be, I generally lean towards the cognitive behavioral, I suppose I'm eclectic although when I really think about it most of what I come from is really more cognitive behavioral and the systemic approach, family systems theories, all those kinds of things.

The LMHP quoted above described how her current out-patient setting enabled her to practice psychotherapy from an orientation that is much further away from a medically focused model. This finding shores up Scheid's (2004) argument that treatment ideologies of mental health professionals are heavily shaped by the characteristics of their institutional work setting.

In comparison, the following licensed Marriage and Family Therapist (MFT) owns her own out-patient practice, accepts mixed forms of insurance, and resists the medical model not because her work setting facilitates this type of orientation, but because she has found that taking a broad view of the patient and his/her presenting issues is more effective than working from a narrow medical model perspective.

My roots are in the family systems model. I'm not attached to that but I usually start with that and it gives me a frame of reference for understanding a presenting problem. It's really important to me to develop a hypothesis around the presenting problem so that I can have a relevant treatment plan. That doesn't mean that I bring the family in for every session but I tend to look at the presenting problem from a family systems point of view. I actually resist medical models and operate more from a strength based model, especially working with adolescents; I get a lot further faster with them when I go from a strength based model.

In other words, her theoretical orientation is shaped much more heavily on the epistemological models of her disciplinary training. Following the findings of both Luhrmann (2000) and Scheid (2004), both of these quotes reveal that disciplinary training, professional socialization and institutional work setting all impact theoretical orientation and approach to treatment. I followed up by asking how her definition and approach to adolescent mental disorders was different from other mental health professionals she has worked with to get a sense for how her disciplinary background and current practice setting might intersect:

Well, again I think it is probably distinctly more from a family perspective, and

regarding that, I just want to pause on this because I think it's really important to understand presenting problems, and to keep it open enough to give it a broad hypothesis. I think sometimes other clinicians might tunnel vision it a little more and have a narrower perspective. Maybe they'll be just as successful in treating the adolescent. I think there can be good outcomes from that as well, but, I think my training brings perhaps a broader perspective. Not only developing a hypothesis but of course, treatment goals and interventions.

Thus for this seasoned professional, her approach to psychotherapy is heavily shaped by her theoretical orientation, one shaped heavily by her background training in family systems theory and practices. She locates her theoretical orientation as distinct from the medical model because family systems theory facilitates a broader view of what is happening in a youth's life.

Several mental health care practitioners identified with multiple models yet also named models and approaches that influenced their everyday clinical work with adolescents. Their theoretical orientations provided alternative ways of defining and intervening in adolescent mental health and illness, although they are currently not part of the dominant biomedical view, the DSM and health insurance companies' forms and requirements. The importance of both language and the family system is noted by this Marriage and Family Therapist:

I studied a lot of structural strategic. I also integrated that with constructivism. . . I think the biggest thing is the heavy influence the family system has on adolescent behavior, but there is an emphasis, still, in the field on the individual approach. You approach an adolescent who may not have a good grasp on their own development, on what they want, on the pay offs they get for misbehaving, but then you put the onus of change on that child or person who is still not 18 years old, they are a child, with a body that's going waaarghuh,. . . That's the thing, being able to garner the attention of extremely defensive, mortified parents. I think any therapist that does not know how to do that will not get very far with treating adolescents.

Thus, the MFT above is eclectic in his theoretical orientation because he integrates epistemological frameworks of structural strategic, family systems and constructivism in his work with adolescents and their families. A very similar sentiment about the

importance of language, narrative and building hope for new possible futures was echoed by a different MFT who worked in the same city but in a different out-patient practice:

I do a combination of solution focused and narrative therapies. Both are very language centered, future focused. I definitely ask questions about the past, but its more, what did we learn from that? Okay, that was a problem, what skill can we use kind of a thing, I don't have people lay on my couch or anything like that. It's definitely about the language they use and looking at the times when it wasn't a problem. Just the other day someone was saying, well sometimes I think about doing these really evil things, and sometimes I do them. So I go, so sometimes you don't. What is different about the times it isn't a problem? A lot of hope and strength building. Some of my girls like to play the game mash. I've had to teach them. Are you familiar with it? You list 5 guys, 5 jobs, and then you figure out who you're going to marry, where you're going to live and we'll end with that sometimes. A lot of the girls here, their world is so small. Where do you want to work? Wal-Mart, burger king, McDonalds, you know. So, I'm a fortune teller and its like you'll move to New York city, you'll be a teacher, let's look at a map of the world, so expand these kids worlds. You don't have to stay in [this town] and have the same life you've always had.

These descriptions of theoretical orientations are constructivist. They reflect an epistemological standpoint about the language adolescents use to talk about and understand their situations, the terms in which they think of themselves and their futures, their problems and their diagnoses. The following quote comes from the lead special educator and liaison between a well known graduate program in a large East coast metropolitan area that trains psychoeducators and administrators that serve special education students. When asked if the special education or ED students she serves are similar to youth treated in out-patient clinics for mental and emotional illness, she emphasized that the important thing to understand is who the student person is, not what their mental disorder or ED label is:

If we're looking at people as individuals, we're going to build a program [treatment or education plan] for them based on their needs. From personal experience, a lot of my time even though I'm a special education teacher, is really spent in general education, helping individual students through a school day, whether it's academically, emotionally or behaviorally. . . The sociological piece, the humanistic piece, the biomedical piece, the emotional piece, behavioral piece, it's definitely a piece. They're all equally important when we're looking at our students. I think the one that impacts them the most is the

environmental piece. . . All of those components are very important from a psychoeducational perspective. It really is individual. From an educational point of view, it's really important to understand who the student is and what the impact of that label, that illness, what that means to them during the school day.

While this professional works with emotionally and/or behaviorally disturbed children in the school setting rather than in an out-patient clinic, she approaches psychoeducation from a constructivist lens that emphasizes the importance of language, who the students are, and takes a broader view of the adolescent in his/her context(s). As a comparison, a clinical psychologist who works in a nearby private practice but sees adolescents who tend to be from more economically advantaged families, also discusses how larger trends in society, the dominant biomedical paradigm of health and illness, and the social context of her patients' and her own practice setting, shape her approach to intervention:

Because of managed care, and the general trend in society, people want a quick fix, they want answers and everything is cognitive behavioral. Unfortunately people eat up the media and their understanding of what mental health work is, is quite superficial. We live in an era where, while we know as much as we do about mental health, everything is very medication oriented and very quick fix. People don't come in to sit on the couch and be analyzed or really transform the way they think or feel or relate to people. You kind of end up staying on the surface a little bit more. I think we refer out for medication more than we would if people were devoted to working . . . I think a lot in terms of the culture we live in, the sort of macro picture, the family and then I think about the internal workings of the kid. And they are probably equal, I don't think of one as bigger than the other. This area is a real pressure cooker academically, everybody has to be advanced placement. I'm all about the values that trickle down onto the youth, their families and family dynamics. Also, their internal workings, their resilience, how fragile they seem and their strengths and weaknesses. I think I'm a little bit community psychologist or social psych, a little bit psychodynamic and family systems is big for me, looking at the whole system.

This clinical psychologist describes her theoretical orientation as eclectic and subtly rebukes the dominance of the biomedical model and how it has shaped larger public definitions of mental illness and perceptions of how to fix the problem. However, she also, like some of the other therapists, acknowledges that the social environment that adolescents come from and live in makes a difference in the presenting problems as well

as the treatment approach. Thus the social environment was discussed as important in several different ways, including how it shapes the definitions and responses to mental illness, as well as the experiences of both providers and patients and their therapeutic interactions. Her theoretical orientation is responsive to the culture of mental health care in the U.S.

In the following description, a mental health practitioner offers a different view of how the social environment is important for her own theoretical orientation toward psychotherapy:

I take more of a relationship approach. I think relationships or lack thereof can be a huge cause of or have a great impact on client issues. The absence of a father, that lacking relationship or maybe a mother that is in the picture but is so busy she doesn't have time to give. The different dynamics of relationships has a lot to do with client issues, so I focus a lot on relationships. That's kind of the heart of where things come from. Unfortunately the program I am in right now, we don't have a lot of family participation. It takes place in the schools so, they are pretty passive and don't feel like they have to be a part of it. We certainly encourage it, so in that case it's more of a, you can't change them but what can you change about yourself to cope more effectively with that relationship?

While the social environment was discussed as important here, she focuses on how the social aspects of the self, relational being or interpersonal relationships strongly influence person's emotional well-being, and therefore, her theoretical orientation.

Another way that mental health practitioners discussed the social environment is how their background disciplinary training and current institutional features of their workplace shape their own as well as their colleagues approach to intervention. A licensed nurse practitioner discusses how her professional training in the nursing field, and the majority of institutional environments in which she has worked have all been shaped by the biomedical model, yet her own theoretical orientation is much more holistic in its approach.



When I worked at [local hospital] they always said I spent too much time with my patients because I look at everything holistically so when I go in and have a patient who is different than the day before I'm actually doing more pursuing, I told them I'm sorry I'm a psych nurse, I see change in behavior, I have to find out why, and I think it helps with how they are doing physically or why they are not doing well physically, so I think that's one thing. I really push that holistic approach to mental health. We need to look at patients, not just a disease, but the whole picture.

In response to the stark contrast between her background professional training, her work contexts (both of which are dominated by the medical model) and her own holistic theoretical orientation, I asked her to elaborate more on these differences:

It's very medical model, very focused on the disease. It's the hip in 214, so we're going to deal with the hip. We have the spinal cord in this room; we're going to deal with all the aspects of a spinal cord injury. We don't deal with the whole individual. Say the person with the amputee-- okay do they have some body image problems going on? Is that why they are so resistant to therapy because in therapy they actually have to look at the missing limb? As nurses we are going to get that leg healed and walking and they can deal with all of the other issues when they get home. It shouldn't be that way, but that is the dominant approach. On the flip side I find there are mental health nurses that never want to go beyond the mental health part of it, but you really have to look at the patient holistically, you have to understand the whole patient.

In the above analysis, I demonstrated that MHPs resist the biomedical model of illness and instead, embrace eclectic and more holistic theoretical orientations and approaches to treatment. First, MHPs situate their theoretical orientations as eclectic and/or in opposition to the biomedical paradigm. Second, their theoretical orientations and approaches to treatment focus on the strengths of adolescents and their families with a turn towards constructivism. Third, their theoretical orientations value the social aspects of mental health and illness, including the central role of relationships and understanding the complex personhood of adolescents in approaching psychotherapy interventions.

### ***Best and Worst Models and Treatment Ideologies: Eclectic Theoretical Orientations***

Another way practitioners located their own theoretical orientations and eclectic

approaches to mental health and illness was by naming and describing models of illness with which they disagree. There was a noticeable degree of discomfort when I asked about this.

I think they all have their strengths as well as their limitations. I struggle with CBT because it doesn't focus on the relationship and the power of the relationship between the therapist and the client but this is where I become eclectic because in my work with some of the youth and even specifically in bipolar disorder, I utilize a lot of CBT techniques that are about changing behavior, but I always have that emphasis on the relationship. I think that makes the CBT techniques more effective because of our relationship. I couldn't say that there are any [theoretical orientations] that I just disagree with, that I wouldn't utilize. I think that as a therapist, you have to be open to what best meets the needs of the client and if I was only to provide CBT, that might not be effective for certain populations.

Practitioners clearly value the authority and wisdom of other practitioners and eclecticism in their fields, and even go at lengths to discuss why openness to multiple models and approaches is better than being too fixed to a narrow perspective or only one approach to intervention. The following quotation offers yet another example of how practitioners' repeatedly valued therapeutic eclecticism rather than adherence to any one model or treatment approach:

I definitely am more along the lines of pulling from different approaches and what's going to be best for each kid. What we call it here is a psychoeducational approach. We look at cognitive theory, behavioral theory, ecological, humanistic, and pull from them equally. You give them all consideration though, especially when dealing with kids with such big issues. If you don't make those considerations you could be completely overlooking something and if you miss that then you've lost your chance at least in that moment. Nothing has stood out for me oh I'm not even going to consider that theory because you just don't know it might work for someone.

Similarly, the following therapist emphasizes the value of multiple models and approaches over one dominant (especially biomedical) model:

I think the biggest danger is when any model is a silo. If any model doesn't respect interdisciplinary models, then I have a concern because the main thing is developing some kind of working perception, hopefully evidence based, so you can gather a hypothesis about the presenting problem. As long as one has a framework, which is hopefully evidence based, so that you can get a working hypothesis and have a plan of

attack so to speak. I strongly believe in collaborating with a client to produce a treatment plan, hopefully in the client's words, so that the client sees what's in it for them. You know some medical models are, I don't want to over generalize, but let's say there is a psychiatrist out there that doesn't have psychotherapy training or background so they see depression purely as something that one needs to be medicated and they don't see the power of relationship affecting that or other stressors in the client's life. If they have no appreciation for the interdisciplinary need to address an issue then that would be an example of a model that I wouldn't respect.

Another example illustrates the extent to which the psychotherapists I interviewed valued eclectic theoretical orientations and approaches to treatment intervention:

I find that while in the schools I primarily worked from a CBT perspective because it was more solution focused and more in the moment, like you could get kids back into classroom. Kid has crisis, remove kid from classroom, process and get them back as soon as possible-- CBT is best model or way to go about doing that and doesn't tap a deep psyche. But when I was doing individual therapy, especially with those older adolescents, I think it has its place, but that's not my go to. I would have a problem with someone who relies solely on one perspective and particularly is a strict behaviorist. Its not 100% effective, it doesn't reach every child, no approach can. I think about what translates, a behavioral approach, works in that moment with that reward, but it's important to have things that translate outside of certain settings. Single minded approaches, I'm not so fond of.

Thus, therapists emphasized the way the social environment of a patient's life, including their social and economic differences as well as the context of treatment setting, all shaped the approach to intervention. In addition to consistently expressing respect for therapeutic eclecticism, when asked about models they disagreed with or found difficult to embrace, practitioners frequently problematized the biomedical and behavioral models and approaches. Clearly, these themes are all interrelated as one of the key problems practitioners have with biomedical and behavioral treatment ideologies are how they leave out important social aspects of health and illness. Biomedical and behavioral approaches to therapeutic intervention were problematized for their focus on symptoms, diagnosis, disorder and surface level responses rather than being concerned with social contexts, relationships and personhood of the patient and his/her life.

I will tell you which one the toughest and that is Psychiatry. It is rampant; they do a lot of talking and not very much listening. Just the way a psychiatrist may look at and talk about a child, they can sometimes misdiagnose but its really good to have them when major mental illness diagnoses come along and they are right because medication is really important for some adolescents, you know all that abnormal psych stuff. We need the psychiatrists around for that but sometimes they will try and grab the therapy space and be the therapist and if they don't even check to see what we were working on, that can unravel things. They really sell the idea that pills are magic bullets for all of these problems that they don't even help in my opinion. Psychiatry that model of illness you have a chemical imbalance that started here and so here pop a pill.

I followed up by asking, so biological psychiatry would be the model of illness or approach you disagree with most? “*Yeah, biomedical as opposed to biopsychosocial.*”

Practitioners often pointed out that they weren't against the use of medication or psychiatry, and recognized each had a proper place in contemporary mental health care. Yet, they also frequently critiqued the biomedical and behavioral paradigms for how they privilege disorders, diagnoses and medication treatment over understanding patient personhood. For example, the following school social worker discusses her disagreement with models or approaches that focus on diagnoses rather than understanding the child or adolescent as a person.

Primarily thinking about kids in terms of their diagnoses, I have a hard time with that. Diagnoses help you understand the child but the child is so much more than their diagnostic label. I think everybody has some challenges in some area but we start to put a name, the labeling thing with kids, I think we need to be very careful with that. Throwing around labels, diagnoses are given out pretty readily. The medication piece also, I see a lot of our kids benefit from medication when it's done very thoughtfully. Some of our kids are put on a lot of medication and it's not done very thoughtfully, and they have a lot of side effects. . . I would hope we could understand why he's behaving, there's so much more to why he's depressed.

Several practitioners discussed how the behavioral approach has become popular in therapeutic interventions but they disagreed with it as being the primary or only therapeutic goal (fixing behaviors): “*It's hard for me to say theoretically but I think some of the behavioral approaches tend to be somewhat punitive because adolescents in*

*particular will come in and it's the behaviors that are upsetting everybody. If you're just trying to stop the behaviors without looking at what the underlying cause is, I have a problem with that."* Similarly, a psychoeducational trainer and therapist discussed how she values relationships with her student-patients over taking a behavioral approach to their immediate behaviors.

I'm not opposed to using the behavioral approach; I just don't think it changes behavior. I call it the yokya approach, and it's everywhere and it doesn't work. It's these big men, who yoke these kids out of their seat or situation. And does it work? Yeah for the moment, but what's the underlying problem? I couldn't do that in my classroom. They can challenge me. I build relationships with kids.

Finally, I offer one more example of how psychotherapeutic practitioners problematized theoretical orientations that focus on behaviors or surface symptoms rather than deeper social relational issues in the youth's life:

The behavioral, the strictly behavioral, I've struggled with that. With the school setting, they focus mainly on the behavior and how to fix the child. It's not about that. There's a whole bigger complex way below the surface but what they [teachers or parents] want is the behaviors to stop. That's putting a Band-Aid on this gaping wound. We don't address what's going on with the family, what's in the best interest of the child I don't think is always necessarily taken into consideration.

Thus, while the mental health practitioners I interviewed valued multidisciplinary models and an eclectic approach to adolescent mental illness intervention, they also critiqued biomedical and behavioral models/approaches for being too focused on the diagnosis, behaviors and surface level symptoms rather than on the deeper social relational issues in adolescents' everyday lives. Practitioners privileged theoretical orientations that considered multiple perspectives and approaches, and a more holistic framework that considered the biopsychosocial and relational as opposed to only the biomedical and behavioral aspects of adolescent mental health and illness.

My data suggests that adolescent mental health and illness as a scientific and

clinical object of study and intervention has become more interdisciplinary in both practice and theory and rather than subscribing to a “model of the moment” as many mental health practitioners called it, practitioners match what they believe is the most appropriate approach for each individual youth and his/her social environmental circumstances.

### **DIVERSIFICATION AND INTERDISCIPLINARITY OF MENTAL HEALTH CARE**

In this section I discuss the knowledge-practice tension between the increasing specialization and interdisciplinarity of psychotherapeutic mental health professionals. I asked practitioners what they perceive to be the costs and benefits of the interdisciplinarity of the field, including what difference, if at all, it makes that mental health professionals enter therapeutic practice from a diverse set of disciplines, specialties and treatment ideologies. My analysis reveals that the interdisciplinarity of the mental health professions has become black-boxed, or a taken for granted aspect of mental health care. MHPs perceive the interdisciplinarity of the field as necessary to fulfill different types of health care coverage needs. Interdisciplinarity at its best is described as facilitating professional collaboration and more comprehensive care, and at its worst, encouraging jurisdictional disputes and the devaluing of some of the professions’ perspectives and contributions.

#### ***Interdisciplinarity as a Taken-For-Granted Fact of Mental Health Care***

In their initial reactions, practitioners discussed interdisciplinarity as though it is just a fact of life. It quickly became clear, after several interviews, that interdisciplinarity has become black boxed, or a taken for granted aspect of contemporary mental health care:

Clearly there have been different fields that have become involved in mental health work, social work, psychology, medicine. I think they all have something to contribute. I don't think it's good or bad it's a fact of life. Do many social workers do something very different than many psychologists do? Yes, they're working at a different kind of agency, they're dealing with often times delinquency, other kinds of issues, if they didn't do that there wouldn't be anyone to do it. There wouldn't be enough psychologists to go around and there aren't enough psychiatrists at present. . . so it's not like they are all making a unique contribution but they are creating levels of coverage that wouldn't exist otherwise.

Similarly, another practitioner thought about the interdisciplinarity of the field in terms of providing a wider continuum of coverage:

Let me talk about continuity of care. You have this vertical continuity of care, like the most intense care all the way down to least restrictive care, is one way to look at it and then you have, at least a second dimension of care, this broad spectrum of correctional and legal, social work, nursing, spiritual, psychological. Without it, I don't think we would be doing a decent service to the clients.

Therefore, both of these practitioners accepted the interdisciplinarity of the field as a matter of fact, and articulated that it serves the important function of providing different types and levels of mental health care. Related to issues of interdisciplinarity and levels of mental health care coverage, multiple practitioners discussed there being a shortage of psychiatrists in their area of practice. For some it was discussed as an overall shortage of psychiatrists, for others, as a shortage of what they considered to be good psychiatrists, and for others, it was a shortage of psychiatrists that will diagnose and treat children and adolescents. In my review of the interdisciplinary literature on the mental health professions, the psychiatrist shortage was a hot topic. For the mental health practitioners who worked in the rural Midwest; this was an actual problem for providing all levels of coverage for their patients. This finding revealed that research debates about psychiatrist shortages accurately reflect rural and Midwestern contexts of mental health care. Some MHPs commented how at times their patients would have to drive up to two hours away for their adolescent to see a psychiatrist.

Overall there are more advantages than disadvantages. There are different needs to be met and it would be tough for one profession or one discipline to do all of that especially with psychiatry and medication. I've been fortunate enough to have the experience that working with professionals from other disciplines has usually gone really well and there's openness to that around here. I think even with improvements or technology just ways to communicate quickly like sending records back and forth has been pretty efficient. It's rare for me but occasionally someone who's not open to communicating or doesn't respond if I send a release, that can be frustrating.

Again, interdisciplinarity is the norm, it fulfills a function. Yet collaboration is pointed out as an integral aspect of how interdisciplinarity gets played out through work activities. Different types of professionals are thought to fulfill different needs that no one profession could fulfill alone but this also requires inter and intra disciplinary professional communication. Regarding the wide continuum of coverage and different needs of the population, one psychologist discussed how one of the primary benefits of interdisciplinarity is the options it provides to patients. *“What’s good is obviously people have access to what works for them. There are a lot of therapists out there that have different ideas and different models. I think it’s incredibly beneficial.”* The MHPs I interviewed recognized that the interdisciplinarity of the field allowed for an expansive continuum of coverage and array of theoretical orientations and approaches, offering patient-consumers choices about their care. In addition to recognizing the importance of interdisciplinarity for comprehensive coverage needs, several MHPs discussed the ways in which the interdisciplinarity of the field facilitates professional communication and collaboration.

### ***Interdisciplinarity: Professional Collaboration and Jurisdictional Disputes***

I think the benefits are you have the chance to view things from so many different ways. We come from so many different places in terms of our schooling, and not that one is right or wrong but we approach them from a different perspective so it opens up for more dialogue. In terms of the costs or the downfall, we don't always see things the same way but you have to have some compromise there too.



Thus both a benefit and cost of the interdisciplinarity of the mental health field is that practitioners are offered new or different ways of approaching the same problem and opportunities to grapple with more opposing or different views. Several practitioners articulated that this kind of collaboration is the ideal benefit of interdisciplinarity. The following practitioner is an out-patient therapist working from within a Physician Clinic in a large metropolitan area in a Midwestern state.

What's interesting about where I work is that the physicians who make the referral are very hands off. They don't really want to get involved in mental health care issues . . . They're not interested in sitting down and talking medications. These are physicians who want to do long term medication management. If we're talking about somebody who is going to be on something as basic as an antidepressant for a year, they don't want to manage that. They'll write the first three months, and then they want them to be referred off. I don't feel like I have much of a multidisciplinary team, which was a very weird thing for me going from RTC to outpatient. That was one thing I feel like RTC got right. That was one thing they did well, that whole multidisciplinary approach-- having everyone meet to discuss cases, coming to the table to talk about what we're all seeing.

Thus, she compared how interdisciplinarity is enacted in different ways in different types of care settings. In comparison to the in-patient Residential Treatment Center (RTC) that she had previously worked at, the level of collaboration across the different types and of professionals was very different at her current Physician's office. Similarly, a therapist who works inside a school that is connected to a residential treatment center, discusses how working in a setting where there are different types of professionals that all see the adolescent allows for a broader picture of what is happening in the adolescent's life.

I think the benefits are that you really do get that systems approach within a smaller microcosm of society. If you're a therapist outside in their office, if I was by myself outside [this organization/school/treatment network], I wouldn't get this whole picture, you know what's going on in school, what's going on with psychiatrists, what's going on with the home environment. I'm here interacting with the teachers; I'm interacting with the behavior support staff. That's certainly a huge benefit. In terms of the costs, I would say, we're trained differently.

Discussing how interdisciplinarity plays out in the day-to-day work activities at her non-profit mental health organization, one therapist observed how different types of care providers learn and perhaps even value, different information about the adolescent and their illness.

We have two psychiatrists on site that our clients see. We communicate with them. I think both of them are terrific and I'm very glad they're here but they only see them [clients] for like 15 minutes every two months. I always know a lot more about families than anybody at the school I've talked to ever does or anybody at CPS ever does, you know I do have a lot of contact with different schools and I find that I just have a deeper knowledge of the client but I have that opportunity to get it you know the teacher has 30 kids in her classroom. I'm one-on-one with them once a week kind of thing. I don't know if that's part of my training as a family therapist or just part of the set up here but I always know a lot more and I'm really bringing in that piece into it, well yeah but there was a baby brother born. That's one of the problems with [local insurance company that manages care including Medicaid] is they want the diagnosis, the goals and I would say well at the same time we've changed schools, or dads just come back in the picture or mom has just been put in the hospital for some illness kinds of things, so I'm looking a lot more at those environmental things and I think other people are like . . . diagnosis, treatment plan, goals, medication, that's all we need to know.

For this practitioner, the interdisciplinarity of the mental health field encourages health care professionals to learn and prioritize different types of information about the adolescent's life. Practitioners I interviewed pointed out that while interdisciplinary teamwork has the ability to provide more comprehensive care for youth than any one type of provider, sometimes the disciplinary differences and lack of time for real collaboration ends up being a downside of interdisciplinarity.

Sometimes the collaboration isn't good. I'm not criticizing the effort, I'm criticizing the result. People want to do what's best; it has the potential to work the very best for a child, to have everybody in the same room at the same table talking. The problem is when everyone has their own agenda. There's so much red tape, so much working across, it's gotten so mired in paperwork. The interdisciplinary idea is brilliant, there would not be a better situation than a caseworker, a therapist, a psychiatrist, a psychologist, you know, all in one room, saying, what do you see? That's beautiful. Does it work? It works great when the focus is on the child. It has the potential to solve a lot of problems. It's when everybody has their own agendas that things don't work very well.

The psychotherapist quoted above notes that while interdisciplinarity has the capacity of

improving care by enabling professional collaboration and dialogue; sometimes it falls short of those goals.

I work a lot with different social work people, and psychiatrists and psychologists and medical doctors. I think everybody wants, generally, everybody has the eye on the big picture, and they want to reduce the concerns with the patient. . . I think the hardest thing is for all of us to get a hold of each other, on a simple level, everyone has people booked, booked, booked.

Again, the benefits of the interdisciplinary field of mental health care is that it allows for a more comprehensive understanding of the clients but difficulties may arise from different perspectives, goals, increased paperwork and time spent on communicating and collaborating with other mental health professionals. Finding the time for collaboration and networking with other health professionals was an important but challenging aspect of daily psychotherapeutic practices.

I think it's great in the sense that the more support a kiddo can have, the more progress or the more successful they will be. That means all professionals have to be talking non-stop so they're not pulling the kid in different directions, or one person is promising that they can do something or get this service for a kid but in reality they haven't talked to that provider and it's not going to happen. It can be a really good thing to have as much support as possible, collaboration of services; we can do a lot better. There is a lot of room for improvement. I don't think we correspond enough.

Interdisciplinarity is a matter of fact in the contemporary adolescent mental health field. Yet the way it is negotiated in daily work practices varies based on the type of care setting and the extent to which professionals value the input from and collaboration with other professionals involved in their patients' lives. At its best, interdisciplinarity enables collaboration across different types of professionals and approaches that result in more comprehensive care. At its worst, interdisciplinarity encourages jurisdictional disputes, with some professionals devaluing each other's perspectives and contributions.

While interdisciplinarity has become a taken-for-granted or black boxed aspect of

adolescent mental health care, it has evolved considerably over the past few decades. For instance, this well respected mental health practitioner who owns and manages a large out-patient clinic in a rural Midwestern state, discusses how mental health practice has changed across her more than 20 years of practice.

My treatment plans have become more interdisciplinary . . . We're really trying to get involved with the primary care physician much more regularly. Not that that always at all means medication, based on the fact that usually my hypothesis is around family systems kinds of things, I don't immediately refer for medication. But I think the physician needs to be aware of emotional issues that are going on. I'm much more assertive about communicating with the PCP than I have been in the past, than when I started twenty some years ago. I think I'm also more careful to assess what's going on with them, for instance at school, probably more interdisciplinary with that when need be. Cultural issues, especially in this community, have changed a lot in the last twenty some years, so the culture of the family is considered more in treatment planning than it was in the past.

I asked if she thought the increased involvement of primary care physicians had to do with trends of increased medication.

I think it's really for other reasons, because actually it's kind of weird that I'll have an adolescent on medication, but I think as I've grown, I've become more aware of the role they play. Also I think our training in continuing education, the physician has influence, and especially if there's sexual issues going on, and for the total health of the adolescent I just feel like it's really important to bridge that communication so when they are in to see their physician so the physician is aware of what else is on the plate.

The field of adolescent mental health care has been interdisciplinary since it's ascendance in the 1980s and 1990s as an object of scientific study and clinical intervention. The knowledge-practice tensions of a growing interdisciplinary yet specialized field of professionals and researchers has been discussed as creating a more fragmented mental health care system. Yet the benefit of this knowledge-practice tension is that mental health professionals currently value multiple models, eclectic approaches and collaboration with their dissimilar professional colleagues. All of this suggests that adolescent mental health care is moving away from the dominant biomedical paradigm and towards a holistic health care approach.

## **THE STANDARDIZATION MOVEMENT: EBPs IN MENTAL HEALTH CARE**

Evidence Based Medicine (EBM) and Evidence Based Practices (EBPs) are part of a larger movement to standardize more aspects of medicine and health care practice. The standardization movement has grown, in part, in response to shifts within the health care system from primary physicians as sole providers to diverse teams of health specialists, each playing their own role in patient care. As discussed in chapter one, the second half of the 20<sup>th</sup> century can be characterized by a rise in medical specialization and diverse board specialty and sub-specialty certifications. In parallel to the diversification of health care specialties has been an exponential rise in health care costs and expenditures. The standardization movement has been one of the primary forms of response to both of these trends across the past few decades (Norcross, Beutler and Levant 2006; Timmermans and Berg 2003). While the standardization movement in the early and middle of the 20<sup>th</sup> century focused mostly on particular tools, skills and infrastructure necessary to perform work, with the reemergence of standardization in the 1980s and 1990s via EBM and EBPs, attempts to redirect or prescribe the way health care practitioners carried out their work became center stage (Timmermans and Berg 2003).

One reason why EBM and EBPs have become so strongly adopted is because the American public and policy makers believe that the U.S. health care system suffers from fragmented and uninformed practitioners (Reed 2006; see Tannenbaum 2003:294). In the face of rising health care expenditures that didn't yield better care, policy makers and the public were galvanized by strong rhetoric suggesting that uninformed and fragmented practice was the problem. As a result, in the 1990s, EBPs gained currency as a public idea (Reed 2006; see Tannenbaum 2003:294).

There is widespread agreement that standards such as EBPs provide order by streamlining medical practices of diagnosis and treatment while alleviating concerns about variability among health care providers (different disciplinary backgrounds, training and theoretical orientations). However, there remains significant disagreement over the definition and measurement of scientific evidence used in the creation of EBPs (Norcross, Beutler and Levant 2006; Reed, Kihlstrom and Messer 2006; Timmermans and Berg 2003).

In their analysis of what standards do in practice, Timmermans and Berg (2003) argue that standards are inherently political because their construction and application changes the way health care practitioners carry out their everyday clinical work. They divide standards into four types: design, terminological (such as the DSM which I analyze in the next chapter), performance, and procedural (such as EBPs discussed here). Procedural standards such as EBPs refer to specific clinical guidelines, policies or protocols that are intended to shape how practitioners proceed in diagnosing and treating patients (Timmermans and Berg 2003).

Although terminological, design, performance, and procedural standards necessarily intertwine; procedural standards are the main focus of our analysis because these standards boost the stakes of standardization to the highest level and form the heart of evidence-based medicine. Such standards attempt to achieve the seemingly impossible: prescribe the behavior of professionals. These standards bring people from different disciplines and backgrounds together with a variety of diagnostic and therapeutic techniques and instruments. They are simultaneously the most difficult to achieve and the most contested. As we will see in more detail later, practice standards raise issues about human autonomy, flexibility, creativity, collaboration, rationality, and objectivity. In short, they reflect important cultural assumptions about how people live and work together. (Timmermans and Berg 2003:26)

The most widely accepted and cited definitions of EBPs is from an Institute of Medicine (IOM) report entitled *Crossing the Quality Chasm: A New Health Care System*

*for the 21<sup>st</sup> Century* (2001:147): “*Evidence-based practice is the integration of best research evidence with clinical expertise and patient values.*” The three components highlighted in this definition: research evidence, clinical expertise, and patient values; are each included in the IOM’s definition, but none of them are privileged as being more important over the others, which is why this definition is considered to be the best and most neutral. When it comes to the debates surrounding EBPs though, it is the differences in how health professionals, insurance companies and policy makers define and distinguish among these three components that encompass the basis of disagreement. While some supporters of EBPs, such as the American Psychological Association (APA), claim that EBP guidelines aren’t meant to be mandatory or definitive (are careful to leave room and respect for professional autonomy and patient difference), other supporters of EBPs privilege scientific research or the evidence component of EBPs over clinical expertise and patient values (Norcross, Beutler and Levant 2006; Reed, McLaughlin and Newman 2002).

One of the major criticisms of EBPs is that their formation relies on a hierarchy of evidence that privileges Randomized Controlled Trials (RCTs), and thus, therapeutic orientations and interventions that are easier to test using RCT methods (Reed 2006; Sackett et al 2000; Tannenbaum 2005). While most mental health professionals agree that research evidence is an important consideration in determining a treatment approach, some critique the way that EBPs and insurance companies privilege evidence over clinical expertise and patient values. They argue that privileging evidence undermines the therapeutic relationship and devalues a wide range of professional knowledge (Reed 2006). In his overview of debates on EBPs in the mental health field, Reed (2006:21)

finds that strict adherence to EBPs suggests that while treatment approach and plans can be determined based on calculated probabilities of success, factors such as the patient, the clinician, culture, context and the therapeutic relationship are just as important.

Similarly, Messer (2006) argues that “*neither an evidence-based DSM diagnosis nor a manual-based EST (Empirically Supported Treatment) is sufficient to treat psychotherapy patients. Diagnoses cannot capture the unique qualities and concerns that patients bring to the clinician nor the specifics of the context in which their problems emerged in the past and are taking place in the present*” (Messer 2006:32). The evidence shows that non-diagnostic client characteristics are just as useful in predicting psychotherapy treatment plans and outcomes as are DSM-based diagnoses because diagnostic categories allow for too much heterogeneity to be valuable as predictors (See Messer 2006:39; Clarkin and Levy 2004:214). “*In other words, it is frequently more important to know what kind of patient has the disorder than what kind of disorder the patient has*” (Messer 2006:39).

Geoffrey M. Reed (2006) takes a similar position. The privileging of EBPs ignores two of the most robust findings in the psychological literature: (1) that specific treatment techniques account for little variance in psychotherapy outcomes and (2) the strongest and most consistent predictor of psychotherapy outcomes are the characteristics of the therapist and nature of the treatment relationship (Reed 2006:41-42). In response to these position papers, Kihlstrom (2006) rebukes that he doesn't think placing scientific research at the top of the hierarchy of evidence will lead to the deprofessionalization of the mental health field. Rather, he argues that professions are defined based on specialized knowledges and if clinical psychology wants to retain its status as a scientific



profession, it needs more, not less research evidence (Kihlstrom 2006:43-44).

As a final response to the debate and dialogue, Messer (2006) acknowledges that he and Reed are closer to what might be called the “romantic vision” which values individuality, subjectivity and unique qualities of human beings; whereas Kihlstrom’s approach to psychotherapy views individual patients as interchangeable and their personal values and subjectivity as impediments in assessing psychotherapy outcomes. In discussing Kihlstrom’s medical metaphor approach, Messer states:

The approach valorizes mechanism, objectivity, and technical aspects of therapy over artistry, client subjectivity, and quality of the therapeutic relationship. . . . To reiterate my main point, there is no escape from the subjectivity of the patient whose preferences, values and expectations the clinician must always keep firmly in mind. Nor is there any escape from the valuative dimension of therapy, which reminds us that decisions about the way we characterize peoples’ problems, conduct therapy, and assess outcomes are not determined by scientific criteria alone. (Messer 2006:45-46; see also Messer & Woolfolk 1998)

In response to these larger knowledge-tension debates in the field, I examine how practitioners negotiate standardization-in-practice.

### ***Negotiating Standardization-in-Practice: Psychotherapy as an Art and a Science***

Here I examine how practitioners negotiate the tensions between the simultaneous push for standardization and personalized medicine. Following the work of Timmermans and Berg (2003) and the debates laid out in the collection edited by Norcross, Beutler and Levant (2006), I investigate the politics of standardization-in-practice. This section sheds light on how mental health practitioners define and negotiate the standardization movement through EBPs in their everyday clinical work.

The mental health professionals I interviewed echoed many of the thoughts and concerns raised in the above discussion about EBPs. When speaking about the importance of EBPs in the field and the role they play in their everyday clinical work,

MHPs emoted a tone of caution and reserved acceptance. In the same way that several were adamant that there isn't one best model of illness or approach to treatment, they were also quick to point out that therapists need freedom to be creative and try unscripted or non-evidence based techniques as well as EBPs. Their everyday clinical work can be understood as an art form as well as a science.

I think [EBPs are] a wonderful thing, for most people. It's a really good starting point. It has given me lots of ideas of what to do, where to go, where to start. Its just after you start, it's more of an art form than a science. [Me: Therapy or?] Yes. I believe so. We always start out with a well thought out treatment plan, lots of evidence based treatments and interventions and goals and all of that but we're still dealing with a human being that can change week to week. A really good example: a young lady, 17 years old, drugs, got kicked out of the senior high school here and was going to a private Lutheran college here, used drugs in the bathroom. I'd seen her couple of times. She's very oppositional, she likes to sneak out. I had a plan for what I was going to do that day. I got half way through the session and she told me her grandmother died. It was like, oh, throw my treatment plan away, my assignment, everything out the window. Let's talk about that. I might have an agenda but it only works after the client tells me where they're at. That's the way I've operated ever since.

This quote is a good representation of the manner and tone in which EBPs were described by mental health practitioners. Most mental health practitioners I interviewed immediately recognized the value of EBPs, but discussed them as a good place to start, not the privileged determinant of their everyday clinical work.

While I'm all about evidence based interventions and goals and treatment plans, it's really important that you allow room for interventions that you can't exactly measure. I think family therapy is one of those, because the relationships, when you work at healing relationships and work on identity issues, through relationships, I can see growth and reduction of symptoms, but I'm not sure I could measure that. Although on my treatment plan, you know it does ask about reduction in symptoms, and we can speak to those. But I use a lot of narrative therapy. I am rather eclectic even though family therapy is my home. I think doing therapy is really an art. If it becomes too quote "scientific" and measurable it takes away the room for the art.

The speaker above is a seasoned licensed mental health professional who runs a group practice in a rural area of a large Midwestern state. She acknowledges the importance of EBPs, yet also describes how the field must continue to allow room for some types of

treatment that aren't currently considered EBPs. In another interview with this professional, she commented on using software programs that help guide the therapists in her practice towards EBP interventions, language and documentation. When we discussed what had changed about the mental health field as a whole, she brought up the related shift between EBPs and theoretical orientations and suggested this shift was the result of third party payer influence.

I think there is more emphasis on evidence based interventions which I think is a good thing. I think there is more accountability which is also a good thing. On the negative side I think we're moving more towards a method driven versus art driven form of doing therapy because of those things. I think keeping the art in therapy is going to be a challenge because I think it is a very creative process and I worry we're losing room for that creative process to work, because there is more charting, keeping demands from everyone, and trying to do more with less time. I'm not sure there is as much appreciation for the family systems model as there was back in the 80s. Our field is shifting; you know more toward a medical model rather than family systems. A large part of that is driven by third party payers, you have to show of course, make a case for medical necessity.

Thus, this practitioner values EBPs; she uses them herself in her everyday clinical work, and has adopted a software program for her entire practice that organizes all of her therapists' work in EBP language and recommendations for interventions. Yet, while fully supportive of EBPs, she expressed her concerns with how they might cause the field to lose room for therapy as an art form, not to mention particular theoretical orientations and interventions that are not considered evidence-based. Similarly, another professional who also directs her own out-patient clinical practice, shared the view that mental health professionals needed the freedom to continue to use non-EBP treatments.

Well, it depends on your definition of evidence-based practice. . . . The things that I use, are they effective? I would say absolutely. Do they have some evidence behind them? Yes. Are they considered, under government standards...? No. They're not. Do I think things like play therapy and art therapy, solution focused type things, things that don't have a quantity behind them, are they effective? Absolutely. But are things like behavior

modification, which can be quantified, are those also effective? Absolutely. Different things, different settings, with the right people, are always effective. But you have to be able to have the freedom to be able to use different things.

Again, MHPs I interviewed emphasized that while they value the scientific aspects of psychotherapy, there continue to be several treatments that have yet to be validated as EBPs.

What I've figured out is you have to be well read and keep up with evidence based practice reading and conferences and list serves, up to date, but at the same time I've also learned you have to have some flexibility. If there's a treatment protocol you can't always adhere to it strictly like you would in research or training. It just doesn't work that way. There has to be some flexibility for being responsive to the individual sitting in front of you.

In the above quote, the mental health practitioner states the importance of EBPs in guiding her everyday work, but stresses the importance of being flexible in enacting therapeutic treatment practices. Here, again, the individual patient is as important in determining how a practitioner proceeds as is the EBP.

Each child is so different just like each therapist. It's not like you're giving a shot or you know, the medicine, you're bringing in your own personality, the social environment, everything that is a factor in shaping emotional well-being.

Thus, MHPs emphasize that not only is the individual patient's subjectivities and social environment important, but so too, is the therapist's own personality, theoretical orientation and treatment techniques. EBPs are valuable, but cannot determine treatment plans without valuable input from all of these other considerations. A mental health therapist who works in an in-patient treatment center where there is usually very limited, if any physical touching between staff, therapists and patients, describes how sometimes therapeutic progress depends on creative interventions rather than just EBPs.

I think they're good. They definitely have their place. It's nice to go to people and say, in research this has been shown to work. However I'm not so sure that

if it hasn't been proven as evidence based, that it's completely discountable, it's not to say it won't work because there's been other things that maybe research hasn't shown yet but I found it to work really well.

As a follow up, I asked if she could give me an example of something that works well but that hasn't been included as an EBP:

There was one young man who had mom attachment issues, no family, never got hugged or touched in the appropriate way. We started doing yoga with him, and the yoga allowed him to self-regulate, and also allowed for some appropriate touching. After watching how we would do the poses or I would do the poses he would mimic them and we would say 'oh no your arm, is it ok if I touch your arm? Your arm needs to go here.' I was kind of doing that on purpose because he had never had touch, to help regulate oh this is what normal touch is. After we would do yoga, he would have great afternoons.

This description illustrates the multifaceted issues that therapists have with EBPs.

While EBPs are almost uniformly valued, practitioners' everyday clinical work was just as much guided by individual patients, their identity and social circumstances. Further, several mental health disorders or problems do not have corresponding EBPs because there haven't been studies either because that area of mental illness or that therapeutic intervention is too difficult to study and measure using RCTs.

### ***Defining Mental Illness and Therapeutic Interventions through EBPs***

In this section, my findings demonstrate how practitioners struggle with the definition and measurement of EBPs, including how the scientific assumptions and methods of EBPs define mental disorders and patienthood. The development and implementation of treatment plans was characterized as much grayer in everyday clinical practices than the way that diagnosis and treatment are framed within EBP protocols such as those adopted by managed care companies. One of the key aspects of the way EBPs redefine mental illness that practitioners

struggled with was the way that individual and social group diversity is unaddressed. When interviewing mental health professionals I asked them questions about what difference it makes that their patients are adolescents, male or female, Hispanic immigrants, or in the process of exploring their sexuality. In other words, I wanted to know to what extent scientific knowledge at the level of the population, and life experiences at the level of social status characteristics—what Steven Epstein (2007) has labeled niche group standardization in biomedical paradigms, matters for defining and intervening in adolescent mental health care. One of the areas of the interview where individual patient differences (both social group and individual subjectivity based) emerged was in the discussions I had with professionals about EBPs.

No [not a best approach]. If best is evidence based practice or empirically based thing, I think that's a limitation of social science research at this point, to have more choices out there, so while I think it's important to understand the research and what is evidence based, I don't put 100% stock into something that hasn't been, and studying for my comps I think it's important to, if something is more experimental or new, I think it's important to inform the client that it's something new. I think it's important ethically to use the most current and most appropriate for your client, considering multicultural factors and being in DC you can't ignore the multicultural diversity, for every age, gender, disability status, race, etc, thinking about evidence based practices, what were the groups that were studied? Especially when it comes to adolescents. What was group that they are generalizing from compared to groups or individuals I'm working with? Personality assessments are pretty much un-normed samples, but being knowledgeable when interpreting those is important.

Similar to the mental health practitioner quoted above, who discussed the limitations of social science and EBPs literature, others discussed their concerns with trying to quantify these differences in ways that are not only nonsensical, but offensive.

I think they're good but they're not applicable to everyone and that's something we have to accept. Unfortunately certain grants require that you use only

evidence based practices. I don't know if that would be referred to as the cookie cutter therapy but that's not how this field I think can be successful. I don't think that every concept can be quantified. Something that I've worked with that I've been pretty vigilant about is having an identity scale for American Indians and I've gone to cultural competency trainings where its recommended that the clinician use a scale to identify how Indian a certain person is and I am just appalled that I would need to put my level of Indianness on a 1 to 10 scale. That's not something that can be measured and I don't truly see the benefit of me having to do that. There are certain concepts that I do not believe should be measured. I think we as humans sometimes have this God complex to where we want to control everything and put everything in numbers so we can put it in a formula, then we can predict behavior and we can control behavior. I'm not in favor of quantifying everything.

Many practitioners questioned the extent to which not only psychotherapy, but emotional well-being, is measureable, especially via the gold standard of RCTs.

Well, I mean that's the hard thing about this field is that it isn't a problem that you can sit down and figure out and come up with an exact number to things. Sometimes you have to be really creative with some of them, to get them to be measurable, and that is hard. You know the whole, "are they better or are they not better?" On my plans I have, under my objectives, I can list different levels of if it's a completed goal or if it's a regression on the goal or if it's some progress and even that helps measure in some degree. You know, if you're regressing then it's not getting good, obviously, but I think it is hard to measure sometimes. You have to be really creative.

The therapist above discusses the difficulty of measuring whether a patient's mental health is improving. Of course the reason why scientific researchers find it so difficult to standardize the definition and measurement of mental health and illness in the literature is because of the sheer variety in its presentation, severity and circumstances.

For some mental health practitioners, the focus on finding a way to measure or quantify mental health and illness and therapeutic progress are things in themselves that they struggle with. *"I see the need for it [EBPs] yet I have a hard time putting numbers and measurements on human life. I think we're more complicated than that. I think progress isn't always shown in those evidence based ways."* In response to my question

about EBPs, the following LMHP questions the extent to which we can even measure emotional well-being in day-to-day emotional healing.

Evidence based medicine and evidence based practices? There's a time and a place for that, I just don't necessarily think that that is all there is. I'm not sure that everything has to be evidence based because I think there's a lot that you're never going to be able to find evidence to substantiate, but I don't think that means that it's not important, significant or that it shouldn't be looked at. Everybody wants to make it into black or white, either or, and for me so often everything is just so gray. As far as I'm concerned, as somebody who is going to encourage clients to consider medication or certainly other times with my son who is going to take medication, I want that to be evidence based. If we're talking about medicine or medical interventions, chemotherapy, cardiac surgery, then that to me seems very scientific and that seems like it lends itself to evidence based practices. If we're talking about somebody's emotional wellbeing, I am not sure how to measure that, how to quantify outcomes. Certainly if you're talking about something like a cutter, you want a cutter to become a non-cutter but even if they become a non-cutter, is their emotional wellbeing really improved or have they just decided they're going to torture themselves in some other way rather than cutting? Do you know what I mean? You can say your intervention is yielding the desired results because they're not cutting but emotional well-being is so hard to quantify. Mental health therapy is all about improving one's emotional wellbeing.

Several mental health professionals voiced concerns about how the field increasingly defines mental health and illness in a discrete, objective or "black/white" versus continuous, subjective "gray" manner. Debates over how best to define and measure mental health and illness are on-going in contemporary clinical and research settings.

I think evidence based gives that baseline and gives that standard, uniform measurable outcome. But then is it the best, is it the best for every person? What could be the best for every person? I think there are a lot of evidence based practices that are very effective but I don't think it's black or white. I think it's gray a little bit.

Another way that mental health practitioners expressed reserved acceptance of EBPs is by questioning the extent to which it works for all individuals. In the IOM (2001) definition of EBPs, scientific evidence, clinical expertise and patient values were each important factors in determining diagnosis and therapeutic



intervention. In a manner similar to Reed (2006) and Messer (2006), therapists did not think evidence should be privileged over clinical expertise or individual patient values and circumstances. In opposition to Kihlstrom (2006), the mental health practitioners I interviewed did not think it made sense to define and measure mental health and illness in a way that ignores the subjectivity of patients nor the social circumstances of their lives.

I love statistics. I took extra statistics courses but you can lie so easily with statistics. It can be so misleading. Okay, so CBT [Cognitive Behavioral Therapy] works great for ADHD kids. We did a study, you know, it was 80% effective, that's fantastic. Well that means every 20 kids out of 100 that come in here, that's not going to be helpful for. It's definitely good to be aware that these things tend to be more helpful than others, but I don't look at the diagnosis in isolation. For those ADHD kids that went to a school with really small class sizes, or the ADHD kids that got sent home from school three days a week and spent the rest of the time at home watching TV or playing video games because they got kicked out of school, you know there are so many more environmental things. I think its good to be aware, but I don't think its good to be like okay, so session one— we are going to do this and this. By session 12, you'll be perfect.

This therapist represents a position I heard frequently – that while it's helpful to have EBPs as a starting point or as a guideline, there are other social environmental factors surrounding the patient that are equally important in therapists' day-to-day work of creating treatment plans and carrying out therapeutic interventions. Mental health professionals also recognized how EBPs were connected to the politics of their field – mainly, their funding or payment sources.

I think they have made a big push towards evidence based. Politics has a lot to do with it. You've got to be able to stay alive-- in your field it might be publish or perish, we need things like parity, and there's nothing wrong with evidence based therapy except it tends to exclude certain approaches that would be effective but that are difficult to measure and study. If you don't have RCTs for this particular approach then someone is ready to throw it in the trash can and I'm not.

In addition to discussing his thoughts on EBPs with me, this therapist who works in a

variety of out-patient therapy settings, and was very knowledgeable about the debates in the scientific literature, sided with the others in his assessment that EBPs are good but several other therapeutic approaches that have yet to be proven to be effective, should not be excluded from clinical practice work. In a different interview with another extremely knowledgeable mental health therapist who worked in a community mental health center in an east coast metropolitan area, EBM and EBPs came up as an important shift in the larger mental health field.

I guess the one emphasis I see is there is a lot of talk about this Evidence Based Practices and I would say that when I was in school, it was more of a strong psychodynamic piece was pretty strong. There were faculty that had cognitive behavioral or family approaches but there was a fairly strong psychodynamic influence. I think that's changed a little bit. our ongoing training there's all this talk about well there's these evidence based practices and manualized treatments which are definitely more along the cognitive behavioral model.

I followed up by asking her what she thinks about this shift from a psychodynamic to EBP and CBT focused training in mental health training and the larger field.

There are some positives and negatives about it. The thing I don't like is there is movement away from that relationship you have with the client. There's research that shows that's one of the things that accounts for change, if you look at various modalities, they all have equal effect and it's the relationship that's the key.

In her assessment, the field of mental health has largely shifted away from a psychodynamic approach where relationships and family systems are a key focus of therapeutic training and intervention. She was concerned about this shift because she obviously values the importance of the therapeutic relationship despite model of illness and type of approach, but is uncertain of the extent to which EBPs devalue the relationship. Yet, she recognized that there are positive aspects of this larger shift (as did others) – such as accountability and concrete therapeutic goals. In addition to hearing about how a push for EBPs has contributed to a move away from a focus on

relationships, mental health professionals also discussed how it favors short term progress over deeper change on an emotional level.

I think its great to a certain point but you know its like, its just cumbersome details that can get in the way in treatment. I think its great to have good data, and we need that, regarding our outcomes but it's very cumbersome. In order to get second order change you have to be able to do all kinds of things to get there. When I sit down with a client I don't necessarily know what approach I'll take that day, but depending on what he or she brings up, well I might go to okay we're going to do a little bit of inner child work today or I'm going to send this home for an assignment and that may be a huge shift that I might not have planned on but it worked or was necessary for this particular client. I don't think about getting the evidence about the outcome, I go with what works for what we're dealing with in the moment. In the end I can see the outcome, we complete treatment and lives change, but that is not the same as what you're looking for [via EBPs].

As a follow up, I asked: "But you believe your therapy is good despite that?" She answered, "*I know it is.*" I asked, "So do you have to translate or prove through treatment plans and measureable goals?" She chimed in, "*No, I don't have to, but that's what they want. You're not going to get more sessions if you can't show evidence based and improvement on the outcomes. On the other hand if you show too much you're not going to get any sessions, they should just be dismissed, discharged. It's just a game.*"

This practitioner, as have many seasoned professionals, has stopped accepting Medicaid clients not because the pay was lower, but because she couldn't handle the way managed care changed and governed her daily clinical practices. Here she discusses how she does not have to make sure that she only uses EBPs or documents her therapeutic interventions in EBP and managed care approved language (measureable goals and outcomes) because she doesn't have managed care regulating her practice. She characterizes the relationship between

managed care and mental health practitioners and requirements of EBP protocols as a game. This dynamic was an important theme in my interviews. The next section offers a glimpse into how mental health practitioners describe actually using EBPs in their daily work.

### ***How EBPs change daily work practices of Mental Health Practitioners***

When asked for more details about how EBPs play out in their daily work practices, most mental health professionals discussed the way their treatment plans have changed to accommodate managed care or insurance company policies. The following explanation of the work necessary to implement EBPs also focuses on treatment plans, but it presents what might be considered an idealistic description.

It's very important that there's some kind of measureable outcome and it can be fairly broad in terms of how that's defined. I think it's important as professionals that we're constantly evaluating the clients. Are we moving in the right direction? Are we working on the things you think are important? I don't tend to do measurable outcomes in practice but I think that could be helpful. I think the industry lends itself to that and that's exactly how they measure things. That's why I like to use that [software] program that I use to help guide my treatment plans, because it's all evidence based practice for their goals. If you're ever going to get audited by insurance companies, you'd better have evidence based stuff to back up what you're doing and not just some smoke and mirrors. Obviously there are things that you deviate from sometimes because something happens. That's part of that flexibility.

I feature this description of implementing EBPs for two reasons. First, the mental health professional quoted above does the majority of psychological testing (assessments and evaluations of new clients) for a large non-profit organization in a Midwestern state.

While her appraisal of the benefits of EBPs is well articulated, after I heard from several other mental health professionals, it seemed that her notion of implementing EBPs was overly idealistic. Because she mostly spends her time doing assessments rather than

actively practicing as a psychotherapist, her vision of EBPs is closer to that of a researcher's. Further, her therapeutic orientation was behaviorally focused, which more easily lends itself to EBPs, compared to many other therapeutic orientations and treatment approaches. The employment of EBPs requires translating therapeutic work into something measureable (both goals and outcomes), including practitioners' documentation and treatment plans.

Practitioners also discussed how EBPs have been a significant feature in the way the mental health field has changed across the past decade. For example, the following professional describes how the shift to relying on EBPs in their daily treatment plans has happened over the course of her professional career.

When I first entered as an intern, treatment plans didn't have to be objective or measureable. You could write a couple of words and call it your goal. The next person reading it wouldn't have a clue what you were intending, so they were very vague. Now writing treatment plans, every goal has to be measureable. We also review our treatment plans monthly and get feedback from the kid as well as from our team to make sure everyone is going in the same path, so there is a lot more supervision, a lot more accountability for the treatment goals and treatment plans. I think the idea of measureable goals is great, because if a kid is transferred onto somebody else for whatever reason, that therapist has an idea, a very specific idea of what you were working on. Reviewing them monthly, ideally that's great because you always know where everyone stands on the goals. Time wise, it's challenging because you have to fill out a whole document for every kid you see every single month and that can get to be overwhelming at times.

Here, a mental health professional describes how in the nine years that she's been practicing, treatment plans have changed from subjective descriptions of what the therapist is working on to become more concrete and measureable. She remarks that the idea of measureable goals is good and helpful for interdisciplinary communication and team-work, but has also increased the amount of time professionals spend on paperwork in their daily work practices. Increases in paperwork and time spent on paperwork were frequently pointed out in interviews as one of the undesirable aspects of how their daily

clinical practices have shifted. However, EBPs have not only increased the amount of paperwork required for contemporary EBP treatment plans and insurance companies, but the content of the paperwork.

I hate writing treatment plans. I absolutely despise writing them because sometimes it is difficult to make something measureable because it's a more qualitative concept. I understand the need to make it measureable, so everybody does know what you're working towards and that it's black and white I guess, so I do understand the need for that. I guess the way I approach it is make a measureable goal but there are so many things, I mean you've got three goals and you can encompass so many things under those, it's kind of like reading between the lines, where all that qualitative stuff can kind of slip in. No I hope they never just make it evidence based. I know Medicaid right now, I don't have any Medicaid clients, cross my fingers, but right now you're having to call, everybody else is having to call and advocate for their clients to say they need more sessions, they need 12 more sessions, 12 individual, 12 family, and Medicaid is deciding yes or no, well [name of local insurance company] is deciding yes or no based on black and white. It's really difficult because people on the other side of the phone aren't necessarily therapists, they aren't necessarily educated in that area so for you to get across the message of all of those qualitative concepts, no, they don't want to hear it, they want black and white.

Insurance companies require mental health professionals to not only use EBPs, but to document their treatment progress and write the treatment plans in particular language of EBPs. The mental health practitioner above discusses how she has to be creative to find ways to work on more qualitative or subjective aspects of a patient's mental health and for those initiatives to be encompassed on her treatment plans under the proper language (objective) and goals (measurable). This kind of translation work appeared to be more difficult for professionals whose theoretical orientations were from more family systems and psychodynamic backgrounds than for behavioral, cognitive or solution focused practitioners. However, these orientations and approaches are not mutually exclusive. In fact, the practitioner quoted above is a licensed marriage and family therapist who describes her approach as constructivist and solution focused. Yet, many practitioners, like her, visibly struggled to translate their theoretical orientation into the language and

content required by EBP protocols of managed care companies.

There is a new realm of information technology in the mental health field that is largely addressing these concerns by structuring the very essence of treatment plans in EBP and insurance company preferred terms. *“Oh I think that’s been a huge enhancement in the field, especially since I’ve started. We have that software called Therascribe, and it helps us with evidence based interventions. There was some resistance when we purchased it a year ago, but now; people were like what did we do before we had it?”*

It has become popular if not almost critical, for psychotherapy practices to adopt some type of computer software program to help translate their diagnoses and treatment goals into EBP language. Programs such as ShrinkRapt, MacPractice, Psychreport, Therascribe and others help contemporary mental health practices and professionals convert their everyday clinical work into the language and content of EBP treatment plans that are managed care approved. Although these software programs greatly reduce threats of audits or other common headaches of dealing with insurance companies for mental health professionals, they don't completely get rid of the translation work required by professionals.

It might start with a struggle to make something quantitative, to make it black and white, so that’s the initial struggle. Then to convey that message to the powers that be that decide how many sessions you get if you get any. Right now more than anything though I think I would definitely emphasize managed care is hindering a lot of services, there is a lot of frustration, a lot more documentation that goes into a lot of behind the scenes work, we’re already filled with client caseload so we don’t have time for all of the administrative side of it but it’s in addition to, so that’s one of the biggest frustrations.

Similar to the description in the previous section about the difficulties of EBPs reframing therapeutic progress in terms of objective, measurable outcomes, the mental health professional quoted above discusses the significant translation work EBPs require. Before

practitioners can even write a treatment plan (software guided or not), they must first figure out how to translate the work they want to do to improve their client's emotional well-being into quantitative terms. Sometimes the translation work goes beyond just the quantification of the client's issues and treatment goals.

We have a certified play therapist and another one that's an art therapist and they [insurance companies] don't like those to show up on interventions anymore so we'll still do them because it's been found to be helpful but whatever study they were looking at says it wasn't so we don't use that. We can't use the word maintain anymore in our plans, so we have to find other ways to say it, and its going to say the exact same thing so we just kind of always have to figure out, you know, communicate with each other, well I just got denied because I said I did play therapy. So, now don't say that and you can do it because it's going to be helpful but don't say that anymore. So I think, we kind of have to code what we're doing in a way, you know, if we just write helping kids, every single time, that's what we do, we just help kids, end of sentence but no, they want to see "as measured by" and you know I start my progress notes before they even come in, reported functioning regarding, and then I fill in the goal ' \_\_\_\_\_ has been impaired' or 'as measured by' . . . or 'as evidenced by' . . . and you know we kind of have to have those specific words in there that they are looking for. We've always said those kinds of information but now they want specific words so. We just all roll our eyes and go to meetings.

Here, a mental health professional discusses how sometimes it's not only the translation of what a professional perceives to be a qualitative, continuous or gray concept into something quantitative, discrete or black/white, but that their treatment plans and actual work begin to take on front stage (treatment plans the insurance companies see) and back stage (the actual techniques used and the way practitioners are viewing the problem) characteristics. Given that diagnoses and treatment plans, and increasingly, EBPs are all connected and controlled by insurance companies, increasingly every aspect of therapeutic treatment, including diagnosis, must be translated or recoded in a formulaic manner to secure approval from the insurance companies.

Yeah, I mean, that's what the push is, you see it in all faucets, it has become insurance driven. I don't agree with that at all. I think there is value in, if a therapist is trying different techniques or doing different techniques, they need to figure out their own that works, you know it's sad that it has to come down to



well, if I give you an adjustment disorder, you won't, you know, they'll only cover services for so long, but if you have something more like anxiety, or depression, then that's a more severe one and I can use the CBT to treat.

Due to this translation work now required by insurance companies, many mental health practitioners such as the one quoted below, leave community or public health settings and start their own practices or stop accepting public forms of payment from their patients.

Largely I don't [use EBPs] because I don't have big brother over me in the form of managed care, and frankly if managed care hadn't of been all about profit as a disguise for mental health intervention, I would have been happy to do evidenced based practice. I'm a PhD psychologist, I would love to measure change in terms of what we're doing in here. It really should be happening, but not by the insurance companies. I would give up the wealthy elite private practice world if I could go back to the real nitty gritty world of treating adolescents in a program with intelligent mental health professionals who can look at outcome and actually make an impact with larger numbers of teens. I don't know many people in my world who have professional PhDs who wouldn't want the same thing. What we were trained for we can't do anymore.

Like many other mental health professionals I spoke with, it isn't EBPs in and of themselves that professionals dislike, but the way that insurance companies use them to constrain or approve of services. EBP protocols have shifted not only the language of psychotherapeutic practice, but in some cases, the actual content. EBPs have been used by managed care in a way that privileges some theoretical orientations and treatments over others to the extent that many mental health professionals really cannot perform therapy the way they were trained (i.e. with a focus on deeper second order level of change in the person). Instead, managed care companies prefer what is labeled in the field as band-aid treatments that focus on surface level symptoms rather than understanding deeper relational or system level problems.

## **CONCLUSION**

The mental health professions encompass a diverse set of disciplinary professions, theoretical orientations and approaches to treatment. While the dominant

paradigm is biomedical or biological psychiatry, the mental health professionals who practice psychotherapy largely ascribe to more holistic theoretical orientations and approaches to intervening in the mental, emotional and behavioral disturbances of youth. For MHPs, the biomedical model leaves out much valuable and necessary information. While biomedicine contributes significantly to scientific understanding of epidemiological and course of illness of various disorders, mental disorders are defined in much broader terms in everyday community psychotherapy. For most practitioners, it was important to adhere to the specific needs and presenting problems of each child and adolescent.

The mental health practitioners I interviewed overwhelmingly adopted theoretical orientations that took a broader perspective of what causes mental health and illness – i.e., they considered multiple aspects as causal in the creation and alleviation of mental disorders. Biomedicine, meaning the biological and genetic aspects of mental illness as well as the potential for chemical imbalances, is viewed as one aspect and thus potential cause of a disturbance, as well as one potential avenue for solution. Contemporary mental health practitioners neither embraced nor dismissed pharmaceuticals or behavioral interventions but often saw them as one aspect of a larger therapeutic treatment plan. In other words, while in popular culture, the social world mental health practitioners with the most power (psychiatry) and the larger medical establishment, biomedicalization processes are rampant or dominate, it is far less influential than these cultural markers would suggest. The significant cultural turn toward biomedical explanations and treatments is not realized in psychotherapeutic practice. Instead, it is actively resisted, negotiated and built upon through eclectic theoretical

orientations and a valuing of social context, relationships and the complexity of personhood.

The psychotherapists I interviewed recognized the importance of the interdisciplinarity of the field and the need to work towards greater collaboration. It is a sign of interdisciplinary professional maturation that each of the different disciplines both understand and value interdisciplinary contributions that are moving the field toward increased team-work and collaboration. With the rapid development of information technologies, not only will documentation, diagnosis and treatment planning be performed electronically, but each of the various types of health specialists and their information will be more easily linked, with more opportunities for collaboration.

There has been considerable discussion about to what extent EBM and EBPs deprofessionalize the health care field via attempts to redefine or heavily shape the content and decisions of health providers. Timmermans and Berg (2003) argue that it makes more sense to figure out how EBPs can be implemented in ways that enhance health professionals' forms of expertise, and better connect different types of professionals together for collaborative opportunities. While I agree with Timmermans and Berg's (2003) analysis and recommendations, I also think that within the mental health field, some professionals' theoretical orientations and therapeutic approaches to treatment are valued more than others and some of this is directly correlated to the hierarchy of evidence discussed by Norcross et al (2006). Mental health professionals are just that – professionals who have gone through years of schooling and certification exams and their clinical expertise as well as the subjectivity and social circumstances of their patients should be valued as much as the evidence produced from RCTs.

It is important to MHPs that psychotherapy continues to be valued as an art form as well as a science. MHPs valued scientific evidence and proven techniques, but not to the extent that they value the diagnosis or disorder more than individual patient subjectivity, background experiences, current values, concerns and social circumstances of their patients seeking treatment. This debate would be easier to address if it occurred in a context where profit motives and the power of the insurance companies was less embedded in the way that EBPs and the DSM have been instituted. Mental health professionals' clinical expertise has been called into question and deprofessionalized to the extent that they are significantly less able to make decisions about the proper theoretical orientation, diagnoses and treatment techniques in their clinical work with patients.

## **Chapter 4: Adolescent Mental Disorder Diagnosis: Taming and Unleashing of the DSM-as-technology in practice**

This chapter examines the social processes of diagnosis with a focus on the ways the Diagnostic and Statistical Manual (DSM) is itself a technology that through the creation of diagnostic categories shapes the everyday clinical work of diagnosis and therapeutic intervention. Two questions guide the analysis: (1) How do mental health practitioners negotiate social processes of diagnosis? And (2), In what ways does the DSM, as a technology, shape the everyday diagnostic and treatment work of mental health practitioners? Addressing these questions begins with the assertion that diagnosis is a sociotechnical process and what is referred to as adolescent mental health care is shaped by and through this process. In what follows, I review two theoretical areas:

### **THE SOCIOLOGY OF DIAGNOSIS**

Diagnostic processes reveal the ways medical institutions define and frame the meanings of mental health and illness; that is, “*diagnosis captures what the medical institution currently believes to be ‘the way things are’*” (Jutel 2009:14). Diagnosis is a work practice that hierarchically orders and organizes ways of being (see Bowker and Star 1999). Sociologists have argued that the work practice of assigning a diagnosis have been made invisible through processes of routinization. Routinization obscures areas of disagreement over terms and meanings. Medical sociologist Eliot Freidson (1970), for example, examined the role diagnosis played in reinforcing medical authority and has led others to more recently analyze the ways diagnostic processes reproduce power relations more generally and include the authority of insurance and pharmaceutical companies.

The social aspects of diagnosis have received a great deal of attention in sociology. In 1990, Phil Brown called for the sociology of diagnosis to become a recognized subfield of sociology due to the potential insight the subject matter can bring to bear on how we define and understand health and illness as well as the social processes that shape diagnostic knowledges and practices (Brown 1990; Jutel 2009). Most recently, the work of Annemarie Jutel (2011; 2009) and several other sociologists (see Blaxter 2009; Gross 2009; Nettleton 2006; Sulik 2009; Van Dijck 2005; Whooley 2010) have revived Brown's call through their work. Seminal publications, symposiums, class syllabi, special journal editions and edited book volumes focused on the sociology of diagnosis continue to assemble. Blaxter (1978) defines diagnosis as both a prescribed set of categories that indicate pathological conditions and the process of judgment whereby a label is applied. Following Blaxter (1978) and Bowker and Star (1999), Jutel (2009) argues that the arena of diagnosis – that is, diagnosis as both category and process is the thing that organizes the clinical practices of medicine but also is a site of contest. Diagnoses and diagnostic processes are contested because of how different disciplinary, scientific and social understandings, explanations, values, beliefs and goals intersect.

#### **THE DSM AS A BIOMEDICAL TECHNOLOGY**

This analysis starts with a conceptualization of the DSM as an innovative biomedical technology. Revolutionary techno-organizational innovations of one era have been found to transform into the invisible infrastructures of the next (Clarke 1988, 1991; Clarke et al. 2010). This is to say that while it might appear obvious that the DSM is a technology supported by disciplinary science, over time, the ways in which the heterogeneity and historicity of the social are embedded inside scientific, technological

and medical assemblages such as the DSM and diagnosis, often become indiscernible (see biomedicalization processes, Clarke et al 2010). Thus, I examine the ways in which the DSM is socially scripted and interpretively flexible, and how meanings of the DSM emerge from practice (for other STS studies that take this approach, see Mamo 2007; Oudshoorn 1996; Petryna 2002).

Within the mental health field, the profession of psychiatry is the dominant professional group with authority to codify diagnostic criteria and to transform a distressed person, into a biomedical identity, through the application of its diagnostic categories. The legally and socially institutionalized DSM, created by the American Psychiatric Association, is a technological actant (non-human actor) that shapes processes of diagnosis. The DSM was initially developed by the American Psychiatric Association as a communication tool for practitioners, with the goal of standardizing the language used to speak about what were, in the early 20<sup>th</sup> century, considered issues of mental hygiene. As discussed in Chapter One, the publication of the DSM III in 1980 was revolutionary in its forging of U.S. biopsychiatry as a mass, global approach to mental distress.

Sociologist Jackie Orr adeptly argues that the DSM III solidified power-knowledge entanglements between “*psychiatry, psychotherapy, medicine, the pharmaceutical industry, the legal system, the insurance industry, social and self identity and popular discourse*” (Orr 2010:354; see also Kirk and Kutchins 1992; Lowe 1995; Wilson 1993). The DSM has been firmly grounded in the medical model and biological psychiatry since the DSM III (the first two versions were more psychoanalytical and psychosocial), and Psychiatry has been legitimated as a medical discipline through these

ongoing scientific efforts at operationalization and standardization of mental disorder diagnoses. The DSM III accomplished the routinization of diagnosis itself as an automated practitioner performance of systematically collecting certain information to determine if standardized sets of criteria were met, including suggestions for treatment for each discrete mental disorder. In part, the field of psychiatry accomplished this by creating an informatics of diagnosis (Orr 2010), or a classification system with its own language of codable symptoms and computerizable criteria.

Recognizing the tensions that have emerged at the level of practice due to psychiatry's strategy to achieve scientificity through DSM standardization, and the organizational constraints external actors such as insurance companies have imposed on clinical practice, Owen Whooley (2010) interviewed psychiatrists in New York to find out how they negotiate the DSM's institutionalization and standardization. He argues that psychiatrists develop strategies or work-arounds to cope with the ambivalence they feel regarding DSM diagnosis and the loss of professional authority that results from institutionalization of the DSM by outside agents such as insurance companies.

Following Whooley, I interviewed mental health professionals about the social processes of diagnosis and how they negotiate the DSM and insurance company policies in their everyday clinical practices. While Whooley (2010) focused on psychiatrists who themselves have been heavily trained in the DSM, diagnosis and the biomedical model, I interviewed other mental health professionals whose primary theoretical orientations tend to be much less biomedical and diagnostic and more focused on biopsychosocial or psychotherapeutic healing.



In what follows, I take the feminist concern with studying the experiences and voices of not only women, but groups in society located in subjugated positions of power seriously and examine the mental health professions from the view of those with the least power hierarchically. The psychologists, social workers, marriage and family therapists, counselors, nurses and paraprofessionals, whose daily work activities are significantly shaped by biological psychiatry and the DSM, but whose use of the DSM emerges from their own material-semiotic meanings and locations, are the focus of this chapter.

### **FINDINGS: DSM AS A SOCIOTECHNOLOGY**

I asked mental health professionals an extensive set of questions about their diagnostic practices and the role the DSM as technoscientific actant plays in those practices. In my interviews, professionals often talked about diagnosis and the DSM as though they were the same thing. I would ask about diagnostic practices and hear answers about the DSM and insurance companies. Thus, it quickly became apparent that the DSM as a biomedical technology functions as what in the STS literature is known as an obligatory passage point—all initial patient-practitioner diagnostic encounters must pass through the DSM in order to accomplish diagnosis (for usage of obligatory passage point, see Callon 1986).

I show how mental health therapists challenge or seek to undermine the cultural authority of the DSM and downplay the significance it has for their everyday clinical work thereby negotiating power relations among multiple institutions, actors, and technologies. I employ the sociology of diagnosis as a framework for analyzing interviews with mental health professionals about their everyday diagnostic work. Mental disorder classifications, enacted through diagnostic practices, hold together or reproduce

sets of social arrangements in the mental health arena. As an analytic framework, the sociology of diagnosis facilitates the identification of the multiple interests and issues shaping and shaped by the DSM and everything that enters the diagnostic process. This allows analysis of the complex interactions of the socio-technical negotiations within the work of mental health diagnostic and treatment practices.

### ***A Necessary Tool for Accomplishing Diagnosis***

While the majority of MHPs' narratives depict the DSM as a simple tool that was necessary but insignificant for their everyday clinical work, some practitioners also discussed how the DSM technology enhances diagnostic clarity, interdisciplinary communication, collaboration with other professionals, and patient education. Before turning to how the significance of the DSM was repeatedly undermined by practitioners in my interviews, first I focus here on the ways the DSM enhanced everyday clinical practices.

I value the DSM. I do. I value having some form of thinking about symptoms and behaviors. I don't think it's a pure thing, but it helps me for example think about the difference in anxiety versus ADHD which are often confused. It helps me think about insecure attachment instead of ODD. Psychologists are very well trained in the DSM and I think if the DSM is used very skillfully it's a really great discriminatory tool. It helps us make discrepancies and pay attention to comorbidity. It also helps educate families and adults and even teens and it helps take the stigma away frankly. When people understand that there is a disorder, they are very relieved by it.

This clinical psychologist describes the DSM as valuable in that it helps her think about symptoms and behaviors, distinguish one disorder from another and address issues of comorbidity. Further, she characterizes the DSM as a discriminatory tool that can be used to educate families and the larger public about mental illness. *"It's helpful in that it gives me a billing code, so the billing people are off my back. It can be helpful when I'm not*

*sure. When I'm just not sure what's going on it can kind of open my eyes to 'these are the possibilities' and at least give me a starter path to what I might be dealing with, so it can be helpful in that aspect."* Similarly, this MHP's description depicts the DSM as a useful tool that she can draw on for ideas of what might be the problem or the disorder of a particular patient, and thus gives her a good starting point for her treatment plan. While the extent to which the diagnostic process and the DSM actually shaped treatment practices was a contentious issue, multiple practitioners noted how they draw on the information the DSM and initial diagnosis provides in writing their treatment plans. Also, the DSM is a helpful tool in that it gives practitioners billing codes so they can get paid for their work. This was frequently cited as the primary way the DSM helps practitioners accomplish the bureaucratic aspects of their work.

Every time I try to come up with a diagnostic impression I use it, every time. It refocuses me. Is it perfect? Of course not. You always have to use your clinical judgment. I keep using it and I never feel like I know it very well. It's not a perfect source. It can't answer all questions because a person is very dimensional you and it is looking pretty specifically at behavior. You know does he do this, this, this, and this, and if he does four out of these six then it's this. That's not a perfect standard because what if he does 3 of those and then you can't technically use it, there is a lot of clinical judgment mixed in.

Here the mental health professional offers a narrative of the DSM as a necessary and useful tool in the accomplishment of diagnosis and documentation of progress in therapeutic treatment. Yet this professional also notes the ways in which the DSM is less than a perfect source or standard because human beings are multidimensional and do not always align with the discrete symptom criteria for one disorder category. This professional uses the DSM technology as a tool to help perform her work but notes that her clinical judgment is crucial in negotiating the DSM in diagnostic and documentation procedures.

In addition to being described as a tool that enhances diagnostic clarity and helps professionals get paid, some practitioners noted the DSM as helpful for interdisciplinary communication and collaboration.

I would say [the DSM is] helpful when I work with the schools because it gives us a common tool to look at, to explain some of the issues or limitations the client might be up against. [People at the] schools [feel the] need to perceive it as a bad behavior that the child has control over, but if I can show them in the DSM, no, this is an actual diagnosis and we're up against this, I think that's a different view for some of the [professionals at the] schools, and even for parents as well.

Just as the DSM legitimated biological psychiatry and the field of psychiatry as scientific medicine, MHPs can draw on its cultural authority to help school professionals and parents understand the complexity of mental, emotional and behavioral problems of youth. *"I do hundreds of mental health assessments a year. That's how I always open a case up. Trying to be accurate with the diagnostic terminology today. I want the other interdisciplinary colleagues; I want to be able to think like them and use language that they can understand so we agree about this person."* Thus, while this MHP adamantly spoke out about the limitations of biological psychiatry, in his assessment work he draws on the cultural authority and terminology of the DSM to help him with interdisciplinary collaboration so all of the professionals in a teen's life agree on the goals and treatment plan.

I use it as a teaching tool too, because I can open it up to, like with a parent, a concerned mom let's say, comes in and she doesn't know what the kid's dealing with, whether or not medication might help and I'll pull that out and show her the list of things, the criteria for diagnosing let's say obsessive compulsive disorder. I'll read them to her, she can picture her kid in that situation, you know. Does Johnny have this, this, this and this? I'll use it for that, and then I'll use it with the kids with Oppositional defiant, I'll pull it out and say this is what I diagnosed you with and say does this sound like you?

Similarly, the professional above draws on the DSM technology and its cultural authority as a tool to communicate with parents and patients about the symptoms they are witnessing and experiencing to reach consensus about the most appropriate diagnosis. “*A diagnosis can be helpful because if you’re working with other professionals or if a case is transferred they know what you saw to be the issue. But again, that could be resolved, just presenting the initial problems, and then just transferring that on.*” This practitioner (who works in both clinical out-patient and school settings each week), points out how the DSM helps with inter-professional communication and collaboration. However, she simultaneously questions the necessity of the DSM by stating that inter-professional communication and collaboration could also be accomplished by using presenting symptoms as a guideline for communication. Her framing and terminology of presenting problems (rather than standardized symptom criteria and disorder categories of the DSM), demonstrates there is much more at stake in social processes of diagnosis, including how mental health and illness is defined and measured, and even how we intervene.

This narrative was a popular one; that the DSM technology is a tool that can be helpful and even necessary for diagnosis and billing, but that it’s not really that important, i.e. it doesn’t really shape treatment plans, therapeutic approach or everyday clinical work. As I will demonstrate, practitioners were quick to dismiss the significance of the DSM, yet they simultaneously (sometimes reluctantly) recognized its role in the accomplishment of their work, especially the cultural authority it holds in the mental health field and society.

### ***Underdetermined Significance of DSM***

While some of the mental health professionals recognized the ways in which the DSM is helpful in the accomplishment of their work (as shown above), it was much more common for my interviewees to be dismissive when asked about the importance or value of the DSM, and the role it plays in their everyday clinical work. “. . . *the DSM I really only get out if I have to do billing paperwork. Other than that, it's really not that big of a deal to me.*” Practitioners depicted the DSM as just a tool, something that doesn't impact their treatment, as a means to an end, as the bible of the psychiatric profession but not their own discipline, as mostly irrelevant when working with teens, and as simply helpful for billing.

I pretty much divide that, I treat that as a paper work thing. The label, the diagnosis that the insurance companies want to know to pay, so that's my business paperwork aspect more than really how I go about treating and working with the adolescents. I use it [the DSM] probably in every client, to diagnose them, to give that label that they need. It does give me clarity on what I'm working with, but I don't let that influence or change the way I work with them.

Thus practitioners often talked about the DSM as a simple tool they use so they can get paid, have the proper paperwork, and even gain clarity about the disorder of their client, but they simultaneously discounted its significance in shaping their therapeutic treatment plans and practices. In addition to minimizing the importance of the DSM in treatment practices, several practitioners also discussed diagnosis itself as though it were an unimportant aspect of their everyday work with adolescents.

We need it in order to do diagnosis, but in our field, especially our work with adolescents, we are constantly updating their diagnosis. Some of our kids have had, no joke, seven different diagnoses, and none of them really fit, so we try to find the best fit but that goes back to why we don't, I don't work with the diagnosis. I work with the child. One kid right now is pretty clearly borderline personality disorder. However, he's 15, so we don't have that as a diagnosis. I do keep that in the back of my head when doing treatment,

because then I have to use certain techniques. Like, if he needs emotional regulation, he needs a lot of different kinds of work than a kid without borderline would have. One kid has had some pre-schizophrenic stuff going on. I definitely considered that when working with him but it didn't drive my treatment.

Again, in their initial response to the role the DSM technology plays in their everyday work, practitioners most frequently discussed it as a necessary tool for diagnosis, but as insignificant for the way they conceptualize the adolescent and his or her illness and their development of a treatment plan. Yet, you also see in this quote that while she emphasizes that she works with children, not diagnoses, she also discusses how the type of disorder, as it is categorized in the DSM, is a consideration (at least in the back of her mind) when carrying out therapeutic work. Thus even when MHPs point out the clear influence disorder categories, and thus the DSM, have on their treatment plans, they discuss the DSM in ways that attempt to undermine its authority over their own clinical judgment and expertise.

I offer two more exemplars below of how practitioners discussed the DSM and diagnosis as insignificant in shaping their everyday therapeutic work.

I'm not sure it really shapes my approach. It's a resource to help me confirm a diagnosis. The majority of cases I see have already been diagnosed, so I can go back and see if that is exactly what I'm seeing . . . With most practitioners, you can't change a diagnosis but you can change your treatment approach because the diagnoses [or the symptoms and life problems] do tend to change.

When asked specific questions about how the DSM and diagnosis shape their treatment practices, practitioners frequently dismissed their significance. *"I'm trying to think of how it would be, because I'm aware now, as if I was a client I would be aware I would probably want to insert a should here, it [the DSM] probably should be more relevant in my daily work than it is but it's really not. I mean I don't really use it. I don't look to it for*

*any sort of intervention because it doesn't really offer intervention.*" Minimizing the significance of the role the DSM technology plays in shaping psychotherapy practice emerged as a primary way that mental health professionals negotiate the bureaucratic and biomedical ordering of out-patient clinical practice settings.

The concept of negotiated order refers to the capacities of different actors to protect their own interests and to achieve their goals while acknowledging and acceding to others' interests (Strauss 1978). Traditionally this concept has been used in interactionist sociology of health and illness studies to examine how meanings are created and sustained through human interactions in organizational settings such as hospitals. Interestingly, in my study, mental health practitioners create and sustain therapeutic meaning not only in interaction with their patients, other providers and insurance companies, but also in interaction with the DSM as a socially scripted, technoscientific actant. Mental health practitioners have conflicting interests and commitments in their negotiations of diagnostic practices in general and the cultural and technoscientific authority of the DSM in particular. While most practitioners must operate under diagnostic standardization, there is interpretive flexibility within and across sites of practice.

In his examination of the standardization of the DSM, Whooley (2010) utilized Clarke and Casper's (1996) concept of workarounds to show the strategies psychiatrists employ that enable them to comply with the formal rules of insurance companies while maintaining their own professional discretion and autonomy. He analyzes three workarounds that were prevalent among the psychiatrists he interviewed in the state of New York: (1) the employment of alternative typologies/taxonomies, (2) fudging the



numbers or codes on official documentation, and (3) negotiating diagnoses with patients. Each of these workarounds was used by the mental health practitioners I interviewed. Rather than illustrating that the mental health practitioners use these workarounds, I demonstrate how these and other workarounds such as Cribbing are necessary for mental health practitioners' negotiations of biomedical and bureaucratic standardization processes that are embedded in diagnosis.

Whooley (2010) found that psychiatrists employ alternative taxonomies because the diagnostic (theoretical) frameworks they apply in practice diverge from the standardized assessment of symptoms as laid out in the DSM. Thus, in using this workaround, mental health practitioners diagnose according to their own understanding of mental illness and then translate that into DSM terms after the fact (Whooley 2010). This strategy demonstrates that even psychiatrists themselves, who are heavily trained in biological psychiatry and use of the DSM, critique the biomedical model, de-emphasize the assessment of symptoms, and privilege professional discretion in their everyday work with patients. Whooley (2010) argues that for psychiatrists this workaround isn't unethical because the DSM's categories don't reflect what they are seeing in their patients, and thus it doesn't fully guide their treatment plans.

The strategy of workarounds was also commonly used by the majority of mental health practitioners I interviewed. Employing alternative taxonomies serves as more than just a workaround that allows MHPs to keep face in their own professional authority and discretion while following bureaucratic policies. The alternative taxonomy workaround enables psychologists, counselors and social workers to continue to view mental illness from their own eclectic, holistic, psychodynamic orientations.

In the second workaround, fudging the numbers, practitioners disguise actual practices while superficially complying with bureaucratic and biomedical standardization. The reason practitioners might fudge the numbers or the diagnostic codes is that they learn certain insurance companies have a history of denying particular diagnoses and thus might have to work around this through over-diagnosis. On the other hand, I found practitioners to be painfully aware of and concerned about stigma associated with diagnostic labels. When they could, they punted low, or utilized a strategy of under-diagnosis. The strategy of making diagnoses vague or giving what are sometimes called garbage can or waste-basket diagnoses, I argue, is also a form of resisting the biomedicalization and bureaucratization of the DSM. Insurance companies have standardized diagnostic policies that demand mental illness reimbursement hinges on proving medical necessity rather than social psychological suffering. However, the majority of MHPs I interviewed didn't define mental health and illness from a biomedical or diagnostic theoretical framework.

With the third workaround, negotiating diagnoses with patients, mental health practitioners undermine the biomedical model enshrouded in the DSM and, instead, privilege patient subjectivity and experiences of illness over objective clusters of symptoms and DSM guidelines. I found that practitioners frequently draw upon the cultural authority of the DSM in working with adolescent patients, their parents and other care providers, but simultaneously undermine its significance in shaping their actual theoretical orientations or therapeutic treatment practices.

## NEGOTIATING STANDARDIZATION

This data section focuses on the different ways that practitioners negotiate the orders of biomedical and bureaucratic standardization in diagnostic practices. While the term standardization implies uniform diagnostic processes, the ways that insurance companies and individual care organizations structure or inform diagnostic practices through paperwork requirements and other policies are as varied as the kinds of mental health professionals who carry out this work, and the array of patients they see. *“Of course because of insurance you have to come up with some diagnosis. Typically you have to make it vague. Medicaid doesn’t cover anything related to developmental disability or autism—basic developmental disorders— so even if a kid has that, you can’t diagnose him with that because it won’t be covered.”*

Bureaucratic standardization took on a different character or negotiated order across different types of care settings. Thus, the practitioner above discusses how in his out-patient practice setting, the insurance company that organizes Medicaid for this large Midwestern state has repeatedly denied authorizations for treating childhood or adolescent patients whose primary diagnosis is a developmental disorder. The counselor above negotiates the insurance bureaucratization he experiences in his work by *“making it vague.”* Whooley (2010:461) found psychiatrists make their diagnosis vague in order to disguise their actual practices of diagnosis and to protect their patients from harsher diagnostic stigma while superficially complying with organizational or bureaucratic requirements.

As I conducted interviews across a Midwestern state and a large metropolitan area on the East coast and across different types of care settings, I struggled to find patterns in

practitioners' negotiations of types of disorder diagnoses they knew to avoid. While some disorder categories repeatedly came up as problematic, those that were often denied seemed to shift without any rational reason. While radical shrinking of the DSM (using way fewer diagnostic categories than those fully represented in the book) occurred as a workaround strategy of mental health providers I interviewed, it seemed to take on a bit more of a forced character when employed by mental health practitioners who are not psychiatrists. Whooley (2010) describes how psychiatrists often drastically reduce the number of categories they use to a few codes and examines all of the motivations for doing so. While some of these motivations such as using different theoretical orientation or logic of diagnosis in which broad classes of patients are created – those with more serious disorders and others to be shielded from the DSM, were heavily used, mental health practitioners I interviewed talked just as much about the ways in which health insurance company histories of denial created a collective knowledge about which codes to/not to use. Therefore, the shrinking of the DSM may exist as a workaround for mental health practitioners to abide by policies while operating under their own interpretations of mental illness and best treatment approaches, but it also serves as a workaround for the insurance companies to restrict payment or types of care to types of patients and disorders.

Well it's the bible for insurance companies. Again, you have to give a diagnosis to be reimbursed; they will only reimburse certain diagnoses. Like United Behavioral Health, which is one of the most annoying ones, they have this huge long list of codes they won't reimburse, like they won't reimburse, ADHD, ODD, Conduct disorder, behavior disorder, they'll reimburse this sort of nebulous term, which is disorder of infancy, childhood or adolescence. 313.9.

All mental health practitioners that work in an organizational setting that accepts public

forms of insurance have to make these negotiations. In each care setting, practitioners talk about their experiences of case authorizations and denials. These on-going negotiations create a collective knowledge that shapes future negotiations. I label this process “Cribbing,” because it signifies the collective knowledge-building and translation work required for MHPs to learn the correct answers or codes that will allow them to receive authorization so they may provide therapy to their clients. Further, the term cribbing represents the way in which MHPs’ professional expertise is treated as infantile compared to the reimbursement policies of insurers. However, the success of cribbing varied. Sometimes, even in the settings where practitioners learned from each other’s experiences, the rationale for insurance company authorization or denial remained a mystery.

I have no clue what they’re thinking. All that I know is that they denied my request for authorization and said that they will review it because; well . . . that particular diagnosis is not covered according to them. It’s covered for others [insurers] so I don’t understand. And then they will review it. They don’t give you a time frame, so I don’t know what’s going on with it.

This practitioner discussed how she had recently had a request for authorization (for new services) denied and was frustrated by the numerous hours she had spent making phone calls and filling out paperwork that requested a review of their denial. Although insurance companies often have standardized policies that guide their authorization decisions, there are multiple insurance providers and different individual agents who make these determinations. What are designed to be rational, standardized decision rules about mental health care are experienced by providers as irrational, at best, and incongruent with how they conceptualize and intervene in mental illness, at worst. This is why cribbing negotiations are practically mandatory, and develop out of on-going interactions

with insurance companies over therapeutic service authorizations and denials. Cribbing processes are on-going in diagnostic work of the mental health professionals and help not only with bureaucratic standardization as demonstrated above, but with the biomedical standardization of mental health and illness.

In order to see me they have to have a diagnosis. I have a DSM. I use it for every client. We all do. For all the managed care purposes, you have to. You can't see a client if you can't prove they have an illness of some kind. Sometimes it's a matter of looking into grey areas to come up with a diagnosis. Like, clearly this client has issues and concerns they need to work on but putting your finger on a specific diagnosis can be difficult, but you're forced to. Sometimes I really hate giving a client a label, for the purposes of getting refunded for the service, because it might not be completely descriptive of that individual, but you have to.

This mental health professional described diagnosis and the DSM as a routine part of her everyday clinical practice, i.e. a bureaucratic requirement. She doesn't describe the DSM or diagnosis as a meaningful aspect of her therapeutic work but frames it as necessary tool for getting reimbursed for services. Not only does she question the significance the DSM and diagnosis hold for her therapeutic work, but she also rejects the idea that a diagnostic (biomedical) label is capable of describing an individual patient. In other words, she subverts the value of the diagnostic label by positioning personhood as the more meaningful aspect of her everyday clinical work with patients. This subversion acts as resistance to the biomedical model by reasserting an alternative taxonomy.

Rejecting the DSM and its role in diagnostic processes on the grounds that the categories didn't seem to fit or fully describe individual patients was a common response to the biomedicalization and bureaucratization of mental illness. The invisible translation work of cribbing, i.e. translating professional logics and valued knowledge about a patient and his/her complex personhood into biomedical categories is an important social

aspect of diagnostic processes and the ways the DSM as a sociotechnical actant shapes those processes. *“It’s hard to categorize anybody so there’s, I guess its just going through the process of diagnosing and putting a person in a category and that’s kind of a hindrance but its not huge. I’ve learned to separate it from the person.”* Sometimes it was the very process of diagnostic categorization (or translation work) itself that mental health practitioners struggled with, as represented in the quote by the mental health practitioner above. Other times, practitioners struggled not with the process of diagnosis, but with the result of diagnosis, the label.

[The DSM is] a hindrance because lets say I give this kid depression [diagnosis], but his depression might look different than the next kid’s depression. This kid might act out in anger because he’s depressed and this other kid might be a recluse and hide himself because he’s depressed. He has the same diagnosis but the symptoms are different. Just because they have the same diagnosis doesn’t mean you treat them the same. I think that can be a hindrance. People just expect them to look the same.

While labeling stands out as an obvious result of diagnostic processes, mental health practitioners were painfully aware of the material consequences labeling can have for youth and frequently cited it as a concern that shaped how they performed diagnosis. Thus, some practitioners struggled with the ways in which diagnostic categories come to represent something about the adolescent person they are treating (see Hacking 2001). In this way, mental health professionals engage in multiple workaround strategies simultaneously. MHPs might fudge the numbers to minimize the consequences of labeling while they also negotiate diagnoses based on patient concerns rather than simply relying on standardized sets of symptom criteria laid out in the DSM. Diagnostic processes and labels strategically become bureaucratic means to providing therapy.

It feels like unless you meet the letter of the criteria, then you're kind out of luck. Then you're stuck trying to figure out where to put a person. They don't meet the criteria for major depression, so you feel like it's not quite a depressive disorder, they don't have five [symptoms of the criteria set], so what do you do with someone who has four, then you give them depressive disorder NOS [Not Otherwise Specified]. But what if while they're short [four instead of five symptoms], they still have frequent suicidal ideation? That to me seems like a major depression, but they don't have five, so that's when it [the DSM] feels like a hindrance. It's so black and white; there is no real room for gray. Sometimes I feel like it misses out on people.

The difficulties of characterizing new clients and their presenting problems in the language and categories of the DSM was a reoccurring theme in practitioners' responses to the ways in which the DSM technology and diagnostic standardization hindered their work.

The point of standardizing biomedical categories of mental disorder in the DSM is to give all social worlds a uniform language and understanding of what they are dealing with. However, as described by the practitioners in the quotes above, sometimes depression looks differently on one kid than another, or some kids might have only three or four of the five symptoms from the checklist to qualify for a given diagnosis. Problems of fit have to do with heterogeneities in patient personhood and experiences of mental illness. For some practitioners, the process of fitting a person and their symptoms into a diagnostic category is uncomfortable for these reasons, but for others, the process of diagnosis and the categories of illness represented in the DSM are in conflict with their theoretical orientation to mental illness and therapeutic approach to healing.

*"I hate giving diagnoses. I hate them a lot. I just really don't feel that they are appropriate. I would rather someone sit down and talk to me for an hour about a client than just five minutes and a diagnosis. I'll give you my time if I feel like its going to be effective, but you are just kind of a hindrance to me because it's another phone call I have to make and I know the information you're getting isn't going to be helpful"*



Thus, for this practitioner, the process and content of diagnosis is an aspect of her clinical work that she despises. While she might not detest the process of coming to some conclusions about the presenting problems of patients, she dislikes having to fit clients and their problems into biomedical categories. Further, she devalues the information that DSM diagnoses collect and offer to insurance providers and others through the medical record. She resists the biomedicalization of mental health and illness by reasserting the importance of patient personhood and information left out of the framework of contemporary standardized mental health practice. As several mental health practitioners' descriptions of diagnosis and the DSM have revealed, practitioners resisted the biomedical model embedded in the DSM and bureaucratic policies by working from alternative taxonomies.

#### **ALTERNATIVE PARADIGMS OF MENTAL HEALTH AND ILLNESS IN DIAGNOSIS**

Mental health practitioners struggled with the bureaucratization and biomedicalization of their work that the DSM and insurance companies facilitated in a number of ways. At the heart of many of these struggles were knowledge-tensions or alternative paradigms in conceptualizing and intervening in mental illness.

No, it's, you have problems communicating, so we're going to work on communication skills today, not, why can't you control your emotions? Or, we're going to do skill building so you can control your emotions. In some ways its like yeah, don't get to the root cause, just put the band aid on and do it quickly and that will save the entire system money. If you make these people better, make them better fast. . . I feel like we're really doing good work, important work, and then you kind of hit up against the DSM wall of the, you can have 1 of 6 diagnoses and all of your goals will come straight from the DSM.

In the quote above, a psychologist who works for a mixed (public and private insurance) practice in a large metropolitan area on the East Coast, critiques how the

biomedical model of the DSM and insurance company policies value and encourage practitioners to work on surface level symptoms rather than deeper communication or emotional issues. This was often a primary way that mental health professionals problematized the influence insurance companies and the biomedical perspective ingrained in the DSM had over their everyday clinical practices.

Several MHPs critiqued how insurance company reimbursement policies limited their work. For example, insurance companies would only reimburse for some disorder diagnoses but not for others, and required treatment plans and goals be written in the biomedical and behavioral language of the DSM. Thus, cribbing isn't just about learning what diagnoses are likely to be covered or denied. Cribbing also describes the collective knowledge building that goes into MHPs' translation work; they must translate their everyday clinical goals, practices and outcomes into the preferred language of psychiatrists and insurers.

It's constrained not by the DSM but by the insurance companies. I think it's interesting because the DSM has changed so much in the past 20-30 years. It used to be that homosexuality was considered a mental disorder, and now PMS has a variation and is considered a disorder, which has caused quite controversy. You know it's a manual for the profession, but it's put out by the American Psychiatric Association, not the American Psychological Association. That's a different approach. It's a medical model.

Again, the mental health practitioner above is conflicted over whether to discuss her work as being constrained by the DSM or by insurance companies. She starts out discussing how it's the insurance companies rather than the DSM that constrains her work, but then goes on to point out how the DSM itself is a manual put out by the Psychiatric rather than Psychological Association. Psychiatrists have demonstrated diagnostic ambivalence due to the way in which insurance companies have taken up the DSM in ways that constrain

their own professional autonomy and expertise (see Whooley 2010). Thus, psychiatrists themselves built the DSM and are heavily trained in its usage and the biomedical paradigm, but experience diagnostic ambivalence due to the countervailing forces of insurance companies and their policies of reimbursement. In contrast, MHPs I interviewed experienced ambivalence about the cultural authority of the DSM. As demonstrated in the previous data sections, MHPs draw on the cultural authority of the DSM to enhance communication and collaboration with their patients and other providers. However, they also resist and undermine the cultural authority of the DSM and the ways it further legitimizes a biomedical perspective of mental health and illness, thereby minimizing their own eclectic and psychodynamic perspectives.

Mental health practitioners struggled in negotiating the biomedical and bureaucratic order established by the union of the DSM technology and insurance companies' policies because of their cultural, legal and scientific authority, and because the biomedical paradigm that authority legitimates are dissimilar from their own. None of the mental health practitioners I interviewed subscribed to a medical model as their theoretical orientation or approach to psychotherapy, yet the majority of MHPs are forced to negotiate their work practices within biomedical and bureaucratic orders. *"I probably under-utilize it. You know if I had good training in it I might more fully appreciate it. My trainer from child guidance, I asked him for training on it and he just poo poohed it. He was Minuchin trained in family systems, which leaves little room for the need of a DSM when you're looking at things from a family systems perspective."*

Mental health practitioners also frequently expressed that they thought maybe if they were trained better they might find more use for, or value in, the DSM. Yet, they

often simultaneously described that they weren't trained on it as much because it never fit with their theoretical framework. Instead, the DSM and the contemporary form of diagnosis that insurance companies impose are positioned as an alternative rather than hegemonic framework.

The only time it hinders my work is [when] you know you get a patient that a psychiatrist or another practitioner has taken the DSMIV and you know it's pretty vague but they tried to make it very specific to the illness. You say 'that's not what I'm seeing,' and they go, 'but the DSMIV says. . .' We only see one aspect of part of that disorder diagnosis rarely, and they will say yeah but it's there, and the DSM IV says that if it's there then it's this. It's hard because . . . we say it's our bible but another practitioner might really believe that.

In the quote above, a psychiatric nurse practitioner discusses how sometimes the authority of the DSM is taken too seriously by other practitioners and how that is when the DSM hinders her work. Mental health practitioners preferred to discuss the DSM as a tool they utilize, and as demonstrated in previous sections, undermined its significance in shaping their work and in ways, resented its cultural authority. As demonstrated in the passage above, the majority of MHPs valued clinical judgment and an in-depth understanding of the patient over the categories of symptom criteria in the biomedical DSM, or the diagnostic label that results from the processes of diagnosis.

We don't treat a diagnosis, we treat the person. Everyone has their own story. Everyone has their own caveats, ways of thinking and perceptions of the world. Getting to know that person, I found to be the most valuable part of treatment. When someone really feels like you know them and understand them, whether you agree with them or not isn't the issue. It's just getting to where they're at, and then they're going to be more open to learning where to go next, or open to suggestions, or open to change. No one wants to change when they're on the defensive.

Thus, mental health professionals valued clinical judgment and understanding the patient over the DSM disorder diagnosis because they argue that understanding the patient

allows therapeutic change, not understanding the disorder diagnosis. Guided by the kind of patient that has the disorder, or patient heterogeneity and complexity over disorder categories, the MHPs I interviewed often reiterated what Messer said about balancing EBPs and clinical expertise: *“In other words, it is frequently more important to know what kind of patient has the disorder than what kind of disorder the patient has”* (Messer 2006:39). The criticism that disorder categories in the DSM fail to account for the complexity of patient experiences of mental illness was at the heart of MHPs’ resistance to standardization.

I think it would definitely be more helpful and more valid to be able to include V codes because often that’s how I see the world, I mean each clinician, that’s why it’s so subjective, each clinician sees the world through their lens of training, but V codes are often how I see, how I understand the client before me, and it’s really hard, and I think part of my disdain for using the DSM is that I can’t really be honest in my viewpoint when I’m billing, because you might have to say oh there’s an adjustment disorder, with depression, when it’s really a parent-child conflict.

Practitioners undermined the significance of the DSM because how they viewed the world and mental illness wasn’t adequately represented in the DSM, but even more so because the relevant parts of the DSM weren’t recognized by their clients’ insurance providers. This is one of many therapists I interviewed who discussed the need to provide counseling to patients who have undergone or are experiencing specific, stressful, life events, which the DSM labels “V-Codes.” V-Codes refer to things like neglect or abuse of a child or adolescent, relational problems such as with a sibling or parent, school problems, bereavement or other social environmental stressors. The DSM specifies that V codes may be given as diagnoses when an individual is suffering from one of these problems but has no behavioral health condition. However, insurers do not recognize V codes as valid Axis I (reimbursable) diagnoses. V codes were discussed as more closely

representing the views of MHPs I interviewed, but their ability to work as a successful workaround was limited.

Practitioners negotiated the DSM and diagnostic practices in ways that opened up alternative meanings of mental health and illness and allowed them to continue seeing and treating patients the way they understood mental illness, patienthood and the world. While the biomedical model of illness remains the dominant paradigm in society, MHPs resist biomedical and bureaucratic standardization in their everyday clinical work. In order to continue to conceptualize and intervene in mental illness and emotional healing in ways more closely aligned with their own theoretical orientations, workarounds and cribbing processes were almost necessary for most MHPs.

I hate the DSM. It's a tool I have to use because of third-party payers. It limits and doesn't begin to define the complexity of what I see in the room with me. It also labels, and I hate doing that. I heard a psychiatrist; his name is Bessel Van Der Koch, from Boston, (Harvard). He was on the committee for the last DSM and the one before that. He said 'it was only meant to be a tool for discussion amongst clinicians, so you could have language to describe a cluster of symptoms, and not have to describe the same thing over and over again when you try to coordinate care. Now it's become this labeling machine that becomes a self-fulfilling prophecy, at least with adolescents, if they're given a label.' I have a young adult now who was labeled as borderline when she was 13, on an Axis II and she's locked into the belief that she's a borderline personality disorder when I'm really not seeing it, but, she believes it. It's a tool, but it's only a tool.

Again, mental health practitioners resist the biomedicalization of their work, and challenge its significance for guiding treatment and capturing patient personhood complexity. By treating the DSM as a bureaucratic tool, or a means to a necessary end, practitioners are able to continue to do the work they love while adhering to formal regulations. These patterns of negotiation demonstrate the ways in which technologies have unintended consequences. As the practitioner above stated, psychiatrists intended for the DSM to be a communication device, but through bureaucratic standardization

processes, it has taken on its own form and cultural power. Practitioners repeatedly expressed their concerns over the material consequences DSM labels have for their patients. Thus, practitioners undermined the significance of the DSM not just as a form of resistance in the name of their own professional autonomy, but in the name of what is in the best interest of their patients. In the following data section on mental health practitioners' negotiations of diagnostic processes, I focus on demonstrating the ways in which practitioners 'fudge the numbers,' or stretch diagnosis to enable them to perform the work they really value— providing psychotherapy to patients.

### ***Adjusting Disorders: Bureaucratic Means to Therapeutic Ends***

Mental health practitioners regularly stretch diagnoses on paperwork in order to accomplish their therapeutic goals while complying with bureaucratic policies of insurance companies that shape contemporary diagnosis. While less frequently discussed by the practitioners I interviewed, one way practitioners may have to stretch the numbers is through the practice of over-diagnosis. This strategy is depicted as a last resort for practitioners to be afforded authorization for providing important patient services.

We cannot as a primary diagnosis, give anything along the Autism spectrum, because managed care will not reimburse, because they feel that is a disability issue. There have been times that we will pull diagnoses that really are encompassed by an autism diagnosis like intermittent explosion disorders, impulse control disorders or ADHD and we'll make those the primary diagnosis. I have a kid right now who is classic PDD [Pervasive Developmental Disorder], but I cannot make that his primary diagnosis. So his secondary diagnosis is PDD, but he's intermittent explosive and he's ADHD, and that comes into the managed care issue, because otherwise all his services will be denied. Even if you put them on as secondary, you'll get denied the first time and you'll have to go through the review process a second time. Which I do, because it's an appropriate diagnosis. I'm not going to just leave it off.

Thus, practitioners only stretch diagnosis in the direction of over-diagnosis when absolutely necessary for insurance purposes. Among the practitioners I interviewed, the

much more common direction of stretching a diagnosis was toward under-diagnosis. *“I’m of the practice where I like to, if you want to call it, diagnose low.”* As this example shows, when possible, practitioners often try to give the least severe disorder classification possible that will garner their patient services.

The most popular form of diagnosing or punting low, according to the mental health practitioners I interviewed, was to assign a new adolescent client with an adjustment disorder. *“I love adjustment disorder. It’s more benign. You hate to sock up major depressive diagnosis on someone, and I wouldn’t do that if they didn’t have the symptoms.”* Thus, whenever warranted, mental health practitioners err on the side of under-diagnosis because of their concerns over the material consequences of labeling youth with more severe disorders like major depression.

More recently, the adjustment disorders, they will give us six months, which I think is appropriate, but there are a lot of clinicians who want to see clients longer than six months but they don't have the need to give them more of a diagnosis, but managed care expects that if you're going to treat longer than six months that they need a little more than an adjustment disorder. We do have kids that are in foster care, that are adjusting to new situations constantly, and so we have to be careful with adjustment disorders and we usually have to find something more, which, we don't want to label kids. You might start with adjustment disorder but then we have to find something else. We have to give them a more severe label, which we don't want to do. Especially with kids in foster care, it's just an adjustment disorder. They're adjusting to new situations. But M [name of insurance company] doesn't see it that way.

Again, practitioners stretch diagnosis in favor of diagnosing low in order to avoid labeling youth with more severe disorder diagnoses. Many practitioners didn't feel this was lying or cheating the system because they genuinely recognized the social circumstances of the youth's lives and how they were “adjusting to new situations.” This is a good example of Cribbing because practitioners have to translate their own understandings of the circumstances of their client's lives into the shifting bureaucratic



regulations of insurance companies. Due to recognition that social environmental circumstances shape the mental problems of youth, and the response of insurance companies to V codes, adjustment disorders are the go-to diagnosis for many practitioners working with youth. *“Adjustment disorder is the one specifically I’m thinking of, because ‘the DSM’ says adjustment disorder should go away in 6 months. Well then managed care, says, you can’t diagnose them with that now because it’s 6 and ½ months later.”* This practitioner was discussing what was problematic not only about the DSM, but about the way insurance companies have interpreted the DSM literally and use it in order to deny authorizations.

While it is common for practitioners to diagnose low in the form of adjustment disorders, there are discrepancies across insurance providers about how adjustment disorders are interpreted and how long providers are authorized to treat adjustment disorders. Commonly, insurance companies give practitioners six months of treatment authorization for an adjustment disorder, but sometimes they give less. As the practitioner below describes, the insurance companies that oversee her patients frequently only authorize three months of coverage for adjustment disorders, and with the insurance provider for Medicaid in this particular state, there was increasingly a push to not authorize treatment for adjustment disorders at all. *“I can justify a lot under adjustment disorder, that’s kind of a global diagnosis. Except now with Medicaid, well, in all insurance, you can’t hold that very long. You need to show after three months if there is movement from that or not. Medicaid has a big push to not use it at all. So you’re forced to hang a heavy duty label on a kid.”* This is another good example of the cribbing work required by practitioners. MHPs become savvy at building collective knowledge or crib

sheets that help them negotiate which insurers authorize services for three or six months for Adjustment Disorder Diagnoses, and which ones such as the company in this area that covers Medicaid patients, are pushing to make Adjustment Disorders illegitimate diagnoses. Adjustment disorders became the go-to diagnosis not only because practitioners were concerned about the consequences of labeling but also because for many, it was an accurate representation of the social circumstances in patients' lives that influenced their social psychological disturbances or symptoms.

Also, practitioners discussed using adjustment disorders as a common initial diagnosis because it allowed them more time to get to know patients and thus more time to make a more accurate diagnosis for something more severe. Some practitioners felt the insurance requirement that they diagnose in the first session, or in the first hour of meeting a patient, was unethical and undermined the importance of building rapport with a patient upon the first meeting. Thus, stretching diagnosis by giving patients adjustment disorders was a bureaucratic means to a therapeutic end, but one with several justifications following professional expertise.

I don't necessarily look at it as though I'm being forced to lie if I can't bill out a V code when I give an adjustment disorder. It's been my experience that those kids generally present with some pretty significant depression or anxiety or, they've got enough chaos or drama in their life to need a v code. Generally that's going to impact them enough emotionally, so I can justify giving them a diagnosis for [Axis I or primary disorder]. Although what I think is problematic about that then is the kid is the one again who walks around wearing the label. They're the one that is depressed. That's what this is all about rather than, no they're depressed because there's all this other stuff going on. The v code can help account for all that other stuff where the Axis I code, you know the adjustment disorder, the major depression, anxiety disorder, conduct disorder, those only apply to one person.

In addition to commonly diagnosing youth with adjustment disorders when their social circumstances heavily contribute to what they experience, several practitioners discussed how they wished V codes were legitimate diagnoses. V codes refer to social or

situational problems such as relational, sibling or parent problems or abuse. V codes frequently came up during my interviews with mental health practitioners because they are not considered legitimate diagnoses. V codes can only be used as secondary diagnoses to help give more specificity or context to their primary or Axis I diagnoses, which are required for billing purposes. The quote from the practitioner above details how she views adjustment disorders and v codes as legitimate and the problematic thing about only being able to give v codes as a secondary diagnosis is that mental health professionals are forced to label a kid even when it is his or her social environment – family, siblings, or relationships, that are the cause of psychological conflict or mental suffering.

Thus, similar to the psychiatrists in Whooley's (2010) study, the mental health practitioners I interviewed used several workarounds in order to comply with bureaucratic requirements and biomedical language of the DSM while opening up spaces for resisting biomedical psychiatry and the commodification of health. However, rather than having ambivalence about the DSM similar to that of psychiatrists who desired professional autonomy as much as the scientific legitimacy the DSM bestows upon their profession, other mental health practitioners such as psychologists, marriage and family therapists and social workers had to negotiate more serious tensions in their diagnostic work. None of the practitioners I interviewed identified with a biomedical model as their theoretical orientation to diagnosis or treatment.

The unintended consequences the American Psychiatric Association's biomedical DSM has created for psychiatrists that led to their situation of sociological ambivalence (Merton 1976; Whooley 2010) take on a very different character for non-psychiatrist

MHPs. Sociological ambivalence arises from “*a tension experienced by psychiatrists as a member of a profession and as an individual professional, from the tension between capturing professional authority in a system of mental health professions and the desire to exercise individual professional autonomy in practice, free of external meddling*” (Whooley 2010:455). Psychiatrists experience sociological ambivalence out of their simultaneous respect and repugnance for the DSM, for their wanting to have their legitimate scientific authority as psychiatric professionals, but not have the tool that bestows them this hierarchical authority – the DSM, used against them. “*It cuts to the heart of the identity of psychiatrists as the DSM is both a guarantor of psychiatry’s position in the mental health field and a tool wielded against individual psychiatrists to monitor their practice*” (Whooley 2010:456). However, the tensions for non-psychiatrist mental health professionals are much more complex than those between the collective membership in a profession and their own individual desire for professional autonomy.

While not all psychiatrists subscribe wholly to the biomedical paradigm, it is dominant, the focus of their training and of the DSM classification system. For other mental health practitioners focused on psychotherapy, their ambivalence is much more complex and based on the ways in which the cultural authority of the DSM helps their diagnostic work while the biomedical model it legitimates and the operationalization of it by insurers, hinders it. Psychodynamic MHPs tend to have more repulsion than respect for the biomedical model of the DSM technology and its unintended consequences.

Alternative mental health professionals, or all non-psychiatrist professionals, experience what I call diagnostic dissonance, which is different from what Whooley (2010) describes as diagnostic ambivalence.

Any classification system valorizes some point of view and leaves another unvalued, unrecognized, or even erased from the record. Clinical, scientific evidence that guides psychotherapy is not at the heart of the DSM or bureaucratic standardization. The diagnostic dissonance non-psychiatric mental health practitioners experience evolves out of a conflict between their own theoretical orientations to health and illness and the biomedical model enshrouded in the DSM technology and insurance company policies. The power, knowledge and experiences of alternative mental health professionals, in comparison to those of psychiatrists, are marginalized by the assemblage of the DSM and insurance company policies.

#### **DIAGNOSTIC DISSONANCE: MARGINALIZED KNOWLEDGES, ERASING THE SOCIAL**

In this analysis section, I focus on how mental health practitioners experience diagnostic dissonance. The MHPs I interviewed enact workarounds not simply out of a simultaneous respect and repulsion regarding the DSM and its cultural and scientific authority, but because their theoretical orientations and background disciplines are marginalized by the assemblage of biomedical and bureaucratic standardization. In addition to discussing the ways they negotiate diagnostic practices to fall in line with biomedical and bureaucratic standards, practitioners also share their frustrations with how standardization minimizes the importance of the social environment in shaping mental suffering of their adolescent patients.

[V codes] are not recognized by any non-clinicians. Anyone who does not work directly with clients doesn't need them, but this is the outpatient hallway, and we'll have a lot of conversations in this hallway. I've said it more than once and I know other people have said it. If V codes could just be recognized. This is the problem. This is what we're going to form the treatment plan around. It's going to be specific to the diagnosis, because the diagnosis is actually appropriate in this situation. Adjustment disorder unspecified. These are so much more appropriate and they say so much more about what is going on. They

can be part of another diagnosis. If I read adjustment disorder I have no idea what that means for that client, whereas if I see they have a life problem I have a better sense of what's going on. You have to look at page 736 to find those.

In the above description, the practitioner bewails that V codes, as opposed to adjustment disorders, are unrecognized by insurance companies. In other words, V codes are found in the DSM (although in the back), but are not considered legitimate diagnoses by insurance companies. Insurance companies will not reimburse for using V codes as a primary, or Axis I diagnosis. Yet, for practitioners, the information they bestow is incredibly valuable to clinicians. This discussion points to how the DSM is guided by diagnostic rather than clinical concerns. Most of North America's mental health professionals being non-psychiatrists are not paid directly for the work they are trained to do. That is, they have to translate their clinical concerns into diagnostic (biomedical and behavioral) terms. Thus, the DSM actant and the way the insurers enforce its usage as a biomedical information technology, focuses on issues of classification rather than therapy. In this way, the DSM technology is reinforced as an obligatory passage point in diagnostic processes by the external actors of insurance companies.

In the following exchange, I had asked the mental health practitioner about the relevance the DSM holds for her everyday diagnostic work. In her response, she demonstrates diagnostic dissonance over this translation work. She notes how unfortunately, it is very relevant for her daily clinical work; while at the same time notes she doesn't look at it very often and goes onto describe all of its inadequacies.

A lot, unfortunately, a lot. It doesn't make it off the shelf much. We have to give a diagnosis the first session. Even for non-Medicaid kids we have to do that, and unfortunately, V codes don't count for anything, even though that's what's actually appropriate. We will joke you know that most people here will just get an adjustment disorder. I have a paperclip on that page because, it's 309.something. I hate to brand people with something, and seeing one client with depression looks completely different

than seeing another client with depression. I hate those commercials for depression medications because they show people in the grey sweat suits and they are lying like this and that's not what it always looks like. I usually, especially with adolescents, I'll tell them, 'I'm going to have to give you a diagnosis, from what I've heard so far, it sounds like this kind of thing is going on.' Sometimes I'll give dysthymic disorder or adjustment disorder. This is what that means. It comes from this book. This is why I'm giving it to you. This does not mean you're crazy or anything like that. This just means you have some rough stuff going on in your life and you're having a hard time dealing with it. And that's okay. So I approach this as a necessary evil and I try to have that transparency with my clients. I'm going to have to write this down; it's going to maybe show up on billing paperwork at some point. I want you to know what this is so you don't freak out and think that I'm saying you need to be institutionalized. I think a lot of times people are like oh if I get a diagnosis that must be really bad. No. That mean's you've seen me once and I have to give you one.

In this quote, the practitioner demonstrates how she employs diagnostic workarounds or strategies that fulfill her obligations toward insurance companies and her patients, such as making a diagnosis in the first session by giving a legitimate primary diagnosis such as adjustment disorder or dysthymic (mood) disorder in order to qualify her patient for treatment. At the same time, she also discusses the flaws in this system of categorization, and the difficulty of immediate diagnosis when even a well-studied, well-understood disorder like depression can appear completely different in each patient, especially among adolescents.

I think it would definitely be more helpful and more valid to be able to include V codes because often that's how I see the world. That's why it's so subjective. Each clinician sees the world through their lens of training. V codes are often how I see, how I understand the client before me, and it's really hard. I think part of my disdain for using the DSM is that I can't really be honest in my viewpoint when I'm billing, because you might have to say oh there's an adjustment disorder, with depression, when it's really a parent-child conflict

This marriage and family therapist's disdain for the DSM is a great example of diagnostic dissonance because biomedical standardization leads her to feel dishonest in her bureaucratic paperwork. In other words, she experiences diagnostic dissonance because she has to hide or minimize the importance of relational aspects of emotional

wellbeing. This description signifies a very different process from the diagnostic ambivalence demonstrated by the psychiatrists in Whooley's (2010) study. The mental health practitioners I interviewed experienced dissonance more than ambivalence, and professional marginalization (in their own forms of scientific and clinical expertise and training), than legitimization. While the above practitioner lamented her inability to get reimbursed for treatment of V-codes (which stand for specific life events and are tucked away in the back of the DSM), this next quote comes from a therapist who actively engages this marginalized literature, only to be forced to crib around it:

I use them. Unfortunately, and I think it's absolutely ridiculous that we cannot use them as a billing code. If we have a kid that comes in that meets the criteria for a V code, we have to find other criteria that meets a standard diagnosis, which I think is absolutely ridiculous. A parent-child conflict is a valid diagnosis. Sexual abuse of a child is a valid diagnosis. But it's a v code, so we have to come up with another diagnosis. I think it's absolutely ridiculous. I think that would be something that the DSM committees should definitely be looking at. I think that definitely comes back to managed care issues. They're in the DSM. They are buried in the back, but they are in the DSM. They are issues and they are therapeutic issues that can be dealt with and treated.

Practitioners strongly disagreed with the illegitimate status of V codes. According to their theoretical orientations and treatment plans, parent-child conflicts and sexual abuse are valid diagnoses, or problems that warrant psychotherapy. Further, multiple practitioners pointed out how V codes, which were more in tune with their definition of adolescent mental illness and the problems around which they form treatment plans, are buried in the back of the DSM. This locating of the V codes that were undervalued by the DSM (based on them being all the way in the back near the appendices), and unrecognized by insurance companies, illustrated the knowledge-power-experience relationships of non-psychiatric mental health professionals with diagnosis and the DSM. Their eclectic and



more holistic theoretical orientations to adolescent mental illness are hidden from view by powerful actors in the mental health arena.

The psychologist on our team just gives somebody an Axis I diagnosis as adjustment disorder unspecified because that is like the least severe disorder you can find in the whole thing. She also gave a V code. You can give them as a secondary diagnosis, but these are what they are. They are relational problems. They are on page 736 so they're, like, hidden, kind of, you know after neuroleptic induced tardive, a word I can't even say, it's all the way back here. [Reading from the DSM:] 'They may be a focus of clinical attention,' yeah, they are – so 'parent-relational-child, physical, sexual abuse, neglect,' we see a lot of cases of neglect that aren't reportable but they are still very neglectful. . . 'academic problems, identity problems, religious problems,' this is a big one with my adolescents, you know they've been brought up Catholic and then they've gone to a Methodist church and they're like, Blasphemy! You know that kind of a thing. 'Intellectual functioning,' that can really start to come out in like middle school, what class you're placing in, tracking, I'm in the dumb class, and everyday life problems. These are all huge huge problems for adolescents.

Again, the practitioner describes how V codes can only be given as secondary diagnoses. Similar to others, she argues they are valid therapeutic or clinical issues that can be dealt with and a major focus in psychotherapy with adolescents. She takes the time to list to me all of the important life problems that fall under the illegitimate category of V codes: parent-child or relational problems, physical or sexual abuse, neglect, academic problems, identity problems, religious problems and more. While each of these are clinical issues that mental health practitioners I interviewed valued as important presenting problems, they are not valued by their positioning in the DSM or insurance companies' reimbursement policies. They remain "buried" in the back of the book, and are not billable codes. V codes are not currently considered valid or valuable diagnostic codes, and this was the main way practitioners problematized the marginalization of their theoretical orientations to mental illness and the erasure of the social.

## **RE-ENVISIONING PSYCHOTHERAPY: RELATIONAL BEING AND THE SOCIAL**

Mental health clinicians were asked what they would revise if they were the chair of a committee tasked with modifying the classification of adolescent mental disorders for the DSM-V. My analysis reveals three areas of significance: (1) A need to legitimize disorders caused by relational problems or the social environment (such as V code diagnoses), (2) A need to create a scientific basis and understanding of normal versus pathological functioning in adolescents, including how the adolescent stage in the lifecourse impacts mental suffering, and finally (3) A need to recognize the power insurance companies hold over DSM utilization and diagnostic processes.

### ***Legitimize Relational and Social Environmental Conditions of Mental Disorder***

First, it was common for practitioners to discuss why V codes should be made into valid diagnoses in the new and upcoming DSMV. Practitioners reasoned that several of their adolescent clients suffer from relational problems that impair their daily functioning. Further, practitioners argued that mental health and illness itself is relational.

I think they [V codes] should be valid diagnoses because if you have relational problems, and that's a V code right there, if those relational problems are causing significant impairment in your daily functioning or academic functioning, then there is something going on and because you are in that situation you may not have the tools necessary to make improvements in that relationship. You may not have the tools necessary to move beyond or seek out help, so yes I think those are valid codes.

In addition to recognizing the relational component of mental illness, practitioners emphasized the ways in which the social environment or social conditions of adolescents' lives shaped their emotional well-being.

I'd like to see something where somebody's disorder is caused by somebody else's behavior, somebody else's attitude. More like an adjustment disorder but not necessarily. I'll give you an example. I have a kid and he's 12 years old and a lot of his behaviors and diagnosis is caused by mom's drug use and leaving him in charge of his little sister. He

has a lack of respect towards her, a lack of respect towards authority, lack of respect towards law enforcement, because they're not doing anything about mom. Giving him a disorder on his own, it doesn't have any kind of part, its impartial to what's going on. An environmental diagnosis, you know? If he's oppositional, I could also put in a diagnosis of something like mom's a drug addict, in and out of prison, etc. I should be able to diagnose something related to the mom; it's not the kids fault. That's what I'd like to see change.

Again, this male Psychologist practitioner, who works in a mid-sized town in a Midwestern state, discusses the importance of the relational aspects of mental health and illness. He discussed at length with me several of his cases, especially male adolescents, who had significant impairment of functioning in school and at home due to their parental or other relational conflicts. Some of the adolescents he spoke of were coping with neglect issues from home, and others just had poor relationships with their parents and were displaying oppositional behavior. Yet, in all of the cases he described, there were significant social environmental circumstances that needed addressed in (and outside of) psychotherapy. That adolescents often experience negative social circumstances that contribute to their emotional well-being is an accepted social fact among the mental health professionals I spoke with. Their professional expertise suggests that labeling adolescent youth with a disorder but ignoring the social circumstances that shape their well-being was an inadequate therapeutic approach; one which is heavily facilitated by the biomedicalization entrenched in the DSM and insurance company policies.

I guess this isn't specific, but its just if those V codes could start being recognized, I don't know if that means removing the Vs or getting other people to pay for them, but you know parent-child relational problem, well that's apparent in a lot of the problems we see here, conflict with mom, or they've changed schools or something like that. Yeah, just a greater recognition of all of the other stuff that is going on besides just the chemical imbalances in their head, the games in the schools, the drugs in the schools, the sex in the schools, all that other stuff and how it, the huge social and educational environmental stuff, the primary support group, all that axis IV stuff, I don't know why they are all the way knocked down to axis IV and axis V, they need to be bumped up. And I have had a

couple of adolescent clients dealing with their own sexuality and some troubles they've had with that too, because it is such a time of discovery of who you are and how you, ya know, all of that kind of thing. The two of them that I am thinking of actually they were pretty at peace with, that that's how they are, and they were both in relationships and so forth but it wasn't okay for the family

Several practitioners focused on how the social environment of youth's lives impacts their emotional well-being, and how the current DSM and insurance company policies fail to recognize, value or reimburse for therapeutic focus on the social conditions of mental illness of youth. This theme was discussed in a number of ways, as illustrated by the practitioner quoted above. Some youth that were in treatment had relational problems with parents or peers at school; others had recent life changes or were struggling to cope with life at school. Practitioners focused on how the DSM-V revisions need to recognize V codes or the social environmental aspects of mental illness. Often, this concern was linked to describing particular features about adolescent personhood or stage in the lifecourse and how it lends itself to social environmental disruptions and identity struggles more than those found during adulthood or childhood.

### ***Normal versus Pathological Adolescent Functioning: The Science of Adolescence***

While practitioners discussed relational disorders as important for all people, some criticisms of the DSM focused on how irrelevant it is for types of problems they see most often in adolescents. *"The DSM is, you know with your typical kid you don't have to look at it. I mean you have to know your diagnoses but if you work with children and adolescents you don't use half of the DSM."* This description of the DSM as being largely irrelevant for diagnosing and treating adolescents was a reoccurring theme. Yet, it wasn't only the DSM that was being questioned, but the extent to which adolescents experience mental illness in stable and chronic as opposed to more dynamic ways. In part, MHPs

questioned the extent to which adolescent mental health problems themselves may be fleeting or dynamic enough to question the necessitation that every patient receives a disorder diagnosis.

If you look through a file, when a child has been assessed 5 or 6 or 10 times, that snapshot of where that child is right now, if they just ran out into the middle of the street and vandalized a car and almost jumped off a bridge you're going to see this kid as much more high risk, suicidal, you know all that stuff then if you catch them at a time in their life that they're assessed that things are going relatively well. A child is very dynamic. They don't just stay in one spot.

Practitioners often discussed adolescent mental health and illness as though it was of a different, more dynamic and temporal nature than the mental suffering experienced by adults. While psychic pain and the stressful social conditions of adolescent lives were never minimized, the way in which children and adolescents are dynamic, and are developing, constantly changing people was stressed as an important aspect of adolescent diagnosis and therefore, the (ir)relevance of the DSM in adolescent diagnostic processes.

Aside from being described as irrelevant for adolescents, practitioners critiqued the lack of clarity in the DSM on the differences between what is normal or abnormal for adolescent emotions and behaviors.

They have a section on children and adolescent disorders. It would be wonderful if the DSM could really branch out an Adolescent section to distinguish adolescent defiance from normal adolescent anger or angst, and to distinguish depression that's not hormonal or mood based or separation from family; to do more distinctions, a section that is truly about adolescence, what's normal and what's pathological.

While there were several ways in which practitioners questioned the extent to which the DSM represented the most common social psychological problems of adolescents, adolescent identity issues stood out as significant, especially in the interviews I did with practitioners from the Midwest.

I know what I would revise. I've had a couple of kids that are questioning or kids that consider themselves transgendered and you have to go right into the adult section and I think it could be more sensitive just the varying stages, you know. Instead of saying, 17 year old male has this disorder, well, is it a disorder? And then finally, I was just like I'm not going to diagnose him with that anyway because if it goes through insurance, Blue Cross Blue Shield would say, I'm not covering that. I just went with depression but, I hope they expand that.

In the passage above, the social worker discussed how adolescents that are exploring their gender and/or sexuality (outside of the prescribed heteronormative options) often presented with social psychological concerns, but it was unclear whether issues of adolescent sexuality warrant an adult disorder diagnosis. Mental health professionals practicing in the Midwest frequently brought up issues of treating adolescents with identity issues and many of these concerns focused on gender and sexuality. While a homophobic culture is rampant in much of the United States, gay, lesbian, bisexual and transgender youth living in Midwestern states, especially in rural areas of Midwestern states, may present to therapists with more social psychological concerns because of the more conservative, and often more homophobic, environments in which they are living.

I mean a therapist has to say this person's mental health is affected by this. When I was treating this kid, I went to Planned Parenthood to talk to the gender educator or whatever, and she gave me some great information and asked if I wanted to be put on the list of recommended therapists. I said the only reason I'm even treating this kid is because he's two hours away from [city with access to mental health practitioners], and there is nobody else out here. So ethically I can treat him but this is not my area, and when he went off to college, I hooked him up with [professional at state college in said city], she's the head of the gay, lesbian, bisexual, transgender, etc etc. and just gave him a list of therapists and you know, and I always said, this is not my area, but this is what I've found out and you know so in that case, the DSM is not very helpful.

Again, this behavioral psychologist who often travels to rural areas to provide behavioral assessments and psychotherapeutic treatment to children and adolescents in a Midwestern state described her difficulty with helping a teen for gender and/or sexual identity issues.

As adolescent identity issues in general and adolescent sexuality in particular, emerged repeatedly as a focus of discussion in my interviews across both rural and urban areas in a Midwestern state, I began asking practitioners to assess the state of the field with regards to its development of psychotherapeutic resources and networked connections for questioning youth. They often told stories about how certain therapists would gain a reputation of getting out their bibles, and others would gain a reputation of being willing and even capable of providing treatment. None of the practitioners discussed the contemporary situation with confidence. While the handful of practitioners that raised these issues noted that there had been some improvement in the area of psychotherapeutic resources for adolescents with gender and/or sexuality issues, they were all in agreement that there remains considerable need for development.

Mental health practitioners emphasized several ways in which the DSM technology and biomedicalization of mental health and illness failed to address the unique aspects of the adolescent stage of the life course. As demonstrated in the analysis above, many practitioners stressed the importance of relationships, the social contexts of adolescent lives and the distinctive aspects of identity explorations. While some practitioners felt adding v codes, or diagnostic categories that refer to relational or social aspects of health would make adolescent diagnostic processes more accurate, others felt there also needed to be a better clinical guide for understanding normal versus pathological adolescent functioning across their everyday environments, and how they are different from those of adults.

I would love for them to really look, and I know that they have the GAF scoring, the global assessment of functioning. You can find them out there for children and adolescents if you like go on the internet and go other places and look for it, but they

need to have a revised GAF scoring for children and adolescents and it's not in the DSM. They have one that's supposed to be used for everybody, and it's not applicable for adolescents in my opinion. So I would love to see them look at that a little further.

Thus mental health practitioners thought adolescents' contexts of life are different enough that the DSM should take into consideration those differences. Several practitioners discussed the ways in which adolescent functioning in schools is a prevalent problem of presentation upon adolescents entering treatment.

Well I would definitely revise the GAF score, one for adolescents as well as one for children. I think that would be hugely helpful. Because even though that's just a number and I keep saying more information is better, but it is, when you're trying to find the number, it looks at the functioning in all of the different areas, which is more helpful probably than just that first Axis I diagnosis of bipolar disorder. So I think an individualized GAF.

Again, while it is widely acknowledged in the literature that domains of functioning or everyday life contexts of adolescents are different from those of adults, the DSM to date has largely based disorder categories based on research on adults and then adapted them for children and adolescents. In comparison to the DSM as a whole, the GAF score is valued as a tool that assesses everyday life functioning. Practitioners value the information the GAF score is able to provide, but want it to be more reflective of the adolescent life experience. Further, similar to wanting the larger field to recognize and value V codes, relational disorders and the social environmental contexts of adolescents' lives, many practitioners discussed how the Global Assessment of Relational Functioning (GARF) is an underutilized diagnostic tool.

When we request more sessions we have to give a current GAF score, Global Assessment Functioning, the Axis IV of the diagnosis, so I'll pull it out just to kind of see where they are on that. Most of the clients we see are between 40 and 60 but sometimes if its an atypical client I'll be like oh maybe they are, they have a global assessment functioning relational GARF where it talks about, where in the score in zero to 100 is this family



doing, but the other one that is used and recognized by insurance and stuff is the one that is just made for individual adults, so it's so hard. No, they haven't lost their job, because they're 12. So I would love to see, and a couple of my colleagues and I have talked about this, a global assessment of functioning for adolescents, or for children that is much more appropriate.

Again, practitioners wanted the DSMV to take into consideration the distinctive contexts of adolescent lives, including a valuing of how relationships and their unique social environments shape their emotional well-being. On the other hand, as is pointed out also in this quotation, in addition to the DSM having its own shortcomings, the way in which insurance company policies privilege some diagnostic codes or tools such as the GAF over the GARF, also was a focus of the change the practitioners envision when they think about a DSMV or a better way of classifying adolescents with mental health issues.

### ***Disentangling the Power Insurance Companies Have over Diagnostic Processes***

For practitioners, it is not simply the DSM in itself that is in need of revision.

MHPs were cognizant of the ways in which the DSM and insurance company power have become entangled:

I would focus on managed care and funding because that seems to be a huge barrier for clinicians to where some clinicians will not accept Medicaid clients at this point but that is what they have to do to survive. If you have a private practice you have to get paid and if you're doing your billing on your own. . . the investment of time . . . would be more focused around that and, then, the diagnoses. They inform treatment but the way, and this goes back to managed care, we have to have those within that first hour of meeting this client and gathering this information where you are just doing so much writing and your interaction is limited. I don't think that its ethical to provide a diagnosis that first hour, even though with your training, you're able to see those interactions between the parent and the child, hear how the child responds, you do get the history and through more experience you are able to provide a diagnosis that fits but its still-- I think doing it within that first hour is not okay.

Practitioners argued that modifying the DSM itself is not a solution in itself. Issues of billing such as insurance companies paying less for some types of clients such as those on

public forms of insurance or Medicaid cannot be fixed by focusing on the DSM itself. Further, the insurance company requirement that MHPs make a diagnosis in the first session of meeting a client prioritizes biomedical coding of information over building clinician-client rapport.

I guess I would change the rigidity of diagnostic criteria. The hold that insurance companies have [on the mental health care system] you know like [name of local insurance company], which is Medicaid. You have to do so much paperwork. You have to create two reports, a treatment plan and a request for services after the first initial evaluation. That's a hell a lot of paperwork and a hell of a lot of time and they put a lot of stipulations on who can see whom and the whole purpose of that is to make it so hard to see people so they don't have to pay for it, and they would argue otherwise of course but I would change that. You need to have accountability but to make it so prohibitive for people to see [name of insurer's] clients? Like [another provider's] practice, I think they are going to stop seeing [name of insurer, or clients with that insurance] because it's so much work. They pay a lot in the beginning, the first evaluation, but it goes down over time. They don't want you to see people for very long, so after a certain amount of visits its down to under \$60 bucks. In line with the national debate, the power of the insurance companies is what also needs changed.

Several mental health professionals agonized over the power insurance companies have over their everyday clinical work. While psychiatrists experienced diagnostic ambivalence because as a result of the way external actors such as insurance companies have adopted the DSM for their own billing purposes, mental health practitioners trained in alternative theoretical orientations experienced diagnostic dissonance. The assemblage of the biomedical model enshrouded in the DSM and insurance company power marginalized MHPs' own professional knowledge-practices and expertise. Revising the DSM to account for the social, relational and adolescent specific aspects of mental health and illness will not in itself, address the issues of the Psychiatry-Insurance-Standardization-Assemblage that dominates the contemporary political economy of mental health care in the U.S. These issues are the focus of the next chapter.

## CONCLUSION

In this chapter, I examined the following two research questions: (1) How do mental health practitioners negotiate diagnoses? And (2) In what ways does the DSM shape the everyday diagnostic and treatment work of mental health practitioners? I employed the sociology of diagnosis and biomedicalization theory frameworks to illustrate how the processes of diagnosis capture how the existing mental health establishment defines and measures mental illness. I argued that the technoscientific classification system of the DSM orders ways of being and contemporary thinking about mental health and illness. While the DSM technology was originally designed as a diagnostic communication device, it heavily structures not only contemporary diagnostic processes, but clinical work.

Biomedicalization theory facilitated a disentangling of the interests and power of different social actors engaged in processes of diagnosis. It elucidates how the role of the DSM as technoscientific actant in diagnosis, and its meanings, emerge from on-going clinical practice interactions. Thus, the DSM is a socially scripted technology, yet its significance is interpretively flexible and negotiated in concrete sites of action. The heterogeneities in type of mental health care provider, care setting, and patient, all shape how the DSM is used and thus how diagnostic practices are carried out. While the biomedical model is dominant within U.S. society, everyday psychotherapeutic practices of adolescent mental health care work challenge cultural authority. Despite the growing assemblage of biopsychiatry via the DSM, Evidence Based Practices, the growth of privatized managed care and big Pharma within a larger neoliberal healthcare economy, biomedicine is not an uncontested hegemonic process. Mental health practitioners'

diagnostic work is constrained but far from determined by the biomedical model and bureaucratic standardization.

Social processes of diagnosis and the interpretive flexibility of the DSM as biomedical technology are different for mental health professionals who are not psychiatrists. The mental health professionals I interviewed interpreted the DSM technology as a necessary tool that sometimes enhances diagnostic clarity, permits reimbursement for services and can help with interdisciplinary and patient communication. The psychiatrists in Whooley's (2010) study experienced diagnostic ambivalence as a result of how the DSM technology bestows scientific legitimacy upon their profession while being used by insurers to undercut their professional authority.

In contrast, the mental health professionals I interviewed were ambivalent about the way in which the cultural authority of the DSM technology simultaneously helped them communicate and collaborate with patients, parents and other mental health professionals while hindering their professional authority. Even more significant though, was the way in which the biomedical model legitimated by the DSM technology marginalized their theoretical orientations and eclectic approaches to psychotherapy. While alternative mental health professionals recognized the ways in which the DSM technology was helpful for their work, there was much more at stake in social processes of diagnosis for them. Clinical interests and practices are guided by definitions and measurements of mental health and illness. Further, definitions and measurements influence societal and professional response as well as experiences of, mental illness.

Despite the multi-sited character of biomedical standardization, the most common interpretation of the DSM technology was that it was insignificant for everyday clinical

treatment practices. MHPs had several ways of being dismissive of the importance of the DSM. They labeled it as just a tool, as the only way they could get paid, as something that only facilitates diagnosis but doesn't impact treatment, as a means to an end, and as the bible for the profession of psychiatry, not their own profession(s). Mental health professionals' talk about the DSM technology undermined its authority over their own clinical expertise.

Like the psychiatrists in Whooley's (2010) study, the mental health professionals I interviewed employed several work-arounds, or local solutions to the problems posed by biomedical and bureaucratic standardization. First, mental health practitioners utilized alternative taxonomies in order to diagnose according to their own understanding of mental illness, and then translated those interpretations into DSM or biomedical terms after the fact. This workaround was more than a local strategy that allowed MHPs to fall in line with standardization while maintaining some professional authority. The alternative taxonomy workaround enables psychologists, counselors, social workers and other non-psychiatrist professionals to continue to define mental health and illness in psychodynamic ways.

Second, MHPs fudged the numbers or diagnostic codes in order to disguise their actual clinical practices while falling in line with the formal rules of insurance company standardization. Fudging the codes often involves practices of over or under diagnosis. MHPs I interviewed viewed themselves as conservative in diagnostics and when possible, diagnosed or punted low, thereby protecting their patients from more severe diagnostic labels such as depression or anxiety.

Finally, MHPs negotiated diagnoses with adolescent patients, their parents and other providers. In this work-around, alternative MHPs shored up the cultural authority of the DSM while undermining biomedical and bureaucratic standardization. In addition to employing these work-arounds, MHPs participated in a process I term cribbing. Cribbing signifies the on going collective knowledge building and translation work required by MHPs to learn the correct answers or codes that will facilitate therapeutic service authorizations and minimize coverage denials. The term cribbing also describes the way in which alternative MHPs' professional expertise is treated as infantile or illegitimate alongside the reimbursement policies of insurers. Cribbing processes reveal the collective knowledge building that goes into MHPs' translation work; they must translate their everyday clinical goals, practices and outcomes into the preferred language of insurers. Thus, cribbing negotiations develop out of on-going interactions with insurance companies.

Mental health professionals resist and reject the biomedical model of the DSM, and bureaucratic standards of insurance companies through workarounds and cribbing. For some professionals, diagnostic processes of fitting their patients and their patient's symptoms into disorder categories are uncomfortable due to issues with labeling or problems of fit. For others, the process of diagnosis and the categories of illness represented in the DSM and legitimated by the insurance companies are in direct conflict with their theoretical orientation to mental illness and therapeutic approach to healing.

At the heart of much of the resistance to biomedical and bureaucratic standardization were knowledge tensions between alternative paradigms in conceptualizing and intervening in mental illness. The biomedical DSM and profit

oriented insurers privilege a therapeutic focus on surface level symptoms and behaviors whereas the mental health professionals I interviewed were trained to focus on deeper communication, relational and emotional issues. This non-fungibility of the DSM and insurance company policies is so problematic for the MHPs I interviewed that they experience what I term diagnostic dissonance. Diagnostic dissonance describes the conflict between mental health professionals' own theoretical orientations to health and illness and the biomedical model legitimated in the DSM technology and insurance company policies. The power, knowledge and experiences of alternative mental health professionals, in comparison to psychiatrist professionals, are marginalized by the assemblage of the DSM and insurance companies.

A key example of how the theoretical orientations and professional knowledges of non-psychiatrist mental health professionals are marginalized in this assemblage is the way in which social environmental conditions and causes of mental illness are devalued in the DSM and considered illegitimate diagnoses by insurers. For example, V codes, which represent social context conditions and/or relational disorders such as parent-child or sibling conflict, sexual abuse or neglect, are found in the back of the DSM under Axis IV. Further, insurance companies will not reimburse mental health practitioners for V codes as primary diagnoses. Yet, for the mental health practitioners I interviewed, the information V codes bestow is incredibly valuable and clinically relevant. Further, mental health professionals view social environmental and relational issues as important to the emotional wellbeing of all people, but especially adolescents. Thus, practitioners strongly disagreed with the illegitimate status of V codes.

In re-envisioning a different way of doing psychotherapy, practitioners focused on three aspects of the DSM and diagnosis that needed to change. First, MHPs argued that the social environmental and relational aspects of mental illness need recognized and legitimated in diagnostic policies. Second, they argued that the DSM-V and the mental health field as a whole needs to develop a better understanding of the normal versus pathological functioning of adolescents. Finally, practitioners argued that fixing the DSM alone will not be enough. The power insurance companies hold over DSM and diagnostic work is a major problem that needs addressed.



## **Chapter Five The Political Economy of Mental Health Work:**

### **Over-Managed, Stratified Care**

In what ways does the political economy, specifically, managed care, shape contemporary adolescent mental health care? This chapter examines the larger, macro-political economy of the adolescent mental health field and the institutional forces that shape the conditions under which screening, diagnosis and treatment of adolescent disturbances occur. In out-patient expert mental health professional settings, managed care is a major, external countervailing force that shapes the everyday care work of practitioners. This chapter examines the common links across care settings and how the biopolitical assemblage of the insurance industry, the DSM, and state governance structure and stratify adolescent mental health care.

### **POLITICAL ECONOMY OF MENTAL HEALTH CARE IN THE US, 1980-PRESENT**

The contemporary mental health care system is fragmented, stratified, and faced with old and new challenges that relate to and are unique from the larger health care system. The majority of shifts in health care systems in the past few decades are the result of larger shifts in the political economies including the end of the deinstitutionalization movement, the rise of managed care organizations, the biomedicalization and commodification of health, advances in technical and technological apparatuses and services, increasing disparities in access to and quality of health care services, declining trust in and power of physicians, a consumer movement that has resulted in more active and knowledgeable health care patients, a blurring between public-private health

distinctions and the Affordable Care Act (ACA) (Cook and Wright 1995; Rosich and Hankin 2010; Stevens 2007).

### ***Neoliberalism***

Beginning in the late 1970s and strengthening throughout the presidency of Ronald Reagan, a new pro-business activism and ethic seized the primary institutions within the U.S. (Duggan 2003). Neoliberalism is a theory of political and economic practices positing that social well-being is best advanced by liberating individual entrepreneurial freedoms and skills (Harvey 2005). Neoliberal policies and practices have deceptively constructed economic policy as a matter of neutral, technical expertise that has nothing to do with politics or culture, thereby shielding its policies and practices from political accountability or cultural critique (Duggan 2003; Moncrieff 2006). However, any good analysis will show that the political economy does not operate separately from other social institutions in society. Economic goals are embedded in and formulated through political and cultural meanings that shape social organization and cultural context (Duggan 2003). Within healthcare in general, and mental health care in particular, neoliberalism has facilitated the privatization of health care, a shift to mental health policies driven by fiscal rather than social goals, and rising, profitable industries such as the insurance and pharmaceutical regimes.

### ***National Governance of Mental Health Research Funding***

In alignment with the rise of a neoliberal ethic of individualism throughout the 1970s and 1980s, sources of research funding for mental health and illness such as the National Institutes of Health (NIH) and National Institutes of Mental Health (NIMH) increasingly shut out investigations of the social conditions and causes of mental health and illness

and, instead, increasingly embraced the disciplines and methods of biology, neuroscience and genetic mapping as the right way to investigate mental illnesses (Orr 2010; Pilecki et al. 2011; Schooler 2007).

Even a quick glance at the list of Intramural Research Programs (IRP) titles demonstrates the disinterest or even disdain the NIMH has towards investigations of how the social environment affects mental health and illness. Schooler (2007:60) points to multiple causes for the decline in funding and devaluing of social science within the NIMH across the past few decades: 1) the value system that underlies the prestige hierarchy within the sciences such that the more micro the phenomena under investigation, the higher level of esteem attributed; 2) the perceived successes of methodologies of studying micro level phenomena such as brain imaging; and 3) the increasing influence of corporations and lobbying groups that steer funding towards research on finding cures for specific diseases.

### ***The Rise of Managed Care and Complex Health Corporations***

The emergence, rise and dominance of managed care structures and strategies designed to reform the financing of health care has drastically altered the US health landscape. Managed Care (MC) emerged in the 1980s as a response to declining government support for public sector health care and the soaring costs of psychosocial and substance use treatments in the private sector (Frank, Salkever, and Sharfstein 1991; Scheid 2003). Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and other group insurance entities were established and have multiplied as have their strategies of external and internal reviews that dictate the type and intensity of treatment

services (Manderscheid and Henderson 1996; Manderscheid, Henderson, Witkin, and Atay 2000).

In addition to controlling costs by limiting access to services, MC companies changed the financial structure from the traditional fee-for-service payments to one in which providers are paid a set capitation fee based on a specified range of services (treatments deemed most effective) for a predetermined length of time (Mechanic 1999). Capitation fees are significantly lower in comparison to traditional fee-for-service (30% lower according to one estimate) (Moffic 1997).

Other predominant strategies of cost-containment include: gatekeeping, precertification, case management and measureable outcomes. Gatekeeping requires patients to get referrals from primary care providers. Precertification or utilization review requires that services be authorized before they can be provided to clients. Concurrent review or case management is when insurance companies scrutinize client cases, documentation of treatment services, and evaluation of treatment outcomes of providers on a regular or on-going basis. Further, managed care corporations emphasize measureable outcomes and require that patients fulfill criteria of 'medical necessity,' which results in denials of reimbursement claims. Often these denials are for therapies that have yet to be proven efficacious. Just as often, therapists are denied payment for their services because their patients suffer from disorder diagnoses that are devalued by the Diagnostic and Statistical Manual (DSM) (Mechanic 1999; Scheid 2000).

While MC organizations started out primarily in the private health insurance market, over time they have moved to dominate the public, state and federal market sectors, including Medicaid and Medicare. The effects of MC on the quality and quantity

of mental health services is just beginning to be studied for different types of services and populations, but hallmark changes include a decline of inpatient care and increase in outpatient care.

In comparison to the previous health landscape, advocates argued MC would improve mental health services by increasing effective use of economic resources. The logic is that by holding mental health providers accountable to high standards of care, treatment outcomes would improve and costs would go down. However, past Deputy Executive Director for public policy at the National Alliance for the Mentally Ill (NAMI) E. Clarke Ross (2000), examined the application of managed mental health care in the public sector and concluded:

. . . other than constraining costs, most managed behavioral health programs have not lived up to their promises. . . In poorly performing public managed care systems, often the managed care vendor lacks a social commitment because of primary obligations to private shareholders or the bottom line [which contributes to the] problems faced by consumers, families and enrollees. (Ross 2000:203)

Thus, the primary criticism of MC is that it undermines social justice through its commodification of health and in the process devalues professional ethics (Scheid 2004). In two articles and a book titled *Tie a Knot and Hang On: Providing Mental Health Care in a Turbulent Environment*, medical sociologist Teresa L. Scheid illuminates the ways in which managed care practices threaten professional logics of health care, autonomy and ethics (Scheid 2004, 2003, 2000). Scheid conducted qualitative interviews and survey questionnaires with mental health providers who worked in both private and public sectors. She argues that managed care significantly altered the paradigm operating in the health landscape from one based on professional ethics and commitment to community care to one of technical rationality and bureaucratic control (Scheid 2004, 2003, 2000).

*“Providers at CARE felt they were not able to provide the treatment or services they believed their clients needed, and they have raised serious concerns about the quality of care”* (Scheid 2003:158). Rather than adhering to a social or biopsychosocial model of mental illness, MC imposes a medical model of illness on its providers by privileging treatment goals that focus on short-term improvements at the expense of deeper changes that would provide longer-term stability (Scheid 2003). In addition, a critical *“consequence of MC is the greater reliance upon psychiatric medication as opposed to more intensive forms of therapy or skills training”* (Scheid 2000:709).

In Scheid’s analysis of interviews with providers in the private sector, she found MC significantly impacted the everyday therapeutic work practices, to the extent that some therapists were considering leaving private practice (2000). Providers in the private sector were working longer hours to augment their incomes due to the significant decline in reimbursement fees and yet had increases in administrative duties such as paperwork and phone calls for treatment authorizations (Scheid 2000). However, it wasn’t just the intensity of administrative labor that providers resented; it was that these duties took focus away from patient care, proper supervision, continuing education and the quality of the therapeutic relationship (Scheid 2000). Further, MC is a coercive threatening system, because if providers spoke out against a managed care insurance company, they were often dropped from mental health panels or put on a provider excluded list (Scheid 2000).

Managed care subjects the treatment decisions of providers and provider-client relationships to increased managerial, financial and bureaucratic scrutiny to the point where both the quality and quantity of interaction between provider and patient are

compromised. In addition to harming therapeutic relationships, managed care threatens professional autonomy over their own work.

***Theorizing Professional Dynamics: Countervailing Powers and Zones of Discretion***

The attention on studying the dynamics of professions, that is, their interdependence with the state, and more recently, corporate and other external actors, led to studies of the power relations embedded in professionalism. Important theories of the decline of professional dominance emerged such as deprofessionalization (a loss of control over the content or form of one's work), proletarianization (a downward shift of status from self-employment to wage labor), and corporatization (the transformation of health care from charitable pursuit into profit maximizing business), to better understand the relationship between the medical profession and the state and/or economy (Abbott 1988; Larson 1977; Light 1995; McKinlay 1988; Wolinsky 1993). While each of these concepts capture an important feature of the shifting dynamics between the medical profession and the political economy, Light and Levine (1988) argue these theoretical approaches mistake the part for the whole, thereby failing to capture the complexity of actors and relations in the larger arena of action. Building on studies of the professions that emphasize the interactions of professions with other actors, especially those of Johnson (1972 and Larson (1977), Light challenges investigations of professionalism based on the assumption of professional autonomy and instead posits the theory of countervailing powers (see Light 1991, 1993).

The theory of countervailing powers locates professions and the strategies of professionalism within a larger field of institutional and cultural forces, and facilitates analyses of interactions of a field of powerful actors that are interdependent yet distinct in

their positions and interests in health care (Light 2009). “*As a sociological concept, countervailing powers is not confined to buyers and sellers; it includes a handful of major political, social, and other economic groups that contend with each other for legitimacy, prestige and power, as well as for markets and money* (Light 2009:241). The sociology of the professions work today starts from the assumption that each medical or mental health profession is one of several countervailing powers in society invested and interested in health care. In addition to the awareness of multiple interested stakeholders, contemporary analyses attend to how these relations change in response to social, political and economic values and priorities.

### ***The Role of the Professions in Transformations of Health Care***

In the past few decades the organization and delivery of health care has undergone significant interconnecting transformations (Hafferty and Light 1995) leading to questioning whether or not health care is best organized through the professions (Feldman 2003; Martin, Currie and Finn 2009; Timmermans and Oh 2010). Opening up the role of the professions in the organization and delivery of health care services is in part based on the fear that professional norms and clinical decision making have been corrupted by the logic of the market and increased consumerism.

In addition to increased attention to the role of organizational contexts and professional norms in shaping the terms and conditions of health care delivery, scholars have investigated external (the state, the economy, insurance companies, pharmaceutical) and internal (diversification, specialization, substitution, oversupply) countervailing forces and the ways they intersect. All of these changes are important and demonstrate professions’ relations to capital are complex. It is easy to both over and under estimate



the role of the professions in the organization and delivery of health care, and in order to better understand the paradox of the expansion of medical sovereignty and decline of professional autonomy, professionalism needs examined within the larger macro context of the political economy (its relations with the state, economy, other professions, all external actors) and within the micro politics of interaction in day-to-day work within and across varying organizational settings (see Light 2009; Timmermans and Oh 2010).

The combination of tightening revenue streams, rising costs, competitive markets and patterns of variation in both availability and quality of health care situate the role of the professions in the center of the contemporary health care controversy. While the government, (federal, state and local) is the biggest purchaser of health care, it is only one among corporate purchasers (insurance and managed care companies), corporate sellers (manufacturers of medical technologies and drugs such as pharmaceutical companies), consumers (including special interest and other consumer groups) and other providers that have been designated as external forces of power and interest within the Medical-Industrial Complex (Hafferty and Light 1995).

While the theory of countervailing powers has led sociological studies of the professions rightly in the direction of examining the historical and situated complexity of actors and power relations in contemporary health care, the distinction between external and internal forces falsely separates actors into distinct collectivities. Instead of focusing on external and internal actors and motives, I argue that we need to examine the co-constitution of health care organization and delivery through specific situations of care that involve professional negotiations and interactions across levels of the social. In addition to countervailing forces, the rise of MC companies and the assemblage of

neoliberal and biomedical discourses are part of the cast that shape the contemporary health care arena, with their power structuring the daily practices of health care professionals.

***Theoretical Framework: The Biopolitical Economy of Health and Illness***

Medical sociologists have been examining what they see largely as technoscientific changes in biomedicine since the mid 1980s (Clarke et al 2010, 2003). If medicalization was the first major transformation of the organization and properties of health care in the U.S. (Bauer 1998; Clarke and Olesen 1999; Conrad 1992, 2007), biomedicalization is the second major transformation (Clarke et al 2010, 2003).

Biomedicalization is our term for the increasingly complex, multisited, multidirectional processes of medicalization that today are being both extended and reconstituted through the emergent social forms and practices of a highly and increasingly technoscientific biomedicine. . . That is, medicalization is intensifying, but in new and complex, usually technoscientifically enmeshed ways. (Clarke et al 2010:47)

The designation of this transformation alludes not only to technoscientific innovations of molecular biology and biotechnologies, but to Foucauldian theories of biopower and biopolitics (Clarke et al 2010). Biopower and biopolitics refers to the emergence of political knowledges, techniques and technologies that enable analysis of processes and forms of life, and thus also, health and illness. For Foucault (1977), biopower and biopolitics signaled a major historical break in the ideas and practices of politics, leading to the reformulation of political sovereignty through the emergence of new forms of political knowledge. Prior to the 17<sup>th</sup> century, a sovereign repressive control over death reigned, whereas contemporary forms of power now make regulative calculations to maximize life and the surplus value it produces or will produce for the

economy.<sup>24</sup> Thus, biopolitics refers to the ideas and practices of government and state institutions that attempt to administer and regulate life processes. Foucault's theoretical constructs of the disciplines, disciplinary society, the life sciences, biopower, the individual and social body (population), and normalization, produce a theoretical frame from which social theorists examine how new technoscientific knowledges intervene in not only life, but processes of life such as health and illness.

In hopes that biomedicalization theory will be used as an analytic framework for future studies, Clarke et al. (2010, 2003) delineate five key interactive processes of the second major transformation of American medicine. I briefly review the interactive process relevant to this chapter: the biopolitical economy of health and illness. This process encompasses how the health care organization is increasingly profit oriented, corporatized, and how new biomedical knowledges, technologies, services and capital are co-constituted. *“Biocapital is the study of the systems of exchange and circulation involved in the contemporary workings of the life sciences, but is also the study of those life sciences as they become increasingly foundational epistemologies for our time”* (Rajan 2006:12). Rajan argues that epistemic and technological assemblages such as genomics (and therefore biomedicine and neuropsychiatry) are impossible to understand without attending to the political and economic frameworks within which they emerge (Rajan 2006:280). Following this, I examine how the assemblage of managed care

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<sup>24</sup> For detailed theoretical and empirical studies of the contemporary bioeconomy and human life as surplus value, see Cooper 2008; Franklin 2006; Harrington et al. 2006; Rajan 2006; Waldby and Mitchell 2006. Although life emerged as a focus of politics in the 17<sup>th</sup> century, the life of a social body, or population, and its economic value – or the political economy of life, emerged later in the 18<sup>th</sup> century (see Foucault 1973; Lemke 2011:45; Rajan 2006:13).

companies and the state structure and stratify adolescent mental health care. I employ the biopolitical economy of health and illness as an analytic lens in this chapter, building on the few studies that have demonstrated the ways that the biopolitical economy further stratifies health care (Clarke et al 2010; Scheper-Hughes 2004; Shim 2010, 2005, 2002).

### **BIOPOLITICAL ECONOMY OF HEALTH CARE: DSM, INSURANCE AND STATE POWER**

As demonstrated in chapter four, the assemblage of the biomedical model enshrouded in the DSM technology, and insurance company power marginalize Mental Health Practitioners' (MHPs) own professional knowledge practices and expertise. Revising the DSM to account for the social, relational and adolescent specific aspects of mental illness will not sufficiently address the issues MHPs find problematic about how the biopolitical economy shapes their everyday clinical work. The power, knowledge and experiences of alternative mental health professionals, in comparison to psychiatric professionals, are marginalized by the assemblage of the DSM and insurance companies. Here, I offer an analysis of MHPs' experiences of countervailing forces to the professions—MC, the DSM and state governance. I asked a psychologist about the ways his work is shaped by the DSM and instead he critiqued the privatization of health care:

I think that the diagnostic codes, I don't know whence they came. I don't know if they were generated because of some pressure from insurance companies, but insurance companies use them the way businesses use any tool. They use them to save money; this is not putting a client's interest first. Every mission statement from every third party payer says we're looking out for you and your care matters to us. No it doesn't. What matters is saving money and they've begun to use that [the DSM] to manipulate to save money because that's what business models do. I don't think it's the fault of the diagnostic codes that this happens. There is something wrong with the privatized for-profit business of health care.

MHPs critiqued the biomedicalization of the DSM and how it constrains their psychotherapeutic work. However, they also recognized that the DSM technology has

been taken up by insurers as a tool to save money. Similarly, when asked about MC and the contemporary health care system, a clinical psychologist discusses privatization:

I think it's owned by business. Americans didn't want government involved in their health care and they got what they asked for. Americans feel very strongly about government not being involved but what they fail to recognize is that if its not government regulated, its going to be regulated by private business industry. Its capitalism at its best and mental health is a humanistic endeavor, it's a social science. Mixing business with social science is not a good cocktail; it's not a good mix. It's a disaster, but if the conservative, anti-government regulation of mental health wins over, there is enough good will in non-profits. The problem is, you really do need money to back up almost anything that is worth while; to get the professionals that all went to school forever, right? You can look at it as a lot of links, why are we going to trained professionals to get doctorate degrees to then offer care for what if you don't pay them? Why go? We'll just have a bunch of paraprofessionals running around, it's all linked. If you want a quality mental health program, you have to pay for it. If the private industry had taken over mental health and they actually paid us well we'd be fine. The fact that they took it so they could have a yacht and then wanted to profit and hold back the mental health provisions, that's why it's a disaster. If they truly cared about mental health and put the money into it, it would be fine.

In the description above of the role managed care plays in shaping everyday clinical work, a clinical psychologist working on the East Coast critiques how mental health care has been taken over by business. She notes that privately run health care could work if money were actually invested in the system, but not under the system of capitalism in which insurers have incentives to hold back on provisions. Below, a social worker who is also involved in state government and policy work describes how MC represents what is wrong about a political economy of health and illness guided by profit rather than health and illness:

I think it's a crock. Managed care is the epitome of what is wrong with the health care system. It's why we need a public option. It's why the rich are getting richer and poor are getting poorer. Especially at the state level it only creates incentive for the guy at the top and his minions to get a bonus. It's an incentivizing type thing. Deny coverage and you get a great bonus. The guy who runs managed care for M for this state, well, multiple states' Medicaid programs, his bonus last year was 65 million dollars. When I read it [in a local reputable newspaper], I called my boss and said 'did you hear me screaming from this side of the state?' Think about how many services you could give people. Managed care doesn't work.

In my interviews with providers across this large Midwestern state, many MHPs referred to a particular insurance company, which I refer to as M, that had the the most problematic policies. In the midst of debates about pending health care reform bills, she argues that a public option of health care would alleviate some of the trouble of the current assemblage of state and insurance power. Below, she goes on to tell me about this Midwestern state's republican governor's decision to hire someone to help their managed care and Medicaid systems save the state money.

The gal we [the state] hired to implement these changes her name is ---. She's lovingly referred to as the ice queen of the legislature. She's a very nice lady but she was brought here to be the hatchet. She was hired out of [state]. What they did there, we liked. She'll tell you that the 75 sessions is not a lifetime cap and that LMHPs can continue to apply for services. Do you know how much paperwork and red tape they create? Nobody wants to deal with that. Think about a kid who is presenting with early signs of schizophrenia or any of the major mental diagnoses. They probably should do therapy at least two times a week if they're not in a residential setting by now.

Again, the social worker above who also works in this state's legislature as a legal aide describes how the on-going state/MC assemblage focuses on how to save the state money. While this social worker clearly knew more about the local and state political governance structure and how it and MC co-constituted the local health care delivery system, other MHPs such as the following Psychiatric Nurse Practitioner also recognized the ways in which local, state and federal government had previously and are currently involved in shaping the health care system:

It's changed mental health care for the worse because it's all about the money. The whole idea behind managed mental health, the original idea, which actually President Kennedy is the one that started community based services. He started the managed health cycle. He had great plans for it and I think it would have been very successful, you know nation wide if he had lived. What I see now is that we get paid for this service and only this service and you only have this amount of time to do it.

MHPs articulated that the assemblage of the state or federal government and MC may have originally been designed with good intentions, but under the current privatized,

capitalist system, insurance companies' practices primarily aim to save money through capping services, setting annual and lifetime coverage limits and by decreasing service provider fees.

Our fees have gone down over the past 5-10 years, and only one company I can think of has raised them consistently. There are a lot of companies that have dropped it even by half. If they're saying okay lets pay you less, and lets make you spend even more time on the phone with these Turkeys and now its going to be a federal turkey. . . The state may have saved but M is profiting very richly. If they fire M which I think they probably will do, they may find some company like C which will come in here and be worse. C is the, I think they probably do get more people covered, I wouldn't know, there are areas in the country that have it and it's spoken of as the worst. I'm almost worried that this is going to fall into the hands of . . .

Above, the strategies MC companies utilize to save states money while profiting are described. What is important here is not only that there are lower fees for services, but the complexity of the relations between the federal government, public social programs such as Medicaid, MC specific MC insurance companies, and the strategies that particular states take in governing their mental health care markets. When I asked MHPs about the DSM as a technology and how it structured their work, they articulated the ways in which MC and the DSM assemble to create a unique form of technoscientific power that requires complex on-going negotiations. Similarly, when asked about MC and how it shapes their everyday clinical practices, MHPs discuss the ways in which MC operates within a larger context of state and federal power and influence (or lack thereof).

Another feature of the political economy of mental health care is that it has been necessary for distinct professions to secure a segment of the market through lobbying and other politicking work. MHPs argued that some of the disciplinary professions within mental health care such as psychiatry and social work have done a better job at lobbying to get their therapeutic approaches legitimated by government and insurers:

Practitioners who use intrapsychic and individual models have gone to bat harder. In comparison, the social workers went really hard to fight to get on Medicare, years ago. Other schools of thought didn't fight to get represented and they didn't get represented. Social workers got, are the only ones who were able to be credentialed with Medicare. Not that I care personally, that's really not a gig I want, but I think the same thing happens when it comes to which fields of thought are acceptable. Are people out there fighting to get random controlled trial studies of their issues and their approaches? If they can get something that works then people can say here, it's in this outcome book, now use our approach. I think Systemic approaches haven't been fighting as hard, until lately, to get that. I think that's one of the reasons why people are willing to treat things with medications, because doctors have always had say so. The people who are really good at individual therapy would like to be paid for that thank you. But there is a lot of research that shows that there are systemic treatments that go along with medication that can help a myriad of issues.

Thus, some of the mental health professions have legally, socially, politically and economically secured a stake in the market of providing health care in ways that some of the other professions (including the recognition of their theoretical orientations and treatment techniques), have not. For example, a newly licensed Marriage and Family Therapist (MFT) discusses how the government program Medicaid recognizes them as desirable providers but Medicare does not.

My field was one of the later ones to be formed. We weren't formed until the 60s or 70s. We are still that little kid on the football team trying to prove that we are just as good as everybody else. Medicare very quickly recognized counselors and social workers as being able to help but we aren't recognized. I have a vested interest in that because I know just as much as the next LMHP. Now Medicaid likes us, Medicare does not. They are both government funded healthcare so we're good enough for poorer younger people but not the elderly?

The section of quotes above illustrates that selection of providers and theoretical approaches is organized by political economic structures and relations. The lobbying actions or lack thereof of the professions impact their ability to receive government support and reimbursement for their mental health care services. In the contemporary privatized market, MFTs are unrecognized by the state/insurance assemblage of the



Medicare program and several types of therapeutic treatments are devalued or are not recognized by insurers as EBPs and therefore are not reimbursed.

Because of managed care, and the general trend in society, people want a quick fix. They want answers. Everything is cognitive behavioral. Unfortunately people eat up the media, and their understanding of mental health work is quite superficial. We live in an era where while we know as much as we do about mental health, and way more than we used to, everything is very medication oriented and quick fix. . . I end up staying on the surface a little bit more. I think we refer out for medication more than we would if people were devoted to working.

Thus the power of the media and MC in shifting the type of mental health care provided is recognized as much as are the relations of power between the DSM, MC and state and federal governance. In what follows, another MHP notes how MC has shifted the field of mental health care away from interpersonal psychodynamic transformations and towards short-term behavioral and medication treatment approaches:

The three years in the in-patient program back in the day before managed care, we had fabulous treatment for adolescents. The staff that worked at -- Psychiatric Institute in [state] were so profound and amazing. The work was very intense, a kind of systems-object relations approach. You can't find programs like that anymore because of managed care. Things became quickly revolving door; behavioral medication oriented starting in the late 1980s early 1990s.

Again, the impact that MC has had on the field of mental health care is discussed as significant. In this analysis section I demonstrated how MHPs are critical of the privatization of care. MHPs recognize the complex relationships of power between the DSM, MC and state governance and critique the ways in which the current system is guided by administrators and bureaucrats interested in saving states money and making companies profit, at the expense of patient care. MHPs argue that MC companies need to be regulated at the federal and/or state level. Further, some MHPs recognize that their own stake in the market is dependent on politicking. Before turning attention to the analysis that reveals the micro-interactions between MC regulations and everyday clinical

practices of providers, I first demonstrate the few (yet still contested) aspects of the managed health care system.

## **MANAGED CARE RECONFIGURES TREATMENT PLANS AND PRACTICES**

### *Managed Care Enhances Professional Accountability and Treatment Plans*

In my interviews, while MHPs were overwhelmingly negative about the ways MC has changed the mental health care field and their everyday practices, there were a handful of practitioners who talked about the positive changes managed care has made.

Probably because I've done this work so long, I see the world as gray not black and white. Years ago I would have said its [MC] just horrible, but now I'm saying there is a place for it. It makes our lives as clinicians more complicated but it also holds us more accountable. I think in a well run managed care system, it can help a clinician be a better clinician. By well run, I mean fair, having the best interest of the client at heart and really understanding what needs to happen for that client. There was a time when Medicaid in the state of -- had no management. Clients could have as many sessions as they wanted. I certainly had clients that had more sessions than they probably needed. I had one client in particular who had multiple Axis I diagnoses, lots of trauma, I could literally justify that she could benefit from therapy for life, but I think because it wasn't managed, neither of us were motivated to say, how are we going to know when we're done? Let's get that figured out. I'm not sure in the end if it served her.

Practitioners often remarked that the positive change managed care has made to the field of mental health care is that it has instituted professional accountability. In the quote above, the MFT argues that MC ensures that professionals are clear about therapeutic goals and are mindful of the financial aspects of treatment. MHPs agreed that before managed care, some professionals abused the system:

Before managed care came along I think some people abused the system. People maybe misused the system a lot and worked it to their advantage and weren't always very diligent. Then there are people that have always been very diligent and done it the right way and they get hammered along with the rest of everyone else. What happens with managed care is that they give guidelines and no wiggle room. It's really hard to break them out of their box so to speak. I think having checks and balances is not a bad thing necessarily. It's when the managed care system says, we're not dictating treatment we're dictating what we will pay for. They're not saying that, they're saying the decisions of treatment still lie in hands of physicians and therapists and stuff, but they won't pay for it. We understand that but if we're talking about a test that costs two hundred dollars and

we're talking about a family who has 4 children and an income of less than 20,000 a year, they can't do that. That leaves it to us. If we think it's clinically necessary, we'll do it anyway and not get reimbursed for it but how often can you do that? If managed care could have a little bit more leeway in how they view things, and be open to things rather than as structured and rigid, it would be better.

A common narrative about the impact of managed care is that it is good to have a system of checks and balances, but that in the management of finances, MC companies too often over-manage clinical aspects of treatment as well. In addition to improving professional accountability, practitioners discussed how managed care policies have improved treatment plans (although this is a highly contested issue):

Within our agency, our treatment plans are phenomenal, I've read treatment plans from other agencies, from private practitioners, and they're very basic and I think that with M or the managed care insurer in this state, they're requesting more on our treatment plans. We have a goal and we have objectives on how we meet that goal. We have how this goal will be measured, how long they have to meet this goal, who will be measuring the goal, and who is responsible for implementing these objectives. We're very thorough in creating these treatment plans. That is in response to managed care, and getting paid basically, but that truly does improve the services that are provided.

Below, another practitioner discusses how managed care has improved their treatment plans. However, the narrative they offer is that while managed care has improved some aspects of mental health care work such as treatment plans, managed care companies are going too far, or are over-managing.

I see the need for it and I definitely think it has its benefits, the way our treatment plans have evolved. I've gone through struggles with seeing a child that clearly is not getting his needs met in the home and making the recommendation for a higher level of care is not acknowledged by a reviewer from managed care for whatever reason they may have. But they haven't worked with this client. They don't know the dynamics of the family. Even though you try to provide as much history as you can in these referral forms. Once managed care reviews it, well you're spending too much money on this. It can definitely limit the services, and I think at this point you're allowed 24 sessions or maybe its 12. Some of the limitations, some of what they're managing goes a little too far I think.

In another example about how managed care has improved treatment plans, a master's level counselor discusses how he has gotten really good at quantifying treatment goals as

a response to managed care requirements. However, he also mentions that a particular insurance company that is predominant in this state has such strict treatment plan guidelines that practitioners are forced to follow their policies even when they aren't the insurer or authorizing the services provided. In other words, it is another example of how managed care has improved treatment plans yet is viewed as over-managing clinical care work.

I think we do a really good job at quantifying it when we are required to do treatment plans that meet up with certain standards. M, one of the companies that has far more power than anybody should, over the private non-profit where I work. Even when they are not covering it or authorizing the treatment you still have to follow their guidelines when you're making up treatment plans.

Finally, there was one clinical psychologist I interviewed on the East Coast who, in comparison to most of the practitioners I interviewed, was overwhelmingly positive about managed care. Yet during our interview he discussed how he rarely documents the way insurers would prefer, choosing to focus on client care rather than documentation. His experiences did not seem to mirror those of the practitioners I interviewed who were working in the Midwest (or others on the East coast whom had stopped accepting some forms of insurance because of how much they limited care). When I asked him about these differences, he determined it was because some practitioners are prejudiced about managed care. Perhaps this is true. I also think a plausible explanation is that some insurance companies "over-manage" or enact policies of capitation and deny services more than others. Of course, that he was a previous director for a managed care company might shape his very different perspective as well:

I think you're dealing with people prejudiced about anyone doing a review of what they're doing. I was director of Behavioral Health for blue cross blue shield of Connecticut. I was chief of mental health services for a community health care plan which was the first HMO in Connecticut, am I managed care? Maybe I have a different

disposition as a result of some of my professional experience from someone who has never been involved directly with insurance companies or dealt with any of their issues. I have patients who have limits on sessions but then I write a review and I get more sessions. It's a pain in the neck I have to god damned write the thing after six sessions but okay. As a citizen thinking about practice in the field, I think these things are important and won't go away.

While his perspective on managed care didn't fit the most common narrative, I think he rightly acknowledges the positive aspects and perhaps original intentions of the creation of a managed care system. The rest of this chapter focuses on how managed care has changed clinical care in ways that are predominantly viewed as negative or harmful to clients' best interest.

### ***Managed Care: More Work for Less Pay***

A common complaint about managed care is that their documentation requirements have decreased the time clinicians have for direct care. *Documentation is required more of therapists. Therapists spend a lot of time on paperwork, versus working. You know if you have to do this, this, and this paperwork wise, that takes time and limits the number of clients you can see. If it pigeon holes you or makes you lose sight of other interventions then it can be a bad thing.* This quote illustrates how MHPs resent spending more time on documentation or paperwork and less time on direct clinical work. Further, while most MHPs agree that treatment plan guidelines can be helpful, they frequently voice the need for clinical flexibility in their treatment techniques.

Managed Care drives everybody nuts. They claim to make improvements, to make it easier to obtain services and for providers to give that service, but it's having the opposite effect. It requires a lot more paper work, it's a lot more time consuming on the clinical side. That's burning people out really fast. Practitioners become overwhelmed with it, because it is too much. Access to services too is pretty huge, because there are a lot of loop holes to jump through.

Thus, practitioners complained about how MC has increased the administrative aspects of

clinical care work. Yet, what they argue is the bigger problem is that they spend more time on paperwork but are also increasingly limited in acquiring access to services for their patients. *“Right now more than anything, managed care is hindering a lot of services. There is a lot of frustration, a lot more documentation that goes into a lot of behind the scenes work. We’re already filled with client caseload so we don’t have time for all of the administrative side of it but it’s an addition. That’s one of the biggest frustrations.”* MHPs recognized that the increases in administrative or unpaid aspects of clinical work was a significant effect of MC and expressed their frustration over the difficulties of balancing the increase in unpaid and undesirable work over their preferred direct clinical work.

The productivity requirements are really high. Clinicians are supposed to have five and a half hours a day of billable time. It’s a lot on top of all the paperwork because so much of what we do is not billable. We can’t even bill for phone calls. We had an audit and they marked us down on networking. You want to say to them, “why do you think that is?” If you’re only going to pay us for face to face contact, of course the networking is going to go down. Also, you are so overloaded with twenty-five clients, and you have to meet all of their needs. You’re just putting out fires for those twenty-five people. I think some of that networking can seem extraneous. You know, ‘I’d love to do that. Just give me four more hours in a day and I’ll be able to.’ Part of my job is training. I was in Minneapolis last week and one of the things I say to them is, if you’re not doing trauma treatment yourself, you at least need to find out who is, so that you can make referrals. Some people came up to me after these trainings and they’re like, “we don’t know anyone in Minneapolis-St. Paul.” There have to be providers in Minneapolis-St. Paul. You can’t have a large metropolitan area like that and not have people who are doing that, but again they just felt bereft at not knowing, ‘where do I begin? How do I find...? Who’s doing this?’

The shortcomings of the mental health field when it comes to networking with other professionals were frequently raised during my interviews. It made a lot more sense as an issue once this professional discussed how all networking, communication and collaboration with other professionals and parents, is unpaid work. In a field that is extremely interdisciplinary, failing to recognize or pay for clinicians’ communication

with other professionals and adolescent clients' parents, families or school providers, seems to be a significant oversight that reduces the quality of care. Practitioners usually discussed these frustrations as a result of how MC is guided by profit rather than the best interest of their clients. Another significant issue with what guides managed care policies is the way they focus on capping or limiting services.

### ***Commodification of Care: Capitation of Services and Spending***

Similar to the findings of Scheid (2000), MHPs complained about how capitation strategies limited the services they could provide and the patient-client relationship. Here I offer a few examples of MHPs' experiences with capitation.

One of the examples, I had seen a three year old with lots and lots of environmental crap, there is just no other word for it. I had written our big assessment and I had done a treatment plan and all that sent to M. They said you can have five sessions total with him. Mom's having a baby this month; dad's getting released from jail soon. This kid just got returned to mom's custody last January. In March mom's partner moved in and he has nightly sleep terrors. They [MC insurance company M] said you can have five sessions. Deal with it. What managed care is doing is putting a cap on spending by eliminating sessions. It doesn't make any sense.

In other words, practitioners were frustrated with how MC companies limited the number of therapy sessions they could provide. The reason why capitation and other cost-containment services are problematized is because clinicians operate under a professional logic of care whereas MC companies commodify care. *Somehow I became the agency guinea pig, with all of this M crap. I was the first one to have kids denied outright without anymore sessions. Right now the director is reading one of my files because I have to fax some paperwork over to M, so that's been kind of stressful.* MHPs discuss various cost-containment strategies of MC organizations and how that impacts their clinical work. Not only do MC companies contain costs by limiting the number of sessions, but they also review documentation and deny services outright, as described in the previous quote.

MHPs frequently discussed precertification or on-going reviews by MC organizations as the most stressful part of their everyday work.

Managed care, I'm lucky in the sense that my [school program] kids are through a grant so I don't worry about insurance or have to fight to get sessions. My other outpatient kids are on insurance and once their insurance sessions run out they have to stop unless we can waive their fee or make arrangements. For managed care to dictate who gets what services and how many sessions they get, I just think it's ridiculous.

Again, the clinicians I interviewed discussed how MC companies used multiple cost-containment strategies that interfered with their everyday work. However, in the contemporary biopolitical economy, it is difficult to make firm conclusions about how managed care effects mental health practice. This is because there are several insurance companies, different cost-containment strategies, and as noted above, multiple sites of therapeutic care. Often, the practitioners that work in the schools or in in-patient residential treatment centers do not have to deal with MC capitation strategies similar to those that out-patient therapists struggle with everyday. While at times the cost-containment strategies of MC companies are described more as a nuisance to MHPs' clinical focus of work, other times these strategies actually hinder what providers see as critical care.

The most confusing thing is that you get different answers from them. I can call in and ask one thing and another colleague can call in and ask the same question and they get a completely different answer. That's statewide. When you talk to people at groups we find out we're all having the same issues. They're maxing people out now, lifetime sessions. We've had patients with major mental health issues that MC says can't receive any further services. It's a money thing; it's all a money thing. I have one patient I used to see two times a week. She has major mental illness, other substance abuse issues, lots of things, and now you can't see them more than once a week. Sometimes it's more cost effective to do some of the work we can do here than these people ending up in the ERs because they're suicidal.

Thus, while MHPs operate from logics of professional ethics and care, MC companies makes decisions based on short term need or medical necessity. Financially speaking, in



the eyes of MHPs, this often costs the system more money in the long run. In both the description above and below, different MHPs provide narratives of how clients with major mental illness are being unduly impacted by the cost-containment strategies of MC companies.

Most private insurance companies allot a certain amount of sessions per year; 24 or 12 sessions a year. That's what, two sessions a month (at most)? For some kids that's not going to be enough. But that's all you get and then it's up to the client to figure out how they are going to fund the rest. In terms of Medicaid, it's about making almost monthly phone calls to M (that manages Medicaid), to hear if they are going to let you see that kid or not, and how many times they are going to let you see that kid. It's jumping through a lot of hoops. They require you, after so many sessions, to submit progress notes, treatment plans, and pretreatment assessments, to whoever is on the other end of the phone. Then they get to decide. So the game is being very careful what you write in your progress notes but you also don't want to be too revealing because that breaches confidentiality. I struggle to find that happy medium. You want to say enough to make sure they are aware your client needs the services but you don't want to say too much.

Managed care has changed the field of mental health by requiring more unpaid work such as documentation and phone calls, while exercising multiple cost-containment strategies that limit the number and type of services clinicians can provide. Cost-containment strategies are frequently discussed as a nuisance and as restricting the quantity of care patients with major mental illness are able to receive. However, the way MC has reconfigured treatment plans, goals and techniques is often argued as changing the quality or content of everyday clinical work.

### **OVER-MANAGED CARE**

The ways in which MC reconfigured treatment plans, goals and techniques was a significant issue that was raised in my interviews. MHPs problematized this reconfiguration in different ways. One major critique was that MC policies that governed what were acceptable treatment plans privileged language and techniques that were biomedical and behavioral as opposed to psychodynamic:

When I first started in mental health treatment plans were more long term psychodynamic and systems oriented. They allowed for fair amounts of therapy and were more global process oriented, focused on reducing conflict and decreasing depression. As managed care came into the world we have had to do treatment plans that are very behavioral. Everything has to be stated with a behavior, everything has to be numbered, and the behavior has to be specified: the patient will have three friends by the end of three months.

In addition to governing the language of treatment plans in a way that expunges psychodynamic and constructivist theoretical orientations, MC policies privilege treatment techniques that are behavioral and biomedical:

We have a certified play therapist and an art therapist and they don't like those to show up on interventions anymore. We'll still do them because it's been found to be helpful but whatever study they were looking at says it wasn't. We can't use the word maintain anymore in our plans, so we have to find other ways to say it, and its going to say the exact same thing. We always have to figure out, you know, communicate with each other, well I just got denied because I said I did play therapy. Now don't say that and you can do it because it's going to be helpful but don't say that anymore. We kind of have to code what we're doing in a way, you know. If we just write helping kids, that's what we do, no, they want to see 'as measured by.' I start my progress notes before clients even come in, reported functioning regarding, and then I fill in the goal \_\_\_\_\_ has been impaired or good, as measured by . . . or as evidenced by . . . We have to have those specific words that they are looking for. We've always given this information but now they want specific words. We just all roll our eyes and go to meetings.

Again, MC policies privilege biomedical and behavioral theoretical orientations and treatment techniques. MHPs exercise numerous work-arounds and processes of cribbing to figure out how to "pass" MC regulations. Several MHPs described this reconfiguration of treatment plans as cookie cutter:

Well because our agency serves so many Medicaid clients, we kind of change our policies as they change theirs. Treatment plans have to be measureable, objective, and something else. You have to use the words that they want you to use. It has become a lot more cookie cutter. To be perfectly honest as an agency when they change their goals, we have to keep figuring out how can we keep providing the care that we need to provide to them in meeting (or fitting) these goals (or rules). If that means we need to close their case for 30 days and just use no money and our time to continue to help that family along and then reopen them in 90 days, then that's what we need to do. It's more work for us but we have to fit within these stipulations.

In other words practitioners critique how MC prefers treatment plans that are formulaic

and behavioral and thus, ignore patient personhood and heterogeneities. MHPs rely on their collective knowledge about MC authorization and denial histories to successfully enact cribs that help them conform to what MC wants in order to be able to continue providing psychotherapy.

[Name of local non-profit organization] has a contract with [public schools] that if we're in certain schools where the need is high, we can provide the mental health services. That's my employer, and then I work closely with [the public schools]. We're getting a lot of pressure right now from the financial aspect, and them not wanting to cover services, so that's definitely changed. Also, our treatment plans need to be more directive and behavioral. Instead of 'Bobby will work on anger management skills,' 'Bobby will identify appropriate ways to deal with his anger 9 out of 12 times,' it has to be more specific. It appears it's financially driven. We're not able to see children that need it, as much as they need it because of that aspect; we're not getting the authorizations to see them.

For many school psychologists and social workers, MC hasn't fully made its way into the funding streams of how they provide services in those settings. However, for some, MC was beginning to fund their programs and thus they were starting to have to deal with the same financial issues clinicians who work in out-patient offices have to deal with. For these practitioners, the cribbing processes – figuring out the preferred language of treatment plans and learning how to do that translation work, is new. For others, their agencies continue to change their treatment plan guidelines as MC changes their policies:

We redid our treatment planning process at the agency to—all of the goals follow just about exactly what the DSM says, so that our treatment plans are sort of audit proof. It's like death to an agency to have paperwork that is wrong. Do you know that when they come in and do an audit, if they find 3% [wrong], so they look at certain charts, and if they find 3% mistakes what that means, we bill 7 million a year. The [east coast state] department of mental health, so if we have 3% mistakes, which doesn't seem bad right, that's \$210,000. In our case it would be the agency that pays it back which is better than an individual therapist, but it's still a lot of money, even though it's a big agency, that's still a lot of money.

Again, individual MHPs, community health centers and private practice groups have to continuously reconfigure the way they talk and write about their everyday clinical work

in order to get reimbursed and continue to be able to provide their services. MC governance of treatment plans was discussed as though it causes a lot of fear. MHPs felt like disciplined subjects rather than expert professionals under the culture of surveillance created by MC policies and responses to treatment plans that didn't conform to their behavioral, profit-logics. As one therapist put it, audits make expert practitioners feel:

Threatened. I went through their audit last year and was just astounded by what came back at me, that I needed to word things just as they say, exact wording. Some people don't have to deal with that so they just don't. Yeah they have to change their way of wording things and their approach into the Medicaid and M [insurance company] language and if you don't really learn it or, you're caught with it when you're audited and then they're saying, no this doesn't work you have to word it this way you have to word it our way. The scary thing about that is the financial piece, the business piece because they then will go after you and say you didn't do it our way, you owe us. I had to pay back \$900.00. They said that I was contracted with them and I didn't do the paperwork the way they wanted it.

Thus, not only do practitioners have to deal with reconfiguring the language of treatment plans and techniques from psychodynamic into behavioral and biomedical terms (cribbing), but also with constant surveillance of their plans and documents with the fear that they might have to pay back money they worked for if their cribs, or paradigmatic translations aren't good enough to satisfy MC preferences.

I think they need more clinicians, more people in their program that know what's going on. Now the intake interview, pretreatment assessment is going to take us about 3 hours. How is somebody going to focus for that long? How is a practitioner going to join in any kind of bond with that person when they're asking them every detail? It's black and white for them. You know on the 12<sup>th</sup> of September, (this is December), what kind of treatment technique did you use? It may change day to day, so I don't know, so then they might come back and say well we're not going to pay for that session because you can't tell us.

In the quote above, the MFT discusses how a new change in MC policies of pretreatment assessments will make it more difficult for practitioners to form a therapeutic bond with their client when their first session together is guided by MC questions rather than a professional ethic of care. In addition, the MFT argues that MC companies need to have

more clinicians as their administrators or care directors. I heard this argument several times—that the MC personnel making treatment decisions were unqualified to be doing so, didn't collect or care about the "right" information, and didn't put the client's interest first. Here is another example of this kind of critique of MC:

I think it's unfortunate, that the people who are writing these laws, and working in behavioral mental health policy have no mental health experience. They are administrators and they don't understand mental health at all. I look at the administrator, the director of behavioral health services here and he's an administrator. He has no mental health background at all, and its like, what makes you qualified to say this is how the system should work?

While there were several aspects of MC regulations that reconfigured treatment plans and techniques in ways that MHPs argued were against professional ethics of care, perhaps even worse was the seemingly irrationality of MC rationalization. Even when MHPs want to figure out the guidelines and make sure they are using the right language in their treatment plans and performing EBPs in their therapeutic techniques, they struggle to figure out the MC rationale:

It's a total guessing game with them. I'm trying to keep ahead of them, you know you call in; I stopped calling in to get answers because it was worthless. I'd get an answer and do that and get reprimanded and I would call back and say so and so told me this and they would say no that's not the way it is, it's this way. It's just a huge game play and its frustrating and not worth it. If you're not getting straight forward answers, how can you work with them?

Thus, while MHPs operate under professional logic of care, they attempt to understand the authorization decisions and regulations that govern treatment plans and techniques.

Yet several mental health practitioners discussed MC decisions as irrational and inconsistent. The inconsistencies in rationale add to the culture of fear.

I can understand the questions that they're asking, because someone from the administrative or operational side, you know they tell us these care managers are licensed mental health practitioners. That's what they say, but they've really been removed from the clinical side. I can understand somebody from the operational and financial side saying these are the questions that are important to ask, but they're not. From the clinical

side that's not what is important. I would be happy to have them come in and sit down with me, and the file, and go progress note by progress note and say on April 12<sup>th</sup> you wrote this and I could say this is why I wrote this, this is what we did, this is what was going on. I would love to do that, give me the chance to do that. This client we're talking about today, I got authorized for three more sessions with her. She is not on any medications but they said, maybe she would be appropriate for medications. And I kind of thought well, you could pay me to see her once a week or medications, I'm a lot cheaper. So even some of the decisions they are making financially don't make sense.

Again, MHPs discussed how there are different logics operating. MHPs are guided by professional logics of care and tend to privilege psychodynamic and eclectic orientations, working on deeper issues of client relationships and focusing on their long-term emotional well-being. MHPs discussed how their organization or agency would find a way to pay for a client's treatment for awhile so they could close and reopen a case in order to get access to care for their clients. It was clear from my interviews that the large majority of MHPs continue to operate under professional ethics of care.

One of the things that have been in place for a long time with Medicaid and M is family authorizations are only given to one member of the family, and I have a couple of sibling sets. For one of the children, I can have family sessions under their name, the other child I can't. During that family session you should be addressing changes the family can make so the environmental changes take place. But the specific siblings, the sister is older, they have different fathers, she has a very difficult relationship with her father and his side of the family, and she has witnessed a lot more abuse that has occurred. They are just so different that a family session for one is nothing like a family session for the other. Clinically it doesn't make sense, and they [MC] don't care. I know I can't change their minds, because I've tried. They really dictate our treatment and they have no idea what our clients are going through. They ask who the legal guardian is, I'll say, its mom, and then they move on— that's their family aspect, and I'll be like hold on a second. There's a new step-dad, a new baby brother, a biological dad who is really abusive and has come back into the picture. You might want to consider that too. They're just not aware of how important all of those different pieces are. They have their questions to ask, they ask them and their job is done. In that phone call, they say, you get 6 more sessions, you get 9 more, I've gotten zero, I've gotten 3, I've gotten 6 and 12 is the most that they can give you.

The information this MFT deems most important in the governance of care isn't considered important by MC personnel making treatment decisions. She struggles with the information MC values, i.e., what they want to know about the family is who the legal

guardian is, not any psychotherapeutic specifics about the dynamics of the family, the quality of their relationships or the social circumstances shaping their different individual treatment needs. This conflict emerges because MHPs are guided by clinical information and professional logics of care whereas MC companies commodify and rationalize care.

I'm having a hard time thinking of the positive ways managed care has affected our practice. It's been really hard going to managed health care and fee for service. Most of us, we did not come into this field to do billable service, we would have become lawyers if we wanted to bill in 15 minute increments. We are told more and more in mental health, this is a business, yet most of us didn't go to school because we wanted to go into business. . . I have some friends who work for for-profit companies and to me that just seems crazy. It's an oxymoron. How can there be a for profit health provider, how do you make money, we can't even, our agency can't even make ends meet with managed health care, but how do these corporations expect to make money? I don't get it.

Thus, several practitioners discussed the commodification of care and how their professional training and motivation for becoming psychotherapists is at odds with a business ethic. Unfortunately, in a for-profit health care system, treatment authorizations and denials are determined by profit. The culture of fear, constant surveillance and disciplining for improper treatment plans, have led increasing numbers of psychotherapists to leave practice settings where they accept insurance from managed care companies that handle Medicaid, or leave managed care insurance payments (panels) all together. This shift in the field has stratified care for providers and patients.

### **STRATIFICATION OF CARE**

Mental health practitioners are perhaps most disturbed by how MC policies create a stratified system of mental health care. In this section, I demonstrate all of the ways in which MHPs problematize MC policies and how these policies lead to the stratification of care providers and patients; with the most impoverished, intense cases of mental illness receiving the least experienced care and the most limitations in access to services.

This system of stratification acts like a reverse continuum, where the more money or the better health insurance plan you have, the more access to practitioners and a wider range of services you receive. In comparison, Medicaid patients and those with more restrictive HMO plans have access to fewer clinicians that are less experienced. Thus, the quantity and quality of mental health care is stratified.

We handle Medicaid and private payers. [names of three local insurance companies, covering both of these niches]. My hourly rate is \$95 and I get paid I think its \$65 a session for Medicaid but its one of those deals that if you don't like it then don't be in their group. There are a lot of people that complain about that. [Name of practitioner] upstairs, he doesn't take Medicaid, one of the ladies in this office, she doesn't take Medicaid, they don't want to work for \$65 dollars and hour and they don't need to. They've been working a long time and they've got a reputation in this town for being good and they don't need to. They do pay less. There are a lot more guidelines and controlling features of it.

The practitioner above describes some of the most frequently discussed issues revolving around why some MHPs choose to stop accepting Medicaid clients, or patients who use certain types of insurance, usually (privatized) public, and usually from HMO insurance companies that not only pay providers less, but govern health care decisions in ways that providers dislike. For example, the following practitioner discusses how it used to be that MC companies annoyed a lot of MHPs but with a new set of restrictions put in place, more practitioners are choosing to leave Medicaid or other public forms of insurance:

I think its going that way right now because of this change in March. Before that there were complaints, but practitioners would still see Medicaid clients. But they are just over-managing. They make you call and talk for a half an hour to another licensed mental health professional and explain. It's almost like you're having to defend your treatment and you're being looked upon as not good enough, as a therapist.

Several MHPs discussed their decision to stop accepting Medicaid clients as a result of MC governance. Practitioners were annoyed at how they were being over-managed and their own professional authority and expertise was constantly being questioned or rejected.

It's definitely a hindrance, it's a paying source we need, but it has too much power.



Managed care makes too many decisions, rather than being a funding source, they are care directors and that's a problem. They don't have any business having anything to say about care. Specifically these are all things, this is why I don't do that work anymore because I can honestly feel myself getting angry and irritated just with the thought of it. These are people who, these aren't people who attend monthly meetings, they couldn't pick these kids out of a line up yet they're the ones taking all of my information and jotting it down and deciding okay you get 30 more days or you get 2 more weeks, or nope they're done tomorrow. There's no continuity of care, they're not interested in what makes transitions better for kids, and so it is definitely a hindrance. I think that system is so broken I wouldn't even know where to begin to fix it. Just sort of scrapping the whole thing and trying to find something better.

Again, MHPs think the level of oversight into their treatment practices and techniques and care decisions is a problem. MHPs understood that a funding source needs to have oversight, but they did not agree with how significant the oversight was, and that MC Company decisions appeared to be guided by cutting costs rather than what is in the best interest of the child or adolescent. Following, I offer some dialogue between a LMHC and myself as she described her decision to leave her previous RTC work setting and how it had to do with MC and the way they regulate treatment decisions:

It was about not being able to get services because I'm really aware that there was one case in particular that was going on which is why I actually, I shouldn't say its why I left, it was the culmination of all the things that gave me a headache about MC and all of the reasons I just couldn't do it anymore.

This LMHP and I worked together at an RTC setting. The client case she discusses below is one where we were both involved in the adolescent female's treatment. The following description details how MC decisions guided her treatment and how this scenario represents how MC companies make decisions based on profit rather than care logics:

What was so frustrating about that was they placed her with us. She was a girl that came from a long line of sexual abuse and I'm giving the story to illustrate my point. She was somebody who they, M [insurance company that governs Medicaid in Midwestern state], came to us and said, 'would you interview her?' Nobody will take her because she has some acting out tendencies. She never fully perpetrated on anybody but she was just so sexualized that she was a risk just to have around. I can't even remember the levels but she was on the highest level forever. So they placed her with us, I remember S [name of director at the time] interviewed her and we sat around the table and said this does not

seem like a good idea. We got pressured to take her, so we took her. I felt like we were doing the job we could do, and we asked for her to be able to receive individual therapy with someone who specialized working with girls who have been victims of sexual abuse, so she would have therapy with me, have specialized therapy with them, this other clinician, and then family therapy. They decided to move her from our facility because they didn't want to pay for that specialized therapy anymore and they could just move her to a different facility where there was someone there that could offer that. I remember saying to them but you forced us to take her! You put her here because nobody else would take her and now that we've made progress enough that another facility will consider taking her, because she's not acting out, you're going to move her so that you don't have to pay for this extra service. It was strictly about reimbursement and them wanting to pay less. They weren't disputing we were saying she still needs this level of care.

Several MHPs discussed leaving certain types of care settings such as Residential Treatment Centers (RTCs) other in-patient or hospital settings where MC companies over-manage, restrict and even harm care. The LMHC quoted above moved to a less-restrictive out-patient clinical setting in order to be able to provide care that was less governed by the financial decisions of MC.

I do accept Medicaid clients. I am trying to wean off that just because I am trying to run a business here but a lot of my other people do and I still have some Medicaid clients and now of course M is managing care it's gone from one extreme to another. I wouldn't say they have found a happy medium in being really fair with clients. It's become more of a legalistic management system versus what's the best interest of the client.

Another reason practitioners opted-out of accepting Medicaid clients was due to the fear of audits. MC organizations that governed care for Medicaid systems were described as extremely restrictive in their decisions about treatment:

I cannot personally keep up with all of the requirements in the record keeping and its fear, to be honest, its fear, and I'm not proud of that, but they've made it – if you don't dot every I and cross every T, they have requested sometimes up to \$30,000 or \$50,000 back pay from cases that they go over the record and things aren't exactly in the right order. If they find something wrong they, I mean, it's become almost absurd. There are a lot of clinicians in the state that say they are no longer going to serve Medicaid people, because the risk is so big. I don't have time to spend hours on all of that. I mean we want to keep a good chart and we do keep good charts in my opinion, but they always, they go in there and look and they can always find something; an I that isn't dotted.

Here, the director of a non-profit mental health insurance agency that accepts mixed forms of insurance discusses why she is personally considering leaving Medicaid and

other restrictive funding sources because of the significance of their regulations and the fear of audits and having to pay back money rendered for services. The culture of fear, the headache of keeping up with all of the restrictions, the increase in unpaid labor, all added up to make “leaving Medicaid” and other MC companies that governed public forms of insurance, a rational, even ethical decision for many providers. Another provider that is also considering “leaving Medicaid” or MC Company M (who governs Medicaid care in a large Midwestern state), framed the decision in an eerily similar way to the practitioner quoted above:

The guidelines that M is putting us through are just atrocious. No insurance company asks us to do this, and then they audit you and you get called on the carpet because you missed you know crossing a t and dotting an I and there isn't enough time to document the files the way they want you to document.

Again, this MHP describes how the decision to stop accepting Medicaid clients or clients whose care is reimbursed by MC Company M, is not just about reduced fees or ridiculous guidelines, but the fear of audits and having to pay back money. It is a combination of all this that creates an undesirable, even unethical context of care for providers and their patients. In the next quote, I asked a clinical social worker that works in a private group practice what she thought about the increased regulations of MC and how it might be impacting the field. She responded by arguing that MC Company M is getting what it wants— to squeeze expert professionals out of the market:

It's already happening. One of my therapists has some openings and she said I want some day time referrals but I don't want Medicaid, I don't want a Medicaid client. What's happening is we're just not going to take it. Basically I'm booked, I see about, I bill out at least 40 hours a week, and I work 4 days, so that tells you what my schedule is like, I start at 7 in the morning and I usually end at 6 or 7 at night and I usually don't take lunch hours. I don't have to take Medicaid, I believe in the work, and want to take Medicaid and want to do that work because I think its an important mission in my life, but they're setting up so that the people on Medicaid are not going to get as good of services because the seasoned therapists are going to say I just don't need it. Add to that the fact that they're (M/Medicaid insurers) is no longer letting provisionally licensed therapists treat

Medicaid clients-- the people that have room in their schedule to take Medicaid patients. . . That's the point; I don't think they want them helped. They're trying to squeeze it out because it's costing money and its working because all of us here are very mission driven to help that population and be a part of it but we're all getting to the point where we just can't take the stress anymore. It's working.

The theme that MC organizations were purposefully trying to push experienced providers out of the market was significant. I had a difficult time understanding at first how MC companies benefit from getting providers to stop accepting their insurance. This was explained to me in different ways, as the following quotes demonstrate: *"The biggest way that it affects practice, I would say is because of the low reimbursement and not being able to hire individuals who have master's degrees. I think that's probably the biggest impediment for being able to provide the level of services that we would like to provide."*

This practitioner who works for a community agency on the east coast describes how they are increasingly frowned upon for hiring Master's level clinicians. Another professional describes the same thing happening at her care setting:

And I think it's also important because I know that one of the things that's happening at our agency because of managed care is that we are hiring more people with only an undergraduate degree, because MC doesn't reimburse us at a high enough rate. We can't afford masters level people. When I came to [this community organization], they only hired people with masters degrees. Also the Department of Mental Health doesn't require that our community support specialists have a masters degree and they almost look at us like, 'your people are overqualified.'

Again, in public settings of care, whether they are community outreach organizations, hospitals, group homes or RTCs, the trend is toward hiring less experienced and qualified paraprofessionals and case managers rather than expert mental health professionals that have graduate educations and/or clinical experience. Following is one last example of how MHPs view this shift in care:

Now they hire a psychiatrist to sign off on the charts and paraprofessionals and social workers, not even social workers, mental health workers, undergrad students to sit with those patients who get drugged by the psychiatrists and then they go to group and

somebody runs the group who, you know we psychologists have too much training, they would have to pay us too much. Programs would be way better but since they are revolving door programs and its all about spending less, they're not really valuable programs. They are crisis, put the fire out programs. Our field is in trouble and the private practice market is flooded with social workers and licensed counselors and pastoral counselors and everybody's a therapist so that psychologists have been diluted in the private practice world. Our field has been diluted. We're trained to do testing and assessment, to do a kind of level of psychotherapy; there is no where for us to go anymore. Teaching, we can go into academia.

Thus, MHPs argued that MC was purposefully driving seasoned, expert professionals, from the field, especially in public care settings. This leads to the patients that tend to have the most intense or serious mental health issues to receive care from providers that have the least educational training and professional expertise. Further, this pushes those seasoned professionals towards private practice and out-of-pocket care contexts.

I think M is way out of line and overboard and I think their agenda is to get rid of providers. I think they're trying to do capitation so they put the money in their own pockets. I think managed care is a bunch of bullshit. The private non-profit, they are gradually just eeking more dollars out of, by denying and making us spend more time on the phone. More unpaid hours, what they want, they want to be able to limit, a lot of people jumped off, they said screw you, I'm not going to work, to take M people anymore. I know somebody else who just sent that letter, and that benefits M.

As I was unsure how MC companies that oversee Medicaid clients would benefit from providers leaving, I asked some follow-up questions. He explained: *"If there is less access to services, there will be lower utilization and they will save money. The less utilization, the more money that they save."* I then asked if that meant that seasoned professionals would switch to seeing different types of clients or just work in different settings. He chimed in:

The worried well, that's right. When practitioners start thinking unethically like that, in terms of unethical business, they're acting just like CEOs who are. . . It's a matter of being able to manage a practice, I want you to know you're sitting talking to a practitioner who takes M, I take Medicaid. I take [names list of health insurance companies] even though those companies don't treat practitioners well. The point is you have to be able to manage a practice, you have to be able to take care of yourself first, I don't mean financially. What I do is, I know how many cases of what I can take, I will take a very low number of severe cases. I will take one domestic violence case, but I also make sure I take sliding fee cases; they can be multiple, depending on a formula. I know how low I can go with how many people, and I periodically take pro bono cases. I

currently work with a [public clinic], to make sure that I'm going to consistently have one pro bono case on my caseload. If we all did that nobody would have to be burned out, but the public sector does not treat its people well. Caseloads are too high, the cases are too acute. The pay is way too low; the job satisfaction is way too low. You know that. It's just like tax burden. If we just distributed the tax burden according to what we can handle. So yeah, less experienced practitioners should have less of that not more. I think there's something backwards about it. It's like, dude I paid my dues, so now it's your turn. It all rolls down hill.

The above practitioner describes how he manages his caseload to make sure he treats diverse types of clients so he can continue to accept public forms of insurance as well as pro bono cases without getting burned out. However, he was the first practitioner I interviewed that made a case for how practitioners could manage their work in a way that allowed them to continue accepting public forms of insurance without getting burned out. As a follow-up to his characterization of some mental health practitioners acting like CEOs, implying that some practitioners make decisions about who to treat based on profit rather than professional ethics, I presented him with rationale I had heard from other professionals about why they have stopped accepting (privatized) public forms of insurance. He responded: *"I can't have a million dollar house and see these people. I can't have my American junk culture dream. I'm not going to pass judgment on anybody but I don't like the word can't. There is kind of won't and don't know how."* Again, he argues that it is both managed care, i.e. the way they encourage providers to stop providing the services, and the way that MHPs manage their practices and are influenced by for-profit logics that is to blame for the current stratified system of care. He offers me the following formula: MC increases restrictions and unpaid labor time hoping more practitioners will leave their panels, this limits access to services for Medicaid or publicly funded clients, which then leads to lower utilizations. Lower utilization saves MC money and increases their profits.

In comparison to his view of MHPs as playing an important role in this system of stratification, most MHPs that had made the decision to “leave Medicaid” or public settings of care, described it as though they had been placed into a corner and didn’t want the system that way but they didn’t see another alternative for themselves.

I should say that in my private practice I am out of pocket and off the insurance panels because the only way I can work with families the way I really need to work with them was to quit being dictated by the insurance companies. I am out of pocket, people come to me, they pay upfront, they can submit their papers to insurance companies and see what they get back but I quit mostly out of severe frustration, professionally, especially working with eating disorders being told you can see people 10 times to treat anorexia, yeah. When you leave managed care, when you leave hospital programs, you become a little bit elitist. Not that I’m happy about that, but you end up treating populations of people who can afford to come to you and this is the metropolitan area. There is a lot of wealth here. When I was in the hospital programs or when you’re a graduate student doing internship programs, you are working with the most troubled, emotionally deprived, chaotic families. In private practice you are still getting significant mental health issues but it largely feels different and it’s focused on anxieties, the worried well, eating disorders, depression, teens who are acting out of anger, children of divorce. What we get in our office really matches what is going on in a metropolitan sort of upper middle class sector of society. . . What we were trained for we can’t do anymore.

Thus, this clinical psychologist works in her own private practice on the east coast and only accepts out-of-pocket payment for her services. She argues that she couldn’t do the kind of work that she was trained for under MC regulations and governance. At a different point in our interview together she told me about a turning point she had that changed the way she provided care. At the time of the turning point, she was practicing under a managed care regime. A college student client of hers that suffered from anorexia committed suicide. She described how the intensity of services she was able to provide to that population was severely restricted by MC and while she knew her patients were at risk, this event had a formidable impact on how she restructured her own care work. While I wholeheartedly agree with the previous practitioner who argued that if all practitioners accepted mixed forms of insurance, including pro bono cases, then the

system wouldn't end up stratified with the least experienced treating those with the most intense issues, I can also empathize with all of the practitioners that argued that MC governance was too restrictive, too threatening, and too harmful to patient care.

It was clear during my interviews that the seasoned professionals who had opted-out of Medicaid and other public forms of insurance cared about those patients they were leaving behind, and wanted to be practicing in a different system that wasn't set up to encourage stratification:

Things shifted for me in my practice at one point when I realized you couldn't fight MC anymore. I was no longer part of the team and in the system I was outside the system. Social workers, we know you have to enter the system to make change and it was a very deflating, powerless situation. I decided, I've got to make a shift here, I can't do this anymore. I felt bad because I am a good therapist and I felt bad that these kids who are state wards and don't have families were no longer going to get good services, because that's what's happening to a lot of people.

Again, this social work practitioner that had been in the field for almost 20 years does not accept clients with some forms of public insurance. She didn't make this decision based on finances and receiving lower reimbursement for her services. Instead, she made the decision because the way MC was governing her treatment made her feel powerless in her care work. I offer one final description of how care has become stratified. The following PsyD was the only practitioner I interviewed that was a salaried employee who worked in a publicly funded care context. I had done some research about the community mental health center before arriving, as it was surprising for me to find it after finding so many more private and mixed-insurance care settings. I asked her to describe how patients (including people without insurance), get access to services at the site (located in an East coast metropolitan area): *"The way that people can get in is, if you have no insurance they have a sliding scale so it goes down from whatever that whole fee is down to \$2 an hour. We*



*serve a lot of folks with Medicaid and fewer with insurance. I would say 60% of my caseload is Medicaid and the other third are sliding scale.*” Following up on the issues of provider burn-out and how at times that was described to me to be a result of caring for more low-income, higher need clients, I asked whether this situation led to high practitioner burnout at this community mental health center. She responded:

I think the burnout comes from the caseload sizes. As the county population has grown, the number of staff in the mental health services has stayed the same, so the caseloads have risen. I think the intensity of the cases also matters. There’s a certain level of intensity that comes with serving you know lower income families that have a lot more risk issues. I think it’s really, it’s the numbers and the lack of time to discuss and prepare to the extent that you might like to. It seems we have high turnover among the newer younger staff and then there are folks that have been around. I’ve been here for a little over 10 years now. A lot of newer staff will come by and get their feet wet and then go into private practice, which is unfortunate because then you don’t get more experienced people treating really troubled families.

I was so pleasantly surprised to hear she had been there for 10 years but that she recognized the stratified system of care, I wanted to find out more about what she thought about this. I followed up by commenting that many of the practitioners I had interviewed who had been in the field for over 10 years had stopped accepting Medicaid patients:

In some ways we’re very fortunate in [this east coast] county because we’re salaried employees. So you know whatever the insurance is, it doesn’t impact me. In [county of state nearby], they have fewer clinics that take Medicaid. It was maybe 5 years ago, I had gone to some training they were using to try to lure people in to get private providers to treat Medicaid cases and it was clear they were having a tough time with that. I think a lot of it is the pay and the paperwork for it you know, for less money.

At a different point in the interview, the PsyD MHP that works in this public care setting described how serving this population is critical to her life mission and purpose. While the professional ethic of care appeared to be alive and well and was demonstrated in several ways, there is no doubt that as MC restrictions and hoops increase and their pay decreases, the system will increasingly become stratified. There is only so far you can go in a commitment to social justice if you’re underpaid with high case loads, case intensity

and more threatening surveillance of your everyday clinical work. The rationale MHPs gave me for the trend in the increasing stratification of care was that MC companies and their decisions were based on for-profit rather than a professional logic of care. It's hard to imagine a system that wouldn't become stratified under these conflicting logics.

### **CHANGE THE POWER INSURANCE COMPANIES HAVE OVER CARE**

During the last section of my interview, I asked practitioners the following question: If you had a magic wand and could change the field of adolescent mental health services, what would you change? MC immediately emerged as the aspect of care MHPs want changed. The undue power MC holds over treatment plans, practices and the structure of mental health services in contemporary society was criticized. The analysis demonstrates that MHPs want care decisions to be guided by what is in the best interest of each individual client. Practitioners call for changing the mental health field so that individual children, adolescents and their families will be the focus of the system rather than MC regulations and profits. Practitioners argue MC regulations are in need of their own regulation: *"It's got to be regulated. Anytime a capitalist is allowed to do what he or she wants to do, they will make money. They will pocket as much money as they can and it's actually the customer that will get stuck."* Similarly, another MHP argues that the for-profit aspects that have corrupted mental health care have to be fixed. However, this practitioner related this concern to the contemporary U.S. debate over health reform and whether adding a competitive public option might help restructure the system of care:

It's got to have those problems and pitfalls taken out of it if it's going to work. I don't think we need a competitive option. They can use it if they want, they [MC organizations] need to be regulated and they need not to have made the regulations with their own lawyers. If there was some way to make sure that it wasn't corrupt to the point where these business men and women are politically in bed with congress men and women I mean good grief. The problem is as old as the institution of politics.

Again, out of anything in the adolescent mental health care that could be changed, the larger political economy of a for-profit system was at the heart of what practitioners with a magic wand would change:

I would focus on managed care and funding because that seems to be a huge barrier for clinicians to where some clinicians will not accept Medicaid clients at this point, but that is what they have to do to survive. If you have a private practice you have to get paid and if you're doing your billing on your own, thinking about the investment of time for that. I think it would be more focused around that and then, the diagnoses, and this goes back to managed care. We have to have those [diagnoses] within that first hour of meeting this client and gathering this information where you are just doing so much writing and your interaction is limited. I just don't think that it's ethical to provide a diagnosis that first hour.

This LMHP argues that the way MC companies govern healthcare is unethical. She argues that managed care funding restrictions not only limit care and encourage practitioners to stop accepting Medicaid clients, but also undermine the therapeutic relationships through their diagnostic regulations. Another practitioner also characterized MC regulations of diagnostic processes as problematic.

I would change the rigidity of diagnostic criteria. The hold that insurance companies have [on the mental health care system] like M which is Medicaid. You have to do so much paperwork; you have to create two reports, a treatment plan and a request for services after the first initial evaluation. That's a hell a lot of paperwork and a hell of a lot of time and they put a lot of stipulations on who can see whom and the whole purpose of that is to make it so hard to see people so they don't have to pay for it, and they would argue otherwise of course but I would change that. We need to have accountability but to make it so prohibitive for people to see M clients? Like [another practitioner's] practice, I think they are going to stop seeing M [clients with that insurance] because it's so much work. They pay a lot in the beginning, the first evaluation, but it goes down over time. They don't want you to see people for very long, so after a certain amount of visits it's down to under \$60 bucks. In line with the national debate, I would change the power of the insurance companies.

Again, the power of insurance companies to restrict access to services and govern expert mental health professionals' everyday treatment decisions was a focus of what MHPs want to change. The rigidity of the MC system and the unchecked power insurance

companies have to influence mental health care was a very contentious issue for practitioners that want the care of their patients to be guided by professional rather than financial ethics or cultural logic.

Another aspect of professional logic of care that was undermined by MC company regulations was patient heterogeneity and a focus on preventive or proactive care. In other words, MC companies required MHPs prove medical necessity. Yet, the logic of medical necessity necessitates waiting until there is a serious identifiable problem. A significant amount of research, including the latest IOM report on MEB disorders of youth, argues that financially speaking, our money would be better spent on prevention efforts. The following MHP argues the same:

I would change programs so that instead of being pathologizing where its just for kids who are sort of bad or are already lost I would promote a focus on empowerment. Mental health programs would be very proactive for building resilience and social competence in teens, educating them about substance dependency and mental health. I would be very proactive. Move it into the education system and normalize it more, so that families maybe sign their kids up for programs in mental health but it would be in the school systems. In the private industry. . . if there were government mental health support, there would be programs for adolescents [divided into three] tiers so that the highest tier would be severe, the clinical kids that are hard anyway, the abandoned ones, the ones that are really impaired. Then there would be something in the middle and then there would be the tier for empowerment and resilience to make youth better in terms of their mental health, to optimize their mental health. That's how I would design it.

This practitioner, who has actually stopped accepting Medicaid or public forms of insurance, would shift the focus of mental health care, from a focus on the pathologization of adolescent mental illness through diagnostic labels and requirements of medical necessity, towards a proactive system that focuses on prevention and enhancing positive aspects of mental health. Her suggested changes for the field of adolescent mental health care include a larger system change that normalizes care and makes it accessible to families and children through the school or other publicly funded

systems.

The following two practitioners envision an adolescent mental health care system that focuses on patient heterogeneities, or individual patient personhood and the dynamics of the family system. *“I would really push for a way to include family assessment, to allow family intervention, and I would love to see that become an evidence based criteria.”* Similarly, another practitioner argues that the mental health care system needs to empower adolescents and their families to be active participants in their own healing processes. *“I would put the focus back on the individual child and the family rather than all the paperwork and insurance. I’m a simple person. Let’s look at each case individually and put the power back into the family and individual instead of trying to overpower and change from the outside.”* As a final characterization of how mental health practitioners want to change the current stratified MC system to something new, the following MHP argues that if MC is going to continue to “manage” care, it should be done with the patient’s best interest in mind.

I’m aware there’s not a limitless pot of money. If they [MC] would make decisions genuinely in the patients best interest were willing to talk to the people who have relationships with the patients and spent time with them or were aware of their family dynamics, or the other situations in their lives, so they’d be able to make a better, more educated guess about what’s in their best interest, then they [MC] could do that. There’s no expectation that they do that. They’re just a funding source and because the dollars are in their hands they get to create all the hoops and we all have to jump through them until we get the dollars. They should simply be the funding source. Instead of it being this whole power thing, it should be a privilege. You have to be a part of this child’s care. How do you want to live up to that responsibility? Managed care should have to come to the table at every treatment team meeting. They should have to be a real presence and stop in and make visitations. What if you called these kids and found out how they’re doing? What if you actually participated? You know, what if you were really a part of their care?

Thus, MHPs argued that MC holds undue power over treatment plans and practices. They argue that MC currently fails to base their decisions on what is in the best interest of each

client. In order to fix the current system, MC needs to be regulated, have their power checked, or actually get involved in client care. MHPs argue that the funding structure, the way they guide diagnostic processes and ignore patient heterogeneities, relationships and family dynamics harms care practices. MHPs desire MC to make funding decisions not solely on financial or for-profit logics but based on clinical issues and information pertinent to individual clients. The conflict between professional and business ethics is at the forefront of how MHPs struggle with providing quality mental health care services under a threatening, privatized, management regime.

## **CONCLUSION**

The power, knowledge and experiences of psychotherapeutic mental health care professionals are marginalized by the assemblage of the DSM, insurance companies and state/federal governance. This analysis of MHPs' experiences of the countervailing forces to their professional autonomy and everyday work demonstrated conflicting logics at work in the biopolitical economy. MHPs feel threatened, over-managed and deprofessionalized to the extent that their professional training is questioned as treatment decisions are guided by financial rather than clinical motivations and ethics. Insurers have taken up the biomedical DSM technology and utilized it as a tool to save money. The privatization of mental health care in a neoliberal, capitalist political economy leads to incentives for MC companies and state governance systems to hold back provisions to save money and reap profits. These assemblages of insurance/state power co-constitute local health care organization and delivery systems. The system is complex with multiple states, insurance companies and mixed or private-public payment systems.

The mental health professions are extremely interdisciplinary, with multiple types of background disciplinary training, socialization, theoretical models and approaches to treatment. It is necessary for professions to secure a segment of the health care market through lobbying and other politicking work. This applies not only to types of disciplinary profession such as social workers or counselors, but to various theoretical orientations and treatment techniques as well. The political economy shapes which providers see which patients and which theoretical orientations and treatments are utilized (or at least privileged). MHPs argue that MC has shifted the field of mental health care from interpersonal, psychodynamic, and transformative types of psychotherapy towards short term, behavioral and medication treatment approaches. MHPs recognize the complex relationships of power between the DSM, MC and state governance and critique the current systems administrators for over-managing and stepping beyond their role as funders into the role of being care directors.

MC was recognized for the ways in which it has enhanced professional accountability and improved treatment plans. The extent to which the MC system has improved treatment plans was contested though because some MHPs expressed concern over how current treatment plans have to be worded in behavioral language and therapists need to be flexible to changing the approach and goals of treatment as mental illness disturbances and context emerge from the therapeutic relationship and the context of the patient's life. Thus, the MC system is acknowledged for its effect on professional accountability and its facilitation of clear treatment goals, but MHPs argue the pendulum has swung too far via over-management of theoretical orientations and treatment practices. Thus, MHPs contest MC governance of the language of their treatment plans,

and how some treatments are privileged or devalued, and their overall regulations have reconfigured treatment plans into formulas devoid of recognizing heterogeneities across patients and unique personhood and social context within the care of each individual adolescent.

A significant criticism of MC was how there is increasingly more paperwork, documentation, phone calls and networking to meet their regulations, while simultaneously, fees for service have decreased. In a more work for less pay scenario, what MHPs struggle with the most, beyond burnout, is that cost-containment strategies of MC reduce the quality of mental health care practitioners can provide. While MHPs operate under professional ethics of care and are guided by clinical information of patients, MC bureaucrats focus on short-term needs and medical necessity. MHPs argue these conflicting ethics lead to reduced quality of care, especially among patients with major mental illness. While the on-going cribbing work required by practitioners to keep up with shifting regulations regarding how they can talk, write and report on their everyday clinical practices is frustrating, the culture of fear created by on-going documentation reviews and potential audits creates unpleasant, if not unethical, organizational work contexts. For instance, MHPs argue that new pretreatment assessment requirements neglect the importance of establishing a bond with new patients in the first session, and that many MC policies such as this one appear irrational and based on administrative rather than clinical expertise. In a context of oppositional logics where MHPs are guided by clinical information and professional ethics of care but must negotiate the regulations of administrative managers guided by a business ethic that



commodifies care, it's not surprising the results are irrational rationalization and increasing stratification.

The privatized, over-managed care regulations of MC facilitate organizational work settings (contexts of care) where providers must negotiate more guidelines or controlling features of their work, defend their professional expertise and get paid less for doing so. MHPs argue that MC system is systematically squeezing expert seasoned professionals out of the market. The MC system privileges undereducated and underqualified professionals for public mental health programs that focus on short-term, medical necessity cases. Some MHPs argue the field is being diluted, i.e. that there is nowhere for highly trained psychotherapists to go except private practices and out-of-pocket markets. MHPs argue the MC agenda is to get rid of providers in order to decrease access to services, which lowers utilization rates and saves money. The MC formula leads to seasoned professionals treating the worried well while new clinicians with the least professional training and field expertise treat the most intense and troubled clients.

At least one MHP argued that this system could be better if MHPs themselves did a better job at managing their practice through diversifying the types of clients they accept at any given time, including taking on Medicaid and pro bono client cases. Despite where you place the blame on the mechanisms of stratification, all MHPs agreed that the public sector insurance panels do not treat providers well. The caseloads are too high, too acute, while the pay and job satisfaction are too low. Yet, many MHPs would deal with the issues of pay and intensity of cases if there wasn't also a culture of fear and shift in the kind of psychotherapy a practitioner can provide. The MHPs I interviewed that stopped accepting Medicaid clients or other forms of privatized public insurance believed

in the mission of that work and wanted to treat clients that were not just the “worried well,” but found they were unable to do the kind of work they were highly trained and skilled at doing, under the MC system. The stratification of care leads to newer therapists treating the most troubled, emotionally chaotic families while the seasoned professionals treat the worried well who can afford out-of-pocket services.

Stratification is a result of complex, fragmented, relations of state/industry power. MHPs resent the constant surveillance of their professional work not only because of the loss of professional autonomy, but because treatment plans have been reconfigured to privilege biomedical and behavioral orientations and treatment practices are governed by profit rather than clinical expertise and a logic of care.

In performing a psychotherapeutic approach to studying the field of adolescent mental health care, I asked professionals what they would change if they had a magic wand. The power that insurance companies have over daily care practices of providers was critiqued as corrupt. The MC system has unregulated power over treatment plans and practices and MHPs desire a system that directs care based on the best interest of each individual adolescent client and their families. In order to achieve this care, practitioners want care to be managed by clinical rather than financial decisions. Practitioners want the professional autonomy and flexibility to perform the work they are highly trained, and from the eclectic theoretical orientations and approaches to treatment in which they have spent time becoming skilled in and that are the best fit for each unique adolescent, their family dynamics and social environmental circumstances. Regulating MC will not increase shareholder value, but will improve adolescent mental health.

## **Chapter Six Conclusion**

### **THE ART AND SCIENCE OF PSYCHOTHERAPY**

#### ***Theoretical Orientations in Contemporary Psychotherapy***

While biological psychiatry continues to be the dominant paradigm of health and illness in U.S. society, none of the psychotherapeutic practitioners I interviewed identified it as their theoretical orientation. Several theoretical orientations and therapeutic approaches were presented as important alternatives to the biomedical paradigm, but often practitioners were resistant to name just one that was the most important. Frequently, practitioners discussed the importance of an openness to multiple models and described their own therapeutic approaches as eclectic.

Theoretical orientations that were described most often include family systems, strength based, Cognitive Behavioral Therapy (CBT), biopsychosocial, psychoeducational, psychoanalytical, solution focused, constructivism and relationship based. Rather than describe the ways in which their orientation, approach or goals of treatment built on or contributed to the biomedical model, practitioners frequently located their therapeutic approach in opposition to biomedical and behavioral theories and treatments. Practitioners discussed aspects of psychotherapy, diagnosis and treatment that have been devalued by the psychiatric profession's DSM, insurance companies and the majority of mental health care research funding. My analysis revealed practitioners resisted the biomedical model of illness in the following three ways: (1) by describing their theoretical orientation and approach as eclectic, as different from, or actively in opposition to, the biomedical model, (2) by (re)focusing on strengths of adolescents and their families and possible positive linguistic constructions of them and their futures

rather than pathologizing them with labels, negative language, or focusing on their weaknesses or bad behaviors, and (3) by valuing the importance of the social aspects of mental health including relationships, the family and reaching an understanding of the adolescent as a whole, complex person.

While the mental health practitioners I interviewed valued multidisciplinary models and an eclectic approach to adolescent mental illness intervention, they also critiqued biomedical and behavioral models/approaches for being too focused on the diagnosis, behaviors and surface level symptoms, rather than on the deeper social relational issues in adolescents' everyday lives. Practitioners privileged theoretical orientations broad enough to allow for multiple perspectives and approaches, or that facilitated a holistic framework in which biopsychosocial and relational as opposed to only the biomedical and behavioral aspects of adolescent mental health and illness shape the definition of, understanding of and response to adolescent mental illness. Despite the growing assemblage of biopsychiatry via the DSM, EBPs, the growth of privatized managed care and big pharma within the neoliberal health care economy, biomedicine is not an uncontested hegemonic process. Mental health practitioners' definitions of and responses to adolescent mental illness are shaped, but not entirely determined, by biomedicalization and standardization.

### ***Interdisciplinarity of Adolescent Mental Health Care***

My findings suggest that adolescent mental health and illness as a scientific and clinical object of study and intervention has become more interdisciplinary in both practice and theory and rather than subscribing to a "model of the moment" as many mental health practitioners called it, practitioners match what they believe is the most

appropriate approach for each individual youth and his/her social environmental circumstances. I asked practitioners what they perceive to be the costs and benefits of the interdisciplinarity of the field, including what difference, if at all, it makes that mental health professionals enter therapeutic practice from a diverse set of disciplines, specialties and treatment ideologies (i.e., social worlds).

My analysis revealed that the interdisciplinarity of the mental health professions has become black-boxed, a taken for granted aspect of mental health care. MHPs perceive the interdisciplinarity of the field as necessary to fulfill different types of health care coverage needs. Interdisciplinarity at its best is described as facilitating professional collaboration and more comprehensive care, and at its worst, encouraging jurisdictional disputes and the devaluing of some of the professions' perspectives and contributions. The field of adolescent mental health care has been interdisciplinary since its ascendance in the 1980s and 1990s as an object of scientific study and clinical intervention. The knowledge-practice tensions of an increasingly interdisciplinary, yet specialized field of professionals and researchers has been discussed as creating a more fragmented mental health care system. Yet the benefit of this knowledge-practice tension is that mental health professionals currently value multiple models, eclectic approaches and collaboration with dissimilar colleagues. All of this suggests that adolescent mental health care is moving away from the dominant biomedical paradigm and towards a holistic health care approach.

### ***The Standardization Movement: EBPs in Mental Health Care***

I examined how practitioners negotiate the tensions between the simultaneous push for standardization and personalized medicine. Following the work of Timmermans

and Berg (2003) and the debates laid out in the collection edited by Norcross, Beutler and Levant (2006), I investigated the politics of standardization-in-practice. The mental health professionals I interviewed echoed many of the thoughts and concerns raised in contemporary debates over EBPs. When speaking about the importance of EBPs in the field and the role they play in their everyday clinical work, MHPs expressed a tone of caution and reserved acceptance. In the same way that several were adamant that there isn't one best model of illness or approach to treatment, they were also quick to point out that therapists need freedom to be creative and try unscripted or non-evidence based techniques as well as EBPs. Their everyday clinical work can be understood as an art form as well as a science.

Thus, the social worlds of psychotherapeutic practice value EBPs as a good place to start in their treatment plans, but claim it is important to maintain clinical freedom (professional autonomy) and flexibility with regards to theoretical orientations and treatment techniques. MHPs critique the way in which EBPs privilege scientific evidence over patient subjectivity, social context and the therapeutic relationship. MHPs take issue with the way MC policies have implemented EBPs in ways that have shifted the field of mental health care from psychodynamic towards more behavioral focused theoretical orientations and therapies. At the heart of this criticism is a tension over how best to define and measure mental health and illness. MHPs struggle with EBP standardization and how it privileges discrete, quantitative understanding and measurement of emotional well-being.

While EBPs are almost uniformly valued, practitioners' everyday clinical work was just as much guided by individual patients, their identity and social

circumstances. Further, several mental health disorders or problems do not have corresponding EBPs, either because studies on those areas of mental illness have not been completed or because some types of therapeutic intervention are difficult to study and measure (quantify) using RCTs. My findings demonstrate that practitioners struggle with the definition and measurement of EBPs, including how the scientific assumptions and methods of EBPs define mental disorders and patienthood. The development and implementation of treatment plans was characterized as much grayer in everyday clinical practices than the way that diagnosis and treatment are framed within EBP protocols such as those adopted by managed care companies.

One of the key aspects of the way EBPs redefine mental illness that practitioners struggled with was the way that individual and social group diversity is unaddressed. When interviewing mental health professionals I asked them questions about what difference it makes that their patients are adolescents, male or female, Hispanic immigrants, or in the process of exploring their sexuality. In other words, I wanted to know to what extent scientific knowledge at the level of the population, and life experiences at the level of social status characteristics— what Steven Epstein (2007) has labeled niche group standardization in biomedical paradigms, matters for defining and intervening in adolescent mental health care. One of the areas of the interview where individual patient differences (both social group and individual subjectivity based) emerged was in the discussions I had with professionals about EBPs. While the push for the standardization of medical, diagnostic and therapeutic practices is great,

processes of implementing and negotiating standard-in-practice are messy. Social worlds of psychotherapists' shared assumptions about the importance of psychotherapy remaining an art as well as a science not only to allow for the heterogeneity of their own disciplinary backgrounds, theoretical orientations and therapeutic approaches, but because at the center of their everyday work were adolescents. Social worlds of psychotherapists shared in a vision of being advocates not only for adolescents in general (as a niche social group), but of adolescent difference or heterogeneity, across personhood and ways of experiencing various kinds of mental illness.

In the IOM (2001) definition of EBPs, scientific evidence, clinical expertise and patient values were each important factors in determining diagnosis and therapeutic intervention. In a manner similar to Reed (2006) and Messer (2006), therapists did not think evidence should be privileged over clinical expertise or individual patient values, circumstances and difference. In opposition to Kihlstrom (2006), the mental health practitioners I interviewed did not think it made sense to define and measure mental health and illness in a way that ignores the subjectivity of patients nor the social circumstances of their lives.

The mental health professions encompass a diverse set of disciplinary professions, theoretical orientations and approaches to treatment. While the dominant paradigm is biomedical or biological psychiatry, the mental health professionals who practice psychotherapy largely ascribe to more holistic theoretical orientations and approaches to intervening in the mental, emotional and behavioral disturbances of youth. For MHPs, the biomedical model leaves out a lot of valuable and necessary information.



While biomedicine contributes significantly to scientific understanding of epidemiology of various disorders, mental illness is defined in much broader terms in social worlds of psychotherapy. For most practitioners, it was important to adhere to the specific needs and presenting problems of each adolescent.

The mental health practitioners I interviewed overwhelmingly adopted theoretical orientations that took a broader perspective of what causes mental health and illness – i.e., they considered multiple aspects as causal in the creation and alleviation of mental disorders. Biomedicine, meaning the biological and genetic aspects of mental illness as well as the potential for chemical imbalances, is viewed as one aspect and thus potential cause of a disturbance, as well as one potential avenue for solution.

Contemporary mental health practitioners neither embraced nor dismissed pharmaceuticals or behavioral interventions but often saw them as one aspect of a larger therapeutic treatment plan that included the social and relational aspects of illness.

The psychotherapists I interviewed recognized the importance of the interdisciplinarity of the field and the need to work towards greater collaboration. It is a sign of interdisciplinary professional maturation that each of the different disciplines both understand and value interdisciplinary contributions that are moving the field toward increased team-work and collaboration. With the rapid development of information technologies, not only will documentation, diagnosis and treatment planning be performed electronically, but each of the various types of health specialists and their information will be more easily linked, with more opportunities for collaboration.

There has been considerable discussion of the extent to which EBM and EBPs deprofessionalize the health care field via attempts to redefine or heavily shape the

content and decisions of health providers. Timmermans and Berg (2003) argue that it makes more sense to figure out how EBPs can be implemented in ways that enhance health professionals' forms of expertise, and better connect different types of professionals together for collaborative opportunities. While I agree with Timmermans and Berg's (2003) analysis and recommendations, I also find that within the mental health field, some professionals' theoretical orientations and therapeutic approaches to treatment are valued more than others' and that some of this is directly correlated to the hierarchy of evidence discussed by Norcross et al (2006). Mental health professionals are just that – professionals who have gone through years of schooling and certification exams and their clinical expertise as well as the subjectivity and social circumstances of their patients should be valued as much as the evidence produced from RCTs.

It is important to MHPs that psychotherapy continues to be valued as an art form as well as a science. MHPs value scientific evidence and proven techniques, but not so much that they value the diagnosis or disorder over individual patient subjectivity, their background experiences, values, concerns and social circumstances. This debate would be easier to address if it occurred in a context where profit motives and the power of the insurance companies was less embedded in the way that EBPs and the DSM have been instituted. Mental health professionals' clinical expertise has been called into question and deprofessionalized to the extent that they are significantly less able to make decisions about the proper theoretical orientation, diagnoses and treatment techniques in their clinical work with patients.

## **TAMING AND UNLEASHING THE DSM-TECHNOLOGY-IN-PRACTICE**

I employed the sociology of diagnosis and biomedicalization theory frameworks to illustrate that the processes of diagnosis capture how the existing mental health establishment defines and measures mental illness. I argue that the technoscientific classification system of the DSM orders ways of being and contemporary thinking about mental health and illness. While the DSM technology was originally designed as a diagnostic communication device, it heavily structures not only contemporary diagnostic processes, but clinical work.

Biomedicalization theory facilitated a disentangling of the interests and power of different social actors engaged in processes of diagnosis. It elucidates how the role of the DSM as technoscientific actant in diagnosis, and its meanings, emerge from on-going clinical practice interactions. Thus, the DSM is a socially scripted technology, yet its significance is interpretively flexible and negotiated in concrete sites of action. The heterogeneities in type of mental health care provider, care setting, and patient all shape how the DSM is used and thus how diagnostic practices are carried out.

Social processes of diagnosis and the interpretive flexibility of the DSM as a biomedical technology are different for mental health professionals who are not psychiatrists. The mental health professionals I interviewed interpreted the DSM technology as a necessary tool that sometimes enhances diagnostic clarity, permits reimbursement for services and can help with interdisciplinary and patient communication. The psychiatrists in Whooley's (2010) study experienced diagnostic ambivalence as a result of how the DSM as a diagnostic technology bestows scientific

legitimacy upon their profession at the same time it is used by insurers to undercut their professional authority.

In contrast, the mental health professionals I interviewed were ambivalent about the way in which the cultural authority of the DSM technology simultaneously helped them communicate and collaborate with patients, parents and other mental health professionals while hindering their professional authority. Even more significant though, was the way in which the biomedical model legitimated by the DSM technology marginalized their theoretical orientations and eclectic approaches to psychotherapy. While alternative mental health professionals recognized the ways in which the DSM technology was helpful for their work, there was much more at stake in social processes of diagnosis for them. Clinical interests and practices are guided by definitions and measurements of mental health and illness. Further, definitions and measurements influence societal and professional responses to, and experiences of, mental illness.

### ***Underdetermined Significance of the DSM-Technology***

Despite the multi-sited character of biomedical standardization, the most common interpretation of the DSM technology was that it was insignificant for everyday clinical treatment practices. MHPs had several ways of dismissing of the importance of the DSM. They labeled it as just a tool: as the only way they could get paid; as something that only facilitates diagnosis but doesn't impact treatment; as a means to an end; and as the bible for the profession of psychiatry, not for their own profession(s). Mental health professionals' talk about and utilization of the DSM technology undermined its authority over their own clinical expertise.

Like the psychiatrists in Whooley's (2010) study, the mental health professionals I interviewed employed several work-arounds, or local solutions to the problems posed by biomedical and bureaucratic standardization. First, mental health practitioners utilized alternative taxonomies in order to diagnose according to their own understanding of mental illness, and then translated those interpretations into DSM or biomedical terms after the fact. This workaround was more than a local strategy that allowed MHPs to fall in line with standardization while maintaining some professional authority. The alternative taxonomy workaround enables psychologists, counselors, social workers and other non-psychiatrist professionals to continue to define mental health and illness in psychodynamic ways.

Second, MHPs fudged the numbers or diagnostic codes in order to disguise their actual clinical practices while falling in line with the formal rules of insurance company standardization. Fudging the codes often involves practices of over or under diagnosis. MHPs I interviewed viewed themselves as conservative in diagnostics and when possible, diagnosed or punted low, thereby protecting their patients from more severe diagnostic labels such as depression or anxiety.

Finally, MHPs negotiated diagnoses with adolescent patients, their parents and other providers. In this work-around, alternative MHPs shored up the cultural authority of the DSM while undermining biomedical and bureaucratic standardization. In addition to employing these work-arounds, MHPs participated in a process I term cribbing. Cribbing signifies the on going collective knowledge building and translation work required by MHPs to learn the correct answers or codes that will facilitate therapeutic service authorizations and minimize coverage denials. The term cribbing also describes the way

in which alternative MHPs' professional expertise is treated as infantile or illegitimate alongside the reimbursement policies of insurers. Cribbing processes reveal the collective knowledge building that goes into MHPs' translation work; they must translate their everyday clinical goals, practices and outcomes into the preferred language of insurers. Thus, cribbing negotiations develop out of on-going interactions with insurance companies.

***Diagnostic Dissonance: Alternative Paradigms of Mental Illness***

Mental health professionals resist and reject the biomedical model of the DSM, and bureaucratic standards of insurance companies through workarounds and cribbing. For some professionals, diagnostic processes of fitting their patients and their patients' symptoms into disorder categories are uncomfortable due to issues with labeling or problems of fit. For others, the process of diagnosis and the categories of illness represented in the DSM and legitimated by the insurance companies are in direct conflict with their theoretical orientation to mental illness and therefore also with their therapeutic approach to healing.

At the heart of much of the resistance to biomedical and bureaucratic standardization were knowledge tensions between alternative paradigms in conceptualizing and intervening in mental illness. The biomedical DSM and profit oriented insurers both privilege a therapeutic focus on surface level symptoms and behaviors whereas the mental health professionals I interviewed were trained to focus on deeper communication, relational and emotional issues. This non-fungibility of the DSM and insurance company policies is so problematic for the MHPs I interviewed that they experience what I term diagnostic dissonance. Diagnostic dissonance describes the

conflict between mental health professionals' own theoretical orientations to health and illness and the biomedical model legitimated in the DSM technology and insurance company policies. The power, knowledge and experiences of alternative mental health professionals, in comparison to psychiatrist professionals, are marginalized by the assemblage of the DSM and insurance companies.

A key example of how the theoretical orientations and professional knowledges of non-psychiatrist mental health professionals are marginalized in this assemblage is the way in which social environmental conditions and causes of mental illness are devalued in the DSM and considered illegitimate diagnoses by insurers. For example, V codes, which represent social context conditions and/or relational disorders such as parent-child or sibling conflict, sexual abuse or neglect, are found in the back of the DSM under Axis IV. Further, insurance companies will not reimburse mental health practitioners for V codes as primary diagnoses. Yet, for the mental health practitioners I interviewed, the information V codes bestow is incredibly valuable and clinically relevant. Further, mental health professionals view social environmental and relational issues as important to the emotional wellbeing of all people, but especially adolescents. Thus, practitioners strongly disagreed with the illegitimate status of V codes.

In re-envisioning a different way of doing psychotherapy, practitioners focused on three aspects of the DSM and diagnosis that needed to change. First, MHPs argued that the social environmental and relational aspects of mental illness need recognized and legitimated in diagnostic policies. Second, they argued that the DSM-V and the mental health field as a whole needs to develop a better understanding of the normal versus pathological functioning of adolescents. Finally, practitioners argued that fixing the

DSM, alone, will not be enough. The power insurance companies hold over DSM and diagnostic work is a major problem that needs addressed.

### **THE POLITICAL ECONOMY OF ADOLESCENT MENTAL HEALTH CARE**

The power, knowledge and experiences of psychotherapeutic mental health care professionals are marginalized by the assemblage of the DSM, insurance companies and state/federal governance. This analysis of MHPs' experiences of the countervailing forces to their professional autonomy and everyday work demonstrated conflicting logics at work in the biopolitical economy. MHPs feel threatened, over-managed and deprofessionalized to the extent that their professional training is questioned as treatment decisions are guided by financial rather than clinical motivations and ethics. Insurers have taken up the biomedical DSM technology and utilized it as a tool to save money. The privatization of mental health care in a neoliberal, capitalist political economy leads to incentives for MC companies and state governance systems to hold back provisions to save money and reap profits. These assemblages of insurance/state power co-constitute local health care organization and delivery systems. The system is complex with multiple states, insurance companies and mixed or private-public payment systems.

The mental health professions are extremely interdisciplinary, with multiple types of background disciplinary training, socialization, theoretical models and approaches to treatment. It is necessary for professions to secure a segment of the health care market through lobbying and other politicking work. This applies not only to types of disciplinary profession such as social workers or counselors, but to various theoretical orientations and treatment techniques as well. The political economy shapes which providers see which patients and which theoretical orientations and treatments are



utilized (or at least privileged). MHPs argue that MC has shifted the field of mental health care from interpersonal, psychodynamic, and transformative types of psychotherapy towards short term, behavioral and medication treatment approaches. MHPs recognize the complex relationships of power between the DSM, MC and state governance and critique the current systems administrators for over-managing and stepping beyond their role as funders into the role of being care directors.

MC was recognized for the ways in which it has enhanced professional accountability and improved treatment plans. The extent to which the MC system has improved treatment plans was contested though because some MHPs expressed concern over how current treatment plans have to be worded in behavioral language whereas therapists need to be flexible to changing the approach and goals of treatment as mental illness disturbances and context emerge from the therapeutic relationship and the context of the patient's life. The MC system is acknowledged for its effect on professional accountability and its facilitation of clear treatment goals, but MHPs argue the pendulum has swung too far via over-management of theoretical orientations and treatment practices. Thus, MHPs contest MC governance of the language of their treatment plans, and how some treatments are privileged or devalued, and their overall regulations have reconfigured treatment plans into formulas devoid of recognizing heterogeneities across patients and unique personhood and social context within the care of each individual adolescent.

### ***Conflicting Logics: Professional versus Financial Ethics of Care***

A significant criticism of MC was how there is increasingly more paperwork, documentation, phone calls and networking to meet their regulations, while

simultaneously, fees for service have decreased. In a more work for less pay scenario, what MHPs struggle with the most, beyond burnout, are cost-containment strategies which reduce the quality of mental health care that practitioners can provide. While MHPs operate under professional ethics of care and are guided by clinical information of patients, MC bureaucrats focus on short-term need and medical necessity. MHPs argue these conflicting ethics lead to reduced quality of care, especially among patients with major mental illness. While the on-going cribbing work required by practitioners to keep up with shifting regulations regarding how they can talk, write and report on their everyday clinical practices is frustrating, the culture of fear created by on-going documentation reviews and potential audits creates unpleasant, if not unethical, organizational work contexts. For instance, MHPs argue that new pretreatment assessment requirements neglect the importance of establishing a bond with new patients in the first session, and that many MC policies such as this one appear irrational and based on administrative rather than clinical expertise. In a context of oppositional logics where MHPs are guided by clinical information and professional ethics of care but must negotiate the regulations of administrative managers guided by a business ethic that commodifies care, it's not surprising the results are irrational rationalization and increasing stratification.

### ***Stratification of Care***

The privatized, over-managed care regulations of MC facilitate organizational work settings (contexts of care) where providers must negotiate more guidelines or controlling features of their work, defend their professional expertise and get paid less for doing so. MHPs argue that MC system is systematically squeezing expert seasoned

professionals out of the market. The MC system privileges undereducated and underqualified professionals for public mental health programs that focus on short-term, medical necessity cases. Some MHPs argue the field is being diluted, i.e. that there is nowhere for highly trained psychotherapists to go except private practices and out-of-pocket markets. MHPs argue the MC agenda is to get rid of providers in order to decrease access to services, which lowers utilization rates and saves money. The MC formula leads to seasoned professionals treating the worried well while new clinicians with the least professional training and field expertise treat the most intense and troubled clients.

At least one MHP argued that this system could be better if MHPs themselves did a better job at managing their practice through diversifying the types of clients they accept at any given time, including taking on Medicaid and pro bono client cases. Despite where you place the blame on the mechanisms of stratification, all MHPs agreed that the public sector insurance panels do not treat providers well. The caseloads are too high, too acute, while the pay and job satisfaction are too low. Yet, many MHPs would deal with the issues of pay and intensity of cases if there wasn't also a culture of fear and a shift in the kind of psychotherapy a practitioner can provide. The MHPs I interviewed who stopped accepting Medicaid clients or other forms of privatized public insurance believed in the mission of that work and wanted to treat clients that were not just the "worried well," but found they were unable to do the kind of work they were highly trained and skilled at doing, under the MC system. The stratification of care leads to newer therapists treating the most troubled, emotionally chaotic families while the seasoned professionals treat the worried well who can afford out-of-pocket services.

Stratification is a result of complex, fragmented, relations of state/industry power. MHPs resent the constant surveillance of their professional work not only because of the loss of professional autonomy, but because treatment plans have been reconfigured to privilege biomedical and behavioral orientations and treatment practices are governed by profit rather than clinical expertise and a logic of care.

In performing a psychotherapeutic approach to studying the field of adolescent mental health care, I asked professionals what they would change if they had a magic wand. The power that insurance companies have over daily care practices of providers was critiqued as corrupt. The MC system has unregulated power over treatment plans and practices and MHPs desire a system that directs care based on the best interest of each individual adolescent client and their families. In order to achieve this care, practitioners want care to be managed based on clinical rather than financial decisions. Practitioners want the professional autonomy and flexibility to perform the work they are highly trained for, to do it from the eclectic theoretical orientations and approaches to treatment in which they have spent time becoming skilled in, and to utilize approaches that best fit each unique adolescent, their family dynamics and social environmental circumstances. Regulating MC to allow mental health experts the autonomy to properly treat patients' mental health concerns may or may not increase shareholder value as it improves patient outcomes, but it will undeniably improve adolescent mental health.

## Appendices

### APPENDIX A: Sample Study Participant Characteristics

Service Providers by Gender and Race	Female	Male	Total
White	30	5	35
African American	3	0	3
Non-White Hispanic/Latina	1	0	1
Native American Indian	1	0	1
Total	35	5	40

**APPENDIX B: MHP’s Professional Backgrounds and Theoretical Orientations**

Disciplinary and Professional Backgrounds →→→→→	AD Counsel and BS Counsel (2)	MA Psych (2)	MA Educ Kids EBDs (5)	MA Counsel (9)	MA Marriage Family Therapy (MFT) (3)	MS Counsel (2)	Nurse Pract. (NP) (1)	MSW (7)	PsyD (1)	Ph.D. Special Educ (2)	Ph.D. Counsel Psych (2)	Ph.D. Ped Psych (1)	Ph.D. Clinical Psych (3)
Theoretical Orientations ↓↓↓↓↓↓↓↓↓↓													
Systemic 9			x	xxx	xx			xxx					
Structural Strategic 1					x								
Constructivism 4				x	xxx								
Biopsychosocial 5				x			x	x	x				x
Psychodynamic 1													x
Family Systems 12			x	xxx	xxx	x		x					xxx
Culture 1													x
REBT 1				x									
Relationship Approach 7			xxx	xx	x	x							
Solution focused 4			x	xx	x								
Language Centered and/or Narrative therapies 2				x	x								
Future Focused 2				x	x								
CBT 8			xx	xxx				xx					x
Behavioral 2		x										x	
Eclectic 6		x		xxx				xx					
Object Relations 1								x					
Interpersonal therapeutic relationship 1								x					

<b>Disciplinary and Professional Backgrounds</b> →→→→→→→→													
	AD Counsel and BS Counsel (2)	MA Psych (2)	MA Educ Kids EBDs (5)	MA Counsel (9)	MA Marriage Family Therapy (MFT) (3)	MS Counsel (2)	Nurse Pract. (NP) (1)	MSW (7)	PsyD (1)	Ph.D. Special Educ (2)	Ph.D. Counsel Psych (2)	Ph.D. Ped Psych (1)	Ph.D. Clinical Psych (3)
<b>Theoretical Orientations</b> ↓↓↓↓↓↓↓↓↓↓↓↓													
Context/holistic 2				x			x	x					
MST 1				x									
Strength Based 6				xx	x			xxx					
ACT 1				x									
Medical model 1								x					
Psychoeducational 5			xxxx										
Art and play therapies 3			x					xx					
Developmental or Psychodynamic 2								x	x				
Parent-Child Interaction 1												x	
Psychoanalytical 5			xx	x				x	x				

APPENDIX C: Interview Consent Form

Initials \_\_\_\_\_ Date \_\_\_\_\_

**HEALTH CARE PROFESSIONAL INTERVIEW CONSENT FORM**

<b>Project Title</b>	<b>Adolescent Mental Disorders: A sociological analysis of an emergent set of professional knowledges</b>
<b>Why is this research being done?</b>	<i>This is a research project being conducted by Amber Nelson at the University of Maryland, College Park. She is inviting you to participate in this research project because you are a professional who provides mental health services to adolescents. The purpose of this research project is to learn about how different professional disciplines define and intervene in adolescent mental disorders.</i>
<b>What will I be asked to do?</b>	<p><b>Interview:</b> Amber Nelson is requesting she interview you about your role as a health professional as it relates to the service delivery of adolescent mental health care.</p> <p><i>The types of questions that will be asked include the following:</i></p> <p>What kind of educational training did you go through in order to become an adolescent mental health practitioner?</p> <p>How does your approach to defining and intervening in adolescent mental disorders differ from other professionals you work with?</p> <p>What difference does it make for intervention when professional’s practices are guided by different models of illness?</p> <p><i>The interview will take place at a time and place most convenient for you.</i></p> <p><b>Please Initial all that apply:</b></p> <p>_____ You agree to be interviewed for this study</p> <p>_____ You agree to have the interview audiotaped. You may still participate in the study and decline to be audiotaped.</p> <p>_____ You agree to have your responses to questions asked in this interview “on the record”. By checking this box you are agreeing to being identified in my research. You may still participate in the study and decline to be “on the record”.</p>



<p><b>What about confidentiality?</b></p>	<p><i>Confidentiality will be maintained unless interviewee chooses to be “on the record,” in which case “you may choose to be on the record and your name and identifying information may be used in publications.” If you choose to be interviewed off the record, a pseudonym will be used throughout all stages of the research, from data collection to analysis, through research dissemination. Non-essential personal characteristics will be changed to protect confidentiality and prevent identification of “off the record” health care professionals who are interviewed. No personal details about particular patients or patient’s health care will be recorded.</i></p> <p><i>Furthermore, informed consent sheets, interview audiotapes, and Microsoft word typed transcripts which may identify study participants (by pseudonym or otherwise) will be stored in a locked cabinet in the primary principle investigator's office at the University of Maryland. As each digital recording of each interview is transcribed into text via a Microsoft word document onto the hard drive, the digital recordings will be erased.</i></p> <p><i>If Amber Nelson writes a report or article about this research project, your identity will be protected to the maximum extent possible (unless you choose to be on the record). Your information may be shared with representatives of the University of Maryland, College Park or governmental authorities only if you or someone else is in danger or if we are required to do so by law.</i></p>
	<p><i>All study participants, including you, will receive a copy of the informed consent document.</i></p>

Initials \_\_\_\_\_ Date \_\_\_\_\_

<p><b>Project Title</b></p>	<p><b>Adolescent Mental Disorders: A sociological analysis of an emergent set of professional knowledges</b></p>
<p><b>What are the risks of this research? What are the costs to me for participating in this research?</b></p>	<p><i>Participation in this study presents no greater than minimal risk to you. You can refuse to answer any question Amber asks you during the interview. Participation in this study could result in some loss of professional and or personal time.</i></p>
<p><b>Do I have to be in this research? May I stop participating at any time?</b></p>	<p><i>Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time.</i></p>

<p><b>What if I have questions?</b></p>	<p><i>This research is being conducted by <b>Amber Nelson, Department of Sociology</b> at the University of Maryland, College Park. If you have any questions about the research study itself, you may contact Amber Nelson at: 1103A, Art-Sociology Building College Park, MD 20742 (office location), 301.405.6417 (office phone) or <a href="mailto:anelson@socy.umd.edu">anelson@socy.umd.edu</a> (email). You may also contact the Principal Investigator of this study, Sociology Professor Dr. Bill Falk at <a href="mailto:wfalk@socy.umd.edu">wfalk@socy.umd.edu</a>, or at 301.405.6396.</i></p> <p><i>You will receive a copy of this informed consent document.</i></p> <p><i>If you have questions about your rights as a research subject or wish to report a research-related injury, please contact: <b>Institutional Review Board Office, University of Maryland, College Park, Maryland, 20742; (e-mail) <a href="mailto:irb@deans.umd.edu">irb@deans.umd.edu</a>; (telephone) 301-405-0678</b></i></p> <p><i>This research has been reviewed according to the University of Maryland, College Park IRB procedures for research involving human subjects.</i></p>
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<p><b>Statement of Age of Subject and Statement of Consent</b></p>	<p><b><i>Your signature indicates that:</i></b></p> <p><i>you are at least 18 years of age;</i></p> <p><i>the research has been explained to you;</i></p> <p><i>your questions have been fully answered;</i></p> <p><i>and that you freely and voluntarily choose to participate in this research project.</i></p>	
<p><b>Signature and Date</b></p>	<p><b>NAME OF SUBJECT</b></p>	
	<p><b>SIGNATURE OF SUBJECT</b></p>	
	<p><b>DATE</b></p>	

## APPENDIX D: Interview Guide

### “Diagnoses and Interventions in Theory and Practice: Adolescent Mental Disorders”

#### I. PROFESSIONAL BACKGROUND INFORMATION

- a. How long have you been in the mental health profession?
- b. Can you tell me about your professional training as it relates to adolescent health?
  - i. What were gaps and strengths?
  - ii. Is there anything you would have changed about your professionalization? If so, what
- c. What stands out as significant about your background educational training in shaping your current approach to adolescent mental disorders?
- d. How has your discipline changed its professional education since you entered the field?
- e. How has your approach to providing adolescent mental health services changed since you left your professional training and entered the field?

#### II. PROFESSIONAL COMMUNITIES AND PRACTITIONER MODELS OF ILLNESS

- a. How do you view adolescent mental illness? What do you think causes it?
- b. Tell me about the model of illness you use in your approach to working with adolescents with mental disorders.
- c. There are so many different words used interchangeably to describe mental health problems such as mental illness, mental disorder, and distress. Do these terms mean the same thing to you? Do you prefer one over another?
- d. How does your approach to defining adolescent mental disorders differ from the other professionals you work with?
- e. Are there any particular models of illness that you disagree with or find difficult to embrace?
- f. What difference does it make for intervention when professionals’ practices are guided by different models of illness?
- g. In what ways do you think adolescents are affected by the models of illness that guide their mental health treatment?
- h. What professional community, communities and organizations do you consider yourself a member of? (probe)
- i. What are the models of illness of those communities or organizations? (probe)
- j. What are the disciplinary backgrounds of the majority of the members of said organizations?
- k. What kinds of other mental health professionals do you work with? How are their approaches to adolescent mental disorders similar to or different from your own approach?
- l. What is it like to work with mental health professionals from different disciplinary backgrounds?
- m. What assumptions about adolescent mental disorders do members of these communities or organizations share?
- n. What are the benefits and costs of the interdisciplinary state of the field?

### III.ADOLESCENT MENTAL DISORDER TREATMENT PRACTICES

- a. How do you “treat” adolescent mental disorders in your profession? What does adolescent mental disorder treatment entail for you as a mental health practitioner?
- b. Do you think there is a “best” treatment or approach to intervening in adolescent mental disorders?
- c. How have the treatment plans for adolescents changed since you began your career as a practitioner?
- d. Do you use any particular tools, software or strategies in writing up treatment plans?
  - a. If so, can you tell me a bit about it? Therascribe . . . others? What do you think about them? What are the costs and benefits of using software in your day to day work?s
- e. What do you think about Evidence Based Medicine and Evidence Based Practices?
- f. Do you use Evidence Based Practices in your professional work?
- g. How are your treatment practices evaluated?
- h. How do you know when a given treatment is “working”? What does a successful treatment intervention look like? What are its core properties?
- i. Do you think the therapeutic work you do is more art or science? Why or how so?
- j. Have the type of adolescents you work with changed in any way throughout your professional experience? If so, in what ways?
- k. What do you think sets adolescent mental health and illness treatment apart from the general field of mental health services, or from adult mental health services?
- l. Tell me about your experiences of working with adolescents. In what capacity, for/at what types of organizations . . .
- m. What is unique or specific to adolescent mental disorders compared with adult mental disorders? How are their disorders and their treatments similar and or different? Why?
- n. Can you tell me about any major turning points, particular experiences or events which guided your areas of expertise and current approach towards working with adolescents?
- o. What ethical dilemmas have you experienced in your day to day work in the mental health field?
- p. How do your personal and or professional values enter into the treatment context?
- q. How do the personal values and orientations of your client matter?
- r. In what ways do the social or cultural backgrounds of the adolescents you see matter?
- s. Do you think we do a good job treating LGBT and culturally diverse populations in the mental health field today? If so, how do you think it has changed or improved or what is your assessment on developments in serving those populations across the past couple of decades?

#### IV. PROFESSIONAL PRACTICES OF DIAGNOSIS AND TREATMENT

- a. Can you tell me about the diagnostic process – what it entails?
- b. Is there anything unique, or different about diagnosing adolescent mental disorders as compared with adult mental disorders?
- c. How important is diagnosis to your everyday work with adolescents?
- d. Are there any specific tools or strategies you use in diagnosis?
- e. What disorders or presenting issues would you say you diagnose and treat most commonly?
- f. Would you say that most of your cases are youth with chronic recurrent conditions or temporary situation induced distress?
- g. What significance does the DSM hold in your work with adolescents?
- h. How often do you use the DSM in your work as a practitioner?
- i. What role does the DSM play in your everyday work practices?
- j. In what ways is your approach to intervention shaped or influenced by the DSM?
- k. How is the DSM helpful to your everyday work as a mental health practitioner?
- l. How is the DSM a hindrance to your everyday work as a practitioner?
- m. What do you think about the discussions surrounding revisions for the DSM V?
- n. What would you revise about the DSM? How? Why?
- o. What do you think about V codes? Do you think they are or should be legitimate diagnoses, that practitioners should receive reimbursement for diagnosing people with V codes?
- p. What do you know about the harmful dysfunction theory or model of disorder? I think it influenced the DSM IV and the way that functional impairment in daily living was added as a criteria for diagnosis?
- q. What do you think about the debate of discrete versus continuous categories of mental disorders? Do you think one is more accurate or makes more sense? Would you endorse the APA revising the DSM from discrete to continuous categories?
- r. What do you think about the debate regarding adding relational disorders to the DSM?

#### V. EVALUATION OF ADOLESCENT MENTAL DISORDER FIELD OF SERVICES

- a. Are there debates in the larger field of adolescent health among practitioners regarding contemporary adolescent mental health services that are important to your work/approach? What do you think about those debates?
- b. What do you think is not given enough attention, research or discussion regarding adolescent mental health care?
- c. What do you think about the Managed Behavioral Health Care System?
- d. What are the most significant changes that have occurred in the field of providing adolescent mental health services since you entered the field? What do you think about these changes?
- a. In what ways do you see the field developing, shifting or changing?
- b. What stands out as the most significant change in adolescent mental health services since you entered the field?
- c. Do you think the adolescent mental health services are more interdisciplinary now than when you entered the field as a practitioner? (probe) What is the impact of this?

- d. Do you think there is more or less integration of services than there was a decade ago?
- e. Do you think there is a formal or informal network in this area of who to go see for different kinds of needs? For instance, is there good communication between therapists that so and so exists and is great for Latina women who have these issues or so and so is great for boys with gender identity issues?
- f. If you had a magic wand and could change the field of adolescent mental health services, what would you change? That is, what about adolescent mental health services do you think needs the most improvement?
- g. Is there anything else you thought I would ask about but I haven't?
- h. Is there anything you want to add, anything else you think might be important?
- i. Could you help put me in contact with other mental health practitioners who might be willing to be interviewed?

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