

PRACTICING UNDER THE INFLUENCE:
THE MEDICALIZATION OF PSYCHOTHERAPY

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Sylvia Herold Olney

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John M. Ingham

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DEDICATION

To my Grandmother who dreamed of archaeology,

With love and deepest respect forever,

Bettina Geis Buelow,

1911-2007.

And to a shooting star, a fine and fiery presence, my little Grandson,

Maximillian Alexander Root,

June 20 - October 15, 2010

What is man, that thou art mindful of him,

And the son of man, that thou visitest him?

For thou hast made him a little lower than the angels,

And hast crowned him with glory and honour.

Psalms 8:4-5

ABSTRACT

Using a postpositivist empirical method with meaning as central, this dissertation is based on a series of interviews with mental health workers and other professionals involved with or associated with mental health. At issue is the extent to which the biomedical model of human functioning has coopted the mental health field especially as it affects the practice of psychotherapy. I believe that this question is important because of the disablement one can observe in client/patients and others, as well as the philosophical dilemmas confronting practitioners, as a result of their collective exposure to the idea that people may be essentially powerless in the face of their own biology. This perception appears to contribute to the vested interests of the pharmaceutical and insurance industries but it flies in the face of developments in the field of psychoneuroimmunology, neuroscience, and other emerging perspectives, which validate a force-like dimension of mind or focus and intention, and which stand to free people from dominance by external agents including psychotropic medication.

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INTRODUCTION

SITUATION AND ARGUMENT

The practice of psychotherapy has changed in a way that few of us in the field were predicting ten years ago: its almost total *medicalization*, to the extent that more likely than not, an individual seeking psychological help from a mental health practitioner is already taking psychotropic medication, having obtained it from a general medical practitioner. The nature of the psychotherapy relationship has changed as mental health practitioners have increasingly become *de facto* “medication managers,” and as clients expect medication to do for them what psychotherapists have been trained to believe comes from somewhere else, namely from the clients themselves as they are held in a caring, informed, and respectful *relationship*. Psychotherapy is a healing art that requires the willing engagement of both the healer and the help-seeking individual. It is a dynamic relational dance, the outcome of which is uncertain. It can include awareness of and consequences for the body but it focuses on the world of thought as the source of *intention* which makes agency in the world possible. It can be argued that it is the last vestige in our biomedicalized world of an older belief in the fundamental holism of being human.

At the same time, I believe that the practice of psychotherapy, despite its cooptation by biomedicine, could be seen to find itself in the forefront of a new validation of the older understanding as the psychological implications of neuroscience findings become clearer, and as mental health practitioners question the burgeoning practice of the reduction of psychological problems to brain states presented by vested interests as autonomous. Already, training opportunities for mental health practitioners include syntheses of psychoneuroimmunology (PNI), meditation, and cognition.

The changed environment of practice for mental health practitioners, whether they are *psychologists*, who have been trained in administering various types of psychological tests; *psychotherapists*, whose expertise lies in managing the nature of client/practitioner communication; or *counselors*, *social workers*, or *nurses*, may be described as revolving around medication and problems arising from containment by the insurance industry. For good or for ill, general medical practitioners now prescribe most of the psychotropic medication used in the United States, and for an ever wider array of symptoms. Therefore either general medicine is recognizing the role of the *psyche* in health and well-being more explicitly, as many mental health practitioners would like to believe, or, as the evidence seems to indicate more directly, the pharmaceutical industry has turned a reluctant physician population into mental health practitioners who have no coherent training in the practice of psychology or psychotherapy.

Mental health practitioners daily face people who have come to believe that medication will do everything for them from managing their children to relieving job stress to numbing the pain of life's predictable crises. To the dismay of many psychotherapists, young people, for example, now seem to believe that suicide is not a choice but a brain disease which a person cannot control. In an ironic twist, in the age of the "war on drugs," the only solution now appears to be drugs.

What is the experience of seeking out assistance with mental or emotional problems like for clients? Two examples follow. A young woman who routinely sees a psychotherapist also occasionally sees a psychiatrist and a psychiatric nurse who give her access to an array of antidepressants; at least one of the antidepressants is for the general management of her mood, and another to help her sleep as the need arises. When she does not like the side-effects of her day-time medications, she takes them only intermittently. The psychotherapist, psychiatrist, and psychiatric nurse have all given her different diagnoses; her only consistent "medical" behavior in relation to her own

management of her mood is her visits to her psychotherapist, whom she values for their relationship.

A chronically mentally ill man in his middle thirties sees a psychiatrist regularly who manages his medications. He also sees a psychotherapist, who tries to help him with his thinking; a case manager, who tries to get him to keep his appointments and other obligations organized; an outpatient “day treatment” group that functions as peer support; and an occupational therapy group that teaches life skills and constructive hobbies. Each type of professional encounter offers a different set of solutions to his personal problems, and expects him to adhere to their protocols for him, showing irritation when he forgets something. Sometimes he finds himself wondering what his problem “really” is, whether it is his brain, his way of thinking about things, or that no one ever seemed to teach him the basics of looking after himself when he was a boy. He has gained a lot of weight, believing that this is due to his medications, and feels trapped.

These examples are not unusual in the present biomedical climate of mental health practice; they will seem quite ordinary to most practicing psychotherapists. However, they indicate specific *philosophical, scientific, and cultural contradictions* that play out in the lives of people who are implicitly vulnerable on the basis of readiness to trust assumed health experts. Furthermore, it is my observation that when help-seeking people accept a biomedical diagnosis, which they seem to do readily, they become even more vulnerable, by which I mean to exploitation, and that this state has become the overt target of the psychotropic pharmaceutical industry. To put it more specifically, by accepting largely culturally constructed mental health diagnoses, based on a biomedical type of appraisal of the human condition, meted out by practitioners often at odds with each other within the same helping institutions, psychologically vulnerable people become entangled in a crossfire of concepts that essentially disables them. This disabling seems to proceed from a set of beliefs that includes a sort of blind faith in practitioners

aligned with biomedicine, the idea that dysphoric states are diseases of the brain, and that medications can solve negative feelings about life. Help-seeking people are then easy targets for an industry that exploits their readiness to trust supposed experts.

The cultural problem

I view this as a growing social trend - perhaps a *culture of disablement* - in which people no longer question their own ability to manage their reactions to life's vicissitudes. Whereas a sense of personal autonomy has been axiomatic in the American cultural imagination, client/patients now seem dangerously willing to believe that they are diseased, and that solutions lie only in legalized chemically induced altered states prescribed by biomedically trained practitioners. Left behind are notions of personal agency that extend to the use of one's own mind, a justified belief in personal efficacy that emanates from the power of intention, and faith in an innate ability to understand the sources of one's own distress. It is as though ordinary persons cannot possibly know their own state and what brought it about, and must defer to outside authorities for a description of it, preferably in biomedical language, and have no choice as to the "real" solution to mental and emotional distress.

What has happened in the world of the helping professions and in the culture at large to our thinking about sadness, anxiety, and anger? I contend that although biomedical research indicates that biological phenomena accompany mental and emotional states, there is no proof to date that a person is either inexorably compelled to act upon their impulses or inclinations in most situations, or that in the case of mental or emotional anguish one is caught helplessly in the grip of ultimately autonomous physical states.

The scientific problem

Neurochemical cascades within the human body ensue as readily from a *thought* as from the perception of an actual external event, leaving many questions about the

nature of the human mind unanswered (Pert 1997). Furthermore, it now appears that the brain itself is configured by attention strategies (Doidge 2007). However, if thought is capable of influencing physical bodily states and the configuration of neurons in the brain, then it too should remain an important site of intervention, and it would be misguided to permit the inference to thrive that psychological distress is best or ultimately only alleviated by outside chemical means. Assuming that thinking is itself causal, for which there is growing neuroscientific evidence, significant individual and social implications follow. How important to mental health, for example, is the thought world to which children are exposed? Or, what is the relevance to the mental health of a population of certain economic arrangements? Parents permit children to be entertained by violent video games, while they themselves work in underpaid dead-end jobs. The same overworked and discouraged parents finally resort to taking neurologically disorganized (“attention deficit and hyperactivity disorder”) or “oppositional and defiant” children to biomedical practitioners who, caught in their own world of “thick prescription” (Oldani 2004), feel compelled to offer psychotropic medications to the whole family.

The philosophical problem

Any healing system is also a cultural construction (Press 1980); however, as with any social institution, change is possible and likely, given enough time. In this study, I examine the extent to which the biomedical model of healing has permeated the mental health field and how affiliated practitioners navigate within it. Both practitioners and client/patients are deeply affected by contradictions in the course of what turns out to be the naturalization or *indexicalization*, to use a Peircean semiotic term (1940), of supposed autonomously diseased brain states as they are encountered within the mental health field. It was only a few decades ago that psychotherapists believed they practiced according to methods of intervention other than biologically based ones; that is, they practiced on the

basis of the recognition that the human mind, whatever its ultimate nature, possesses qualities that often permit people a means of escape from entrapment by themselves (Hedges 1987), if not from every dissatisfying social arrangement. They did not align themselves with the biomedical model on principle, having some awareness of the philosophical and scientific contradictions that they would face. However, economic considerations prevailed, and now psychologists and psychotherapists and other allied workers find themselves precisely in the quandaries that their professional elders foresaw.

The mental health field has become increasingly fragmented as various treatment philosophies within it have collided, and it is client/patients who suffer the brunt of this. The choice of term for people seeking mental health support is itself an indicator, as “client” - deemed a more egalitarian term by psychologists and psychotherapists - came to replace the older term “patient.” Ironically, a psychotherapist’s “client” becomes a “patient” when he or she sees a psychiatrist or other medical practitioner, and the client/patient is left up to his or her own devices in sorting out the status differentials in these encounters with professionals. Whereas, for example, a client is encouraged by his therapist to practice straightforward communication in his encounters with his psychotherapist, the same person is generally expected to conform compliantly with his medical practitioner, not unlike a child who is rewarded for showing respect and deference to a parental figure. And if the biomedical practitioner prescribes a psychotropic medication, the client/patient is unlikely to question this form of intervention and also seems to take it more seriously than the psychologist’s or psychotherapist’s interventions which consist of thought and behavior modification. In other words, in the current climate of practice, the client/patient is more likely, usually, to swallow the pill than to do the assigned cognitive or behavioral “homework.”

Philosophies at issue also concern the working models of mind that practitioners use more or less consciously as a basis for their interventions. The mental health

practitioner who sees the mind as a type of habituated or deeply programmed computational device will use different therapeutic interventions than the psychodynamic therapist who believes that human behavior is largely purposive or intentional. Many psychiatrists, on the other hand, tend to assume, as a result of their deeply ingrained biomedical training, that “mind” is probably an emergent property of the brain which can best be influenced through chemical interventions. Strangely, psychiatry used to be the home of psychodynamic theory in the form of Freudian psychoanalysis with its developmental and topographical descriptions of mind, but in the course of pressure to submit to positivist scientific method, it mostly abandoned dynamic theory in favor of behaviorism, cognitivism, and, most recently, almost exclusive reliance upon drug management. At the same time, the only consistent finding as to efficacy of intervention in relation to type of presenting mental health problem is the nature of the client/practitioner *relationship*; in other words, the most consistently important variable is whether or not the client or patient has an affinity for their practitioner (see Karasu 2001:123; and Rogers 1961:32–35).

Currently, mental health practitioners are at pains to keep up with the latest brain research, assuming that it may hold answers to their clients/patients’ problems. At the same time, there is a growing suspicion of science as enmeshed with economic interests in the form of profitable psychotropic agents. Yet, the *status* accorded this type of research tends to sideline lifestyle and awareness issues that psychotherapists, social workers, and occupational therapists, on the other hand, know to be involved in their clients’ problems. These implicit contradictions, as experienced by practitioners and client/patients alike, can be modeled as follows (Figure 1), with my research having focused on the dependent variable: mental health practitioner “buy-in” into the biomedical model of human functioning.

Table 1

<i>Independent variables</i>	<i>Intervening variables</i>	<i>Dependent variable</i>
Biomedical/positivist model of human functioning	Economics: cost of professional practice	Mental health practitioner “buy-in” into biomedical model of human functioning
Psychological models of human functioning: philosophical, e.g existential, dynamic; developmental/ biological	Cultural acceptance of strictly materialist/ reductionist views of the human condition: behaviorism, cognitivism	

Argument

The problem, as I see it, consists of the consequences to client/patients, mental health and other allied practitioners, as well as to society in general, of the unquestioning acceptance of a biomedical model of human functioning that is predicated on an increasingly outdated scientism (Habermas 1971; Schlitz, Amorok, and Micozzi 2005). This positivist approach neither accepts nor acknowledges healing phenomena that cannot be explained in strictly materialist and reductionist terms, largely refuses to acknowledge the cultural construction of many of its diagnoses, and undercuts the salience of human relationships to illness phenomena and in healing enterprises. As a result, client/patients, practitioners, and ordinary people are discouraged from discovering, affirming, and using their own intuitions and meanings in relation to health and illness - they are essentially disabled by the very institutions they turn to for answers to human distress. Meanwhile, it has become increasingly clear that there is an economic benefit to certain institutions to maintain this status quo. My interest, however, is in the philosophical and cultural cost to society, in particular as it pertains to the delivery of mental health services.

The last fifteen years of neuroscience have begun to reveal a far more complex picture of human health and illness than biomedicine imparts to patients (see for example Doidge 2007), although it is interesting to note that much philosophical writing and thought from our own and other cultures appears to have anticipated some of the findings (Hahn and Kleinman 1983; Micozzi 2002). Many of these are emanating from a field of inquiry currently loosely described as psychoneuroimmunology or PNI, and may be related to the problem described above on the basis of the rediscovered significance of the world of thought and states of consciousness to the human condition (Rich 2000:2). It appears to me that the implications of PNI and of the emerging studies in the neuroplasticity of the brain can be applied to various levels of social analysis and can be seen as harboring solutions to the contradictions presently residing in the health care professions, especially mental health; this is to say that PNI and findings in relation to neuroplasticity, in their growing ability to bridge physical phenomena of the body and brain and human thought, stand to recover the significance to health and healing of thought itself (Pert, Dreher and Ruff 2005; Doidge 2007).

ETHNOPSYCHIATRY AND HUMAN AWARENESS

The licensed practice of psychotherapy in the United States today is carried out under the auspices of biomedicine. This form of medicine is, in turn, at least in the United States, dominated by the pharmaceutical industry. This arrangement is socioeconomic and material as well as symbolic. Currently, medical training in the United States is largely underwritten by the pharmaceutical industry, which has also served to inhibit the investigation and status of alternative healing methods including psychotherapy (see for example Elliott 2001). Other methods of curing and healing abound, however, and are utilized extensively as consumer patients express dissatisfaction with the narrow range of biomedical treatment options and seek out alternative forms of illness intervention, paying the costs themselves if necessary. The

insurance industry, in its desire to contain its own costs, actively resists alternatives to biomedicine. There exists, then, a *de facto* collaboration between the pharmaceutical and insurance industries, resulting in a highly profitable arrangement for a health care system that is based on business rather than *wellness* models (see Chestnut 2005:16–21).

From an anthropological perspective, the treatment of mental and emotional distress as a form of medical treatment in the realm of biomedicine is one human cultural possibility among many; it is, most generally, an example of the “culturally situated nature of knowledge,” including medicine (Gaines 1992:xi). Furthermore, as Gaines points out, regardless of the degree of professionalization of practice, operating ideologies are not “ontologically distinct from local popular ethnopsychiatries and ethnopsychologies” (Gaines 1992:xii). Whether a practitioner is a healer invoking energy and using prayer or a psychiatrist who dispenses psychotropic medication, for example, it can be shown that the principles of practice employed are cultural productions. More specifically, they can be seen as “epistemologically comparable,” and therefore “one is no more, nor less, privileged than another” (Gaines 1992:xii). Biomedical practice, in this case in the form of psychiatry, then, cannot be seen as “universal in its scientific bases and in its objects of concern, mental diseases” (Gaines 1992:xii). Indeed, psychiatrists can now be “considered in the same discourse as shamans and medicine persons” (Gaines 1992:xii), and it can readily be argued, moreover, that mental and emotional distress is best understood and treated in a local and cultural context (see also Jodorowsky 2004:vii).

The specialty field of study within anthropology of *ethnopsychiatry* was first named by the Haitian psychiatrist Dr. Louis Mars but it was given shape by the “Hungarian-born, French and U.S.-trained anthropologist-psychoanalyst-classicist George Devereux,” who died in 1985 (Gaines 1992:4). Devereux saw “ethnopsychiatry” as “one of two forms of research” extant in relation to human psychology, the first one consisting of “the systematic study of the psychiatric theories and practices” of a given cultural

group, leading to an understanding of ““mental derangements . . . as (locally) understood”” (Devereux 1969:1 in Gaines 1992:4). And the second, ““the recording of all obtainable information on psychiatric illnesses . . . and an analysis of their social and cultural setting,”” such that ““this work is a contribution to the study of “culture and the abnormal personality,” or, as this field of inquiry is presently called, ethnopsychiatry”” (Devereux 1969:1 in Gaines 1992:4). Gaines calls the second approach “cross-cultural” or “transcultural psychiatry,” which “uses Western categories and looks for what are believed to be local permutations, but assumes that Western categories and nosologies are universally applicable” (1992:4). Instead, he proposes a “new ethnopsychiatry,” which “takes as its subject all forms of ethnopsychiatric theory and practice whether folk or professional,” having “as its focus mental derangements as locally understood, managed, and classified,” thus representing “an updating of Devereux’s original conception(s) of the field” (Gaines 1992:4–5). Consequently, “the distinction between folk and professional medicine is . . . seen as one of (culturally constructed) degree, not of kind,” and,

the term *folk psychiatry* . . . refers not to one kind of system relating to abnormal ethnopsychology and its treatment(s), but simply to a less formalized system than those represented by professional ethnopsychiatries. Professional ‘scientific’ ethnopsychiatries of the United States, France, Japan or Germany are, then, to be seen as formalized, professionalized, folk systems; they are epistemological siblings of their respective folk psychiatries (Gaines 1992:5).

The result of this approach has been the discovery “that there is no universal psychiatric reality, no firm external base beyond culture on which stands a given ethnopsychiatry or upon which it reflects. . . . Rather, each professional and folk system is recognized as a reflection of a constructed world” (Gaines 1992:5).

The field of ethnopsychiatry in anthropology, which can be seen more generally as a subfield of psychological anthropology, is predicated on the largely tacit acknowledgement of the existence of a foundational propensity for awareness or *sentience* in human beings. However, many anthropologists have long perceived the relationship between culture and psychology (the latter which may be defined as the outgrowth of consciousness) as dialectical (see Bourguignon 1979:15), therefore reifying neither culture nor psychology consistently as causal in the human condition. The nature of the relationship between human awareness in the form of psychology and culture is reciprocal, and given the relatively lengthy period of biological dependency of human children, it is clear that this awareness or sentience is shaped, as is culture in turn by individual and collective creative expression. Anthropologists have written extensively, for example, about the construction of *self* and *agency* - the human propensity for self-directed thought and action - without necessarily addressing human phenomenal awareness.

I contend, however, that in order to grasp the significance of the practice of psychotherapy under the influence of biomedicine, it is important and necessary to delve deliberately into what can be known about human consciousness, both philosophically and empirically, and that this is necessary on humanistic grounds. As such investigative technologies as magnetic resonance imaging (MRI) and positron emissions tomography (PET) have become available, it has become increasingly evident that human consciousness is itself a driver of metabolic processes, including in the brain itself. This in turn is reviving philosophical questions about the nature of being human and about the scientific method of the West which has, since the seventeenth century, been committed to *materialism*, a philosophical position that has had no room for the analysis of subjective experience.

Knowledge and power

Biomedical knowledge is power as a medical diagnosis sets in motion the wheels of prescription, insurance reimbursement to the practitioner, and a sense of security, if not healing, for the patient. Despite the real possibility of iatrogenic death in the United States, particularly as people age (Steel, Gertman, Crescenzi, et al. 1981), social and cultural pressure today leads people to believe that biomedical practitioners have the ultimate answers to pain and suffering. What they have, however, is the power to diagnose or *name* physical and psychiatric conditions based on culturally defined complexes of signs or symptoms, to prescribe largely palliative pharmaceutical agents, and, depending on their specialty, the ability to perform surgery. Ideally, they also have a good “bedside manner,” meaning the ability to inspire patients with the idea that their physician is competent and *caring*.

Whether or not a given medical intervention works to alleviate suffering, then, is also highly dependent on the *placebo* effect, which is to say that a patient generally must also have faith that a given intervention will be effective. This condition of effective medical practice, regardless of type, helps to explain the persistence of the diversity of healing interventions across human cultures. It can also be seen as pointing to the significance of human thought and attitude and the capacity of specific states of consciousness to affect physiological or metabolic expression. Levi-Strauss once gave the following perhaps underappreciated example of this complex interrelationship between culture and psychology in a case of shamanic healing:

Once the sick woman understands . . . she does more than resign herself; she gets well. But no such thing happens to our sick when the causes of their diseases have been explained to them in terms of secretions, germs, or viruses. We shall perhaps be accused of paradox if we answer that the reason lies in the fact that microbes exist and monsters do not. And yet, the relationship between germ and

disease is external to the mind of the patient, for it is a cause-and-effect relationship; whereas the relationship between monster and disease is internal to his mind, whether conscious or unconscious: It is a relationship between symbol and thing symbolized, or, to use the terminology of linguists, between sign and meaning. The shaman provides the sick woman with a *language*, by means of which unexpressed, and otherwise inexpressible, psychic states can be immediately expressed. And it is the transition to this verbal expression - at the same time making it possible to undergo in an ordered and intelligible form a real experience that would otherwise be chaotic and inexpressible - which induces the release of the physiological process, that is, the reorganization, in a favorable direction, of the process to which the sick woman is subjected (Levi-Strauss 1963:197–198).

Today, PNI research indicates that thought itself, within limits, catalyzes and arranges the neuropeptides that form the basis of intercellular communication within ourselves as living organisms. The implication is that thought contributes to human physiology, and the content of thought is, of course, also a cultural artifact (Pert 1997; and Chopra 1989).

Whereas critical medical anthropology has often concerned itself with the domination of folk ethnomedicines and society itself by biomedicine (Gaines 1992:7), my concern is with biomedicine's *reductionism*, particularly in the form of its disavowal of the significance of mental and emotional states in the formation of illness. From this perspective, the power exerted is perhaps more insidious, as scientific method is used to justify the neglect of the role of conscious awareness in health and illness. Yet, as Gaines and others clearly show, "cultural conceptions and formulations encoded in professional or popular ethnopsychiatric knowledge and practice . . . are hundreds, in some cases,

thousands of years old,” including “with respect to U.S, Chinese, German, French or other ethnopsychiatric system one might care to investigate” (1992:7). In other words, the argument of modern biomedicine as hegemonic and somehow beyond culture can be seen as overstated and I argue that the more profound problem of its influence lies in its rejection of human meaning-making as causal, including at the organismic level. In contrast, “ethnopsychiatric beliefs and practices appear under the anthropological gaze as complex, historically constructed cultural tapestries which both cloak and reveal fundamental understandings about life, disorder, experience, person and cultural voice” (Gaines 1992:8).

This is not to claim that a macrosystems focus, with its accent on “nonsentient economic systems, structures, and forces,” has not contributed useful insight; rather, it is to say that overarching claims about knowledge and power break down in the face of “local-level realities” (Gaines 1992:17). Conversely, although local realities also reveal knowledge-and-power dynamics, they are characterized by *diversity* and all the creativity of which human agency is capable (Gaines 1992:18–19). Further, of particular salience to this project is that, as Gaines describes it, “the shift to interpretive perspectives was forced by inherent weaknesses in the materialist positions” that had been inherent in critical medical anthropology. Meaning-making by individuals, for example - in this case mental health practitioners and client/patients - as a nonempirical phenomenon can be counted on at times to seriously undercut theoretical generalizations and predictions about the effects of material conditions. Although biomedical training predisposes practitioners to particular points of view which can be described in economic, social class, political, as well as other universalistic terms, in practice each physician finds him- or herself having to creatively adapt his or her views to local conditions which include the meaning-making about illness which client/patients bring with them to consultations. This implies that “medical systems are not autonomous, isolated sociocultural strata They represent

moments of historical social and cultural processes including borrowing. Given instances are but moments of a culture-in-the-making, and as such provide one of many windows in the house of culture into which one might choose to gaze” (Gaines 1992:19).

Rhodes examines the locus of power in the emergency unit of a community mental health center during a period of time when the staff was engaged with a patient who could not speak and who could not be placed readily anywhere else (1992). His very condition not only gave him a certain kind of power, but enabled the staff to highlight absurdities of their own enforced practices. In general, Rhodes finds that whether one chooses to analyze it from a “macro-level” or from a “clinical” perspective, “power is always present, but the question of precisely who has it evades one at every turn” (1992:53). In this case, she found Michel Foucault’s work particularly useful “for an understanding of institutions” which, according to her, he describes as “sites for the construction of the relationship between the individual and society”; thus,

in his studies of the asylum, the hospital, and the prison, Foucault shows that in the late eighteenth and early nineteenth centuries the inner space of these institutions developed a configuration that provided for the development of the peculiarly modern relationship between subject and object; through the manipulation and management of the body, the inmate became an object of knowledge and a subject of discipline (1992:53).

Rhodes agrees with Foucault that under these conditions “power does not ‘rest’ in the hands of individuals or groups; rather it is fluid, and diffuse, operating in a net-like grid of relationships” (1992:53–54). Coinciding with my own clinical work as a psychotherapist and case manager in community mental health agencies, Rhodes finds that “staff, patients, administrators, and other institutions have to be seen as bound together in the same disciplinary space, one in which all, to varying degrees, exercise and

are subjects of power” (1992:54). In this type of space, as Foucault also pointed out, one inevitably also finds resistance, although on the part of the staff it may be “covert, ephemeral, and oblique” (Rhodes 1992:54). Rather than being “peripheral to the ‘real’ work of clinical practice,” it can be seen as “part and parcel of the work itself,” as a way to “make something tangible out of their [own] experience of disjunction, contradiction, and absurdity” (Rhodes 1992:54).

These observations by Rhodes become a way to understand similar aspects of my own findings such as practitioners alluding to “playing the game,” which can apply to almost every dimension of their work, from the way in which psychiatric disorder is noted and described in client/patients’ files, to how they broker their relationship to medical insurers, to how they discuss client/patients’ progress in case management meetings. They also apply to the ways in which client/patients wield power and carry out resistance: perhaps most notably in the present climate of practice by abandoning their own innate abilities for self-healing and insisting on psychotropic medication and drug management. Rhodes concludes and I agree that when all is said and done, it may be that “the tension between the speaking subject and the object of power is an irreducible given in clinical, and other settings,” and that “we must try to make the most of it” (1992:63). I take this to mean that we do well to engage with our whole selves in the dynamic potential inherent in each moment of the encounter with another speaking subject regardless of power differences.

Culture: The symbolic order

Perceptual phenomena as human beings describe them are deeply encultured. This means that most perceptions that human beings take note of are apprehended through a veil of culturally ascribed meaning, often beginning with the name given to a phenomenon. Of course we may have perceptual experiences which we find difficult to define or name, and certainly the experience of childhood can be described in terms of the

discovery of a preexisting-existing cultural order, which implies that there exists the possibility of knowledge outside of or before culture. But in general it can be said that we live inside of and through an order, at least in our minds, that is *symbolic*, and which most of us have not developed independently, rather than one consisting of the bare perception of *things in themselves*. This order shapes virtually every dimension of life as we experience it, including the most personal behaviors.

It can be surprising to discover, then, that, as Gaines describes it, while most researchers now accept the fact that culture shapes normal behavior, even many culturally cognizant authors explicitly or implicitly, and contradictorily, assert that abnormal behavior is somehow exempt from the impress of socialization, training, and experience. That is, they suggest that while normality is cultural, abnormality is acultural and universal. Such is the basis for the biological approaches to mental illness (1992:8).

This position is neither logical nor congruent with the anthropological data. I would add that so-called abnormal behavior as well as ascribed and psychological meaning is also often unique to individuals, as any practicing psychotherapist will have encountered, the recognition of which Alfred Adler developed into Individual Psychology (see Ansbacher and Ansbacher 1956). So, although unique behavior and meaning-making can be perceived at the individual level, at the group level of comparative analysis it is most certainly in evidence in the form of culturally defined notions of and adherence to appropriate and normal or inappropriate and abnormal behavior and thinking.

An ethnomedical system, then, like any other cultural artifact, can be seen as a construct which is “an unfinished product of culture history” (Gaines 1992:23). From this interpretive or “constructivist” perspective, as Gaines calls it, medical systems are not static; rather, they show themselves to be ever changing as “much is borrowed from other traditions and [is] refashioned over time” (1992:23). More specifically, ethnopsychiatric

systems are “embodiments of their respective ethnopsychologies’ concerns for, and delineations of, the normal and abnormal self and the Other” (Gaines 1992:8). In the light of PNI, “embodiment” can now be taken literally, as the neurological pathways of psychological and other states of consciousness are being revealed empirically. It becomes clear that although human beings share the same biology, the *meaning* made in relation to physiological states is encultured on the basis of such “nonpsychiatric phenomena” as “person concepts, forms of conflict resolution, terrorism, stress” (Gaines 1992:17).

Gaines reminds us that Devereux had already described how diagnosis itself is a comparative undertaking resting on “cultural models of pathology, not the assessment of the pathological nature of the presentation in its own terms”; in other words, especially in the world of mental and emotional disturbance or perceived suffering, the designation of a specific state of consciousness as illness depends on concepts of normalcy that are culturally defined (1992:21–22). Therefore, the “objects of medical and psychiatric research and therapeutic gaze” are not “things of an independent, acultural ‘Nature,’ an entity that is itself a cultural construct” (Gaines 1992:21). Moreover, as I discovered myself and describe below, “attempts to find and describe a homogeneous psychiatric establishment in the United States instead find a highly heterogeneous mix of ideologies and institutions that are largely autonomous but grounded in their local areas” (Gaines 1992:22).

Biomedical orientations purport to be timeless and universal, yet comparison of them even as they currently exist in highly developed, post-industrial societies show the impress of local culture and history. Gaines examines “the ontological status of ‘biology’ in French and American biomedicine,” by showing how certain French bodily afflictions, in this case *spasmophilie* and *fatigue*, are glossed and classified according to U.S. medicine (1992:171). In the U.S., these problems would be regarded as psychiatric

(Gaines 1992:171). Gaines then, by “reversing things,” demonstrates “the absence in France of the U.S.’s peculiar social classificatory system” with its attendant “diagnostic and therapeutic choices . . . often made on the basis of patients’ social identity, whether it is ‘race,’ class, or sex” (1992:171, 186).

Culture history can be seen to include “sickness histories,” which are “those historical experiences out of which a culture’s folk and professional ethnomedicines fashion their understandings of sickness and ascribe meaning to them such that people organize themselves in a culturally sensible way to address their experiences” (Gaines 1992:172). These ways include “etiological theories, medical organizations, sickness realities, and specific means for diagnosing and treating them” (Gaines 1992:172). So, although biomedicine claims to rest entirely on acultural biological bases, Gaines shows that “some rather central conceptions are not shared between French and United States biomedicines” (1992:174). Rather, these particular “professional ethnomedicines” can be seen as “distinct symbolic systems which, like world religions, are locally received and constructed and, through local history, create and (re)interpret central symbols” including biology (Gaines 1992:175).

I find it particularly interesting that whereas in the case of these French diagnoses, which are “seen [there] as biologically based . . . though their etiology is psychosocial,” the body is regarded as “an expression of the mind” in a way that is “normal, customary, and expected in lay and professional circles in Mediterranean (and New World Latin) lands,” in the United States this connection is simply labeled as “somatization” (Gaines 1992:184), without any development of the theoretical implications. This can be seen as itself an example of a cultural split which still informs biomedicine in the United States, in this case between the mind and the body, or *psyche* and *soma*. Since biology is the “key symbol” in U.S. biomedicine, somatic interventions, then, also serve as “the criterion of ranking in the status system” of the profession (Gaines 1992:189). As I found

to be true and Gaines makes clear, “this symbolic potency is adopted by contemporary psychiatrists who view their work in biological terms . . . and as the means by which psychiatry will raise its status within medicine and become part of ‘mainstream’ medicine” (1992:190). This helps one to understand, moreover, why it is that “the criteria of evaluation are not necessarily efficacious practices” (Gaines 1992:190).

In an article encapsulating much of what ethnopsychiatry reveals in theory and in practice, Paul Farmer, physician and anthropologist, provides an outline of professional Haitian psychiatry (1992). The first half of Farmer’s witty title, “The Birth of the Klinik,” is clearly a nod of recognition in the direction of Foucault, whose work, as already noted above, has proved to be an important source of inspiration for much of the social science of institutions, including medicine (see Foucault 1973). Farmer begins by pointing out that “many anthropologists would be startled by the fluency with which Haitian psychiatrists discuss the social construction of illness categories, the myriad ways in which culture shapes psychopathology, and other topics that are, in most settings, the province of medical anthropologists alone,” revealing them “to be on far more familiar terms with anthropological concepts than, for example, their North American and French counterparts” (1992:251). Generally educated in the “First World,” Haitian psychiatrists as well as other Haitian intellectuals understand that “the content and contours of this knowledge are the products of historically and culturally peculiar preoccupations and bound indissociably to certain linguistic categories” (Farmer 1992:251).

Citing Louis Mar, the pioneering Haitian psychiatrist who coined the term ethnopsychiatry, Farmer explores the historical imposition of, but also resistance to, a specific cultural ideology on Haiti, touching on some of the profound connections between culture, personality, and mental illness, revealing the “‘flimsiness of the French categories that we were using so uncritically, mechanistically imposing Western categories on Haitian reality’” (1992:251). At the same time, in the absence of adequate

health services in the Western sense, Haitian culture has retained its own understandings of the nature of the human mind and emotions as well as ways to alleviate related suffering (Farmer 1992:266-267). The results for Haitian psychiatrists today include deep ambivalence about Western concepts generally (Farmer 1992:252).

Attempts to medicalize mental illness continued throughout the twentieth century in Haiti (Farmer 1992:256). As in other parts of the world where biomedicine makes inroads, the treatment of choice has been pharmacologic, although it has only been the relatively wealthy who could consistently obtain such treatment (Farmer 1992:256). At the same time, the self-conscious ethnopsychiatry of Haiti continued to evolve out of the local response to the racism displayed by the North American occupation of Haiti begun in 1915. Setting out to prove that “‘the black race’ was every bit as capable as [Europe and North America] of ‘civilization’ and ‘refinement’” seemed to “pave the way” for Haitian ethnopsychiatry as people such as the medically trained anthropologist Jean Price-Mars (Louis Mars’ father) objected to the effects of voodoo being classified in pathologizing Western terms (Farmer 1992:258–259).

More recently, psychiatry has been part of general medical training in Haiti, and Haitian psychiatrists, thanks to Price-Mars and Mars, do not object to voodoo (Farmer 1992:262–263). Indeed, psychiatrists have had to compete for patients with indigenous healers who, as in other parts of the world, adopt new medical perspectives only very slowly (Farmer 1992:263). Although Louis Mars appeared to believe and taught that mental illness was “fundamentally organic” in nature, he also believed that “the role of culture could be quite determinant in psychopathology,” and it is possible that he overstated “the ‘organicist’ position” for political reasons (Farmer 1992:263). A modern Haitian psychiatrist, Dr. Jeanne Philippe, points to “the concept of the person” as possibly the lynchpin in how mental illness expresses itself, this also being “a chief source of dissonance between Western psychiatric theory and Haitian ethnopsychology” (Farmer 1992:264). In her words,

Even in the middle classes, there is a tendency to live in and for the group. To use the expression of Dr. Louis Mars, this renders the Haitian idea of the individual very “diffuse.” There isn’t really an individual distinct from the group, or distinct, even, from the universe. And thus can one be harmed: there are so many strands linking one to the social and material world (Farmer 1992:264).

Obviously, the implication is that “if personality is socially and culturally constructed . . . then it stands to reason that nosologies and etiologic theories elaborated in radically different settings will have limited applicability in Haiti” (Farmer 1992:265), or, I would add, anywhere else other than where they were derived. And, as Farmer notes, quoting Levi-Strauss, ““if . . . the mental and the social merge together, then it would be absurd, in instances in which social and psychological are in direct contact, to apply to one of these two orders a notion (like illness) that has no meaning without the other”” (1992:265).

This cultural constructivist perspective also shows that socially organized attempts to alleviate suffering - ethnomedicines - are themselves “constituents and expressions of their respective cultures” (Gaines 1992:23). Ethnomedicines include Western psychiatry because it too is based on culturally determined selective processes that work to include and exclude specific concepts (Gaines 1992:23). More specifically, an ethnomedicine is characterized by “cultural assumptions whose form expresses and conceals popular ideas,” and, as Gaines says directly in relation to biomedicine, “the notion that medical and cultural ideas are separate is merely a replication of a particular Western cultural point of view” (1992:24). As shown below, the idea of the mind and body as separate entities, known as the *psyche/soma* split, which constrains and shapes the practice of biomedicine in the United States, is an example of a cultural assumption characterizing an ethnomedicine.

The phenomenon of personality configuration and personal influence in relation to social context can serve to demonstrate the relativistic nature of ethnomedicines. Using

Devereux's concept of "social mass," Charles Nuckolls examines the strangely powerful social influence of a former Jalari priest (1992). Devereux believed that a person could have "social mass" or disruptive influence as a result of being "conspicuously at variance with the mores" of the society in which he or she finds him- or herself; depending on the strength of the "symptoms," which also serve to "gratify the idiosyncratic and socially negativistic needs of the patient," such a person constitutes a "social trouble unit" (Nuckolls 1992:70). Nuckolls describes such a person, a man who commands inordinate respect in an Indian village in which in general it is consensus rather than authority that reigns.

This former shaman by the name of Naidu "achieves social mass" by "abusing the status which attaches to him by virtue of his past office," which had included communicating with and controlling goddesses (Nuckolls 1992:71). In other words, people were afraid of him and his presumed powers to command the supernatural; indeed, he relished his status as a witch, managing in this negative way to duplicate the authority he had enjoyed formerly as a priest (Nuckolls 1992:71, 72). However, he also accomplishes something for the village by inhabiting this role: in a society in which what counts morally is *intention*, Naidu "calibrates" the scale of intentionality by setting its upper limit at the extreme intentionality of the "witch" (Nuckolls 1992:75). This helps to explain why the village tolerates him; not only does his behavior and attitude provide a benchmark, but he becomes a target for the displacement of "all nonsociocentric, ego-centered feelings" in the community (Nuckolls 1992:76). This displacement is important in Jalari culture and diagnosis because bad luck and illness are attributed to faulty human intention and subsequent attacks by goddesses (Nuckolls 1992:72). Further, because he seems to be able to act as freely as the goddesses he commands, he is both despised and admired (Nuckolls 1992:76–77). Nuckolls points out that in this way Naidu is "a classic example . . . of a 'pattern of misconduct' . . . an expression of 'social negativism' . . . and

a ‘social cynosure’” (1992:77); that is, his behavior makes sense from a cultural point of view and fulfills multiple purposes, both for himself and within his community.

How does American psychiatric diagnosis compare? First, as Nuckolls points out, although Jalari diagnosis would seem “subjective and impressionistic” in its use of a specific person as a means of calibration, “a nonscientific sample of American psychiatrists . . . remarked that the complex diagnostic criteria of the DSM [Diagnostic and Statistical Manual of Mental Disorders (see for example American Psychiatric Association 1994);] play almost no role in diagnosis except secondarily as terms for justifying medical insurance reimbursements” (1992:77), which I have also found. In practice, “the further away from the ‘psychoses’ and the more toward the ‘affective’ and ‘personality’ disorders one moves, the less usable formal diagnostic criteria become” (Nuckolls 1992:77). That is, practitioners can be observed to use subjective criteria, such as cases they have known, to make a diagnosis (Nuckolls 1992:78). Moreover, just as in the situation of Jalari diagnosis, American diagnoses can be shown to be socially iconic, carrying positive cultural imagination as well as ambivalent qualities, such as heroism and rugged individualism in the case of mania (Nuckolls 1992:79).

A recent work making these same points and more is by Emily Martin (2009). In her book, Martin reveals her own travails as a person who had been diagnosed with so-called bipolar disorder and yet was functioning as a professor, continuously facing the potential stigma of madness (2009:xvii). Martin, who prefers the older term *manic depression* based on her own subjective sense of living with extremes of high and low *moods* (2009:28), sets about “to explore the daily experiences of those who, for better or worse, are participating in the world that psychopharmacology has opened up,” hoping that “the word ‘crazy’ would come to mark the ways that everyone belongs in one way or another - even if only in their dreams - to the realm of the irrational” (2009:xix). Thus, by looking at the culturally constructed aspects of this particular mental health diagnosis,

including the bipolar nature of American society itself (2009:29), Martin comes to question the very concept of rationality as the West has inherited it from ancient Greece (2009:6).

Martin questions the assumption that “the normal person is wholly rational,” and suspects otherwise: “In their everyday lives, most people have various degrees of awareness of reality and of the consequences of their actions, various degrees of ‘reason’ in their decisions and opinions” (2009:7). She finds that “most of the tidy dichotomies that float in the wake of the separation between rational and irrational (sane/insane, controlled/uncontrolled, responsible/irresponsible, reasonable/unreasonable) are inadequate to the task of capturing complex experiences like living under the description of manic depression” (2009:8), and wonders whether manic depression might not be better understood as also a psychological style rather than only as an illness (2009:28).

Martin’s perspective is deeply interesting to me given my training as an Adlerian psychotherapist. From the point of view of Adler’s Individual Psychology, which posits all behavior including styles of thinking as *purposive*, manic depression can indeed be seen as a psychological style (Sperry and Carlson 1993:21–22), including one that under the right social conditions, such as in the United States with its cultural accent on personal drive and achievement, confers advantages (Pevan 1993:91). Furthermore, by describing the role of the pharmaceutical industry in the production of the diagnosis of bipolar disorder, Martin confirms some of my own impressions and findings that there are vested interests not only in declaring people mentally ill, but in pathologizing common behavioral and ideational tendencies.

It can be argued that the predominant method for the creation of meaning in human culture is the use of language; some have even convincingly argued that the human sense of self, perhaps in particular the unconscious, is structured and configured like a language (see Dor 1998). The process of making meaning is not simply referential.

Rather, it is characterized by the dynamism that human subjectivity brings to it; in other words, meaning-making is ultimately unpredictable since it arises creatively. So, although people are compelled to use the consensually meaningful parts of their culture to communicate and express anything to someone else, the ways in which people do this and the private meanings that they may assign to cultural expressions are apt to be unique or to include unique dimensions.

The philosophical approach which in my opinion captures human meaning-making most completely, and which I use to analyze my own data, is that of Charles Sanders Peirce, who elucidated the logical as well as existential fact that human meaning-making depends upon abstract mental operations (Buchler 1940:100–101). An elaborate application of the Peircean sign system can be found in E. Valentine Daniel's ethnography of the Tamil in which he illustrates how anyone apprehends an object (a so-called Second sign), on the basis of having accepted a cultural representation for it (a so-called First sign), and then usually goes ahead and accepts a cultural interpretation of it (a so-called Third sign) (1984:21). By definition, however, this system or process of meaning-making is open, dynamic, and infinite on the basis of the phenomenon of the Third, or *interpretive*, sign. Daniel proceeds to claim that a culture may also exhibit a *mode* of representation, another Peircean idea, which may be *iconic*, *indexical*, or *symbolic*. I find this interesting because the cooptation of the field of mental health by biomedicine and allied industries may be seen as an example of an *indexical* mode at work, in that dysphoric states of any kind, some invented by the pharmaceutical industry itself, are “sold” to potential client/patients or consumers as “natural” or unambiguous indicators of disease.

Dysphoria

The favored Western distinctions between the body and the mind as well as nature and society dissolve as privileged accounts of reality through the kaleidoscope of the

anthropological data, which reveals that dysphoric states tend to conform to cultural constructions and expectations. Further, the very variety of illness expression and healing undermines the Western account of human physiology as purveyed to the rest of the world in the form of biomedicine (Gaines 1992).

Despite the checkered intellectual history of the so-called *culture-bound syndromes*, for example, “distinctive and consistent” patterns of distress appearing to be “closely related to a society’s distinctive understanding of self and its prescribed norms” are observed by anthropologists and others in societies around the world (Littlewood 2000:77). It seems that only paranoia (as in schizophrenia) is found everywhere in the form of its Western biomedical description. However, as Arthur Kleinman has made clear throughout his career as both anthropologist and psychiatrist, not only is much medical thought itself a cultural category but mental illness will never be adequately understood in biological terms alone; that is, although “physiological correlates” may be isolated “to justify the dominant paradigm of heterogeneous disorders with specific biological sources,” sociological factors “place individuals at higher risk” (1988:2). In other words, there is a “social contribution to vulnerability” which includes people’s *perceptions* of stress (Kleinman 1988:2).

Recognition of personal psychology as an intervening variable in cultural expression has been one of the discipline’s great humanistic contributions, and the collection and writing up of people’s *life histories* has influenced the practice of psychiatry as it has become clear that individuals are compelled to make sense of their “social and historical circumstances” (Skultans and Cox 2000:20). At the same time, such stories reveal, sometimes in painful detail, how distress is constituted. Perhaps the best work of its kind, Wilson’s *Oscar* shows how anyone’s identity, including whether or not they are mad, is always also a social construction and a dynamic of reciprocal recognition by which everyone is shaped (1974:138–140).

Western etiological theories about madness have been characterized by form-content dichotomies that emanate from the scientific method. Accordingly, “apparent wholes” are dissected into “presumed parts” and described on the basis of “an empiricist theory of linguistic realism” (Littlewood 2000:70). Applied to the phenomenon of psychosis, the terms *pathogenicity* and *pathoplasticity* came to delineate the positivist view of the relationship between culture and psychological disease, in which culture merely provides the plastic or malleable expression of the underlying “real” disease. However, this distinction was and has remained problematic because “distinguishing and characteristic, and thus biologically determining” symptoms are “notably elusive in psychiatry where anxiety, irritation, insomnia, anorexia, depression, self-doubt and suicidal preoccupations are common to virtually all identified illnesses, and which themselves shade into everyday experience” (Littlewood 2000:72).

Historically, anthropology attempted a different approach to the relationship between culture and madness on the basis of linguistics, in the form of so-called *etic* and *emic* perspectives. These adjectives derive from the terms “phonetic” and “phonemic,” which describe contiguous relationships of sound sequences and “relations of semantic or meaning similarity,” respectively (Skultans, et al. 2000:12). The etic approach was used to study supposed objective dimensions of social reality, while the emic was used for subjective dimensions. The latter became the more powerful within the discipline because of its ability to demonstrate the role of culture in the construction of individuals’ world view or “explanatory model (EM)” and facilitated the recognition of the dialectical nature of the relationship between individual minds and their social environments (Skultans and Cox 2000:13; see also Kleinman 1988:3).

Today, differences in theoretical approach between and among anthropologists and psychiatrists are more commonly described in terms of *rationality* versus *relativism*. Psychiatry, however, finds itself “having to engage in both camps, specifically those of

natural science as well as human subjectivity and intentionality,” and contributes to an intellectual stance that finds that science does not necessarily have the more “special” relationship to “truth” (Skultans, et al. 2000:13–14). No one can really overlook the influence of culture, given the “creatureliness” of human beings which can and must be shaped to meet the demands of social living; at the same time, it is obvious that individuals vary in their ability to control their own impulses, and that problems can result that appear to coalesce in disorders that “transcend particular cultures” (Skultans, et al. 2000:15–16). However, the most disabling psychological conditions tend to have a better prognosis in nonindustrialized societies, quite possibly due to less attached stigma when Western biomedicine has not been involved in its categorization (Hutchinson and Bhugra 2000:243).

The biomedical paradigm presently seems consumed with an emphasis on discovering “the genetic basis” of mental disorders, an agenda that not only attests to the continuing “supremacy of biomedicine,” but is largely backed by Western pharmaceutical commercial interests (Skultans, et al. 2000:27–28), and raises the perennial question of who stands to benefit from the knowledge as it is constructed. Clearly, there is a “politics of medicine” that involves a “struggle for control over information and resources,” as well as the status of particular medical models and their practitioners (Staiano 1986:xv-xvi).

A case in point, in terms of the “politics of medicine” and access to resources, is the construction of the diagnosis known as post-traumatic stress disorder (PTSD). Allan Young pieces together the history of traumatic memory which happens to include observations made by the anthropologist Rivers during World War I (1997:6-7). The form that this diagnosis now takes is intricately bound up with the evolution of the Diagnostic and Statistical Manual of Mental Disorders (DSM), specifically the third edition, published in 1980, which Young describes as

fundamentally different from the preceding volumes, both in its positivism and in its authority. The adoption of DSM-III was part of a sweeping transformation in psychiatric knowledge-making that had begun in the 1950s. . . . based on research technologies adopted from medicine (experimentation), epidemiology (biostatistics), and clinical psychology (psychometrics). In the course of these developments, the traumatic memory, up to this point a clinically marginal and heterogeneous phenomenon, was transformed into a standard and obligatory classification, post-traumatic stress disorder (1997:7).

However, PTSD came to qualify as a “‘service-connected’ disability” which has meant that military veterans could more readily gain access to medical and psychiatric treatment and financial reimbursement for their suffering (Young 1997:7).

The semiotics of the biomedical paradigm provide an even deeper look into its social construction. Whereas physiological and neurophysiological symptoms may be *indexical* in the Peircean sense, psychoanalytic signs seem to belong to a different order, given that they lack “fixed referents”; they are extraordinary in that their “communicational qualities” depend upon “the intentionality of the subject” (Staiano 1986, citing Baer 1975:37). However, biomedicine attempts to “ignore or minimize” the semiotic dimension of disease and seeks to describe all symptoms in a “non-arbitrary” relation to their signs, although, as Staiano points out, all illnesses may be regarded as psychosomatic in a way (which is to say *symbolic*), in that the psyche and the body continuously influence each other (1986:2, 14; 28; and Littlewood and Dein 2000:25).

Two more recent works of particular salience to this research project, integrating or touching on many of the ideas and approaches outlined above, are by T. M. Luhmann, and William Glasser, respectively. Although very different in style, these works compliment each other because Glasser, a psychiatrist of 40 years experience and the inventor of *reality therapy* and, more recently, of *choice theory*, makes many of the same

observations about the state of American psychiatry as Luhmann does, but as a true insider. However, whereas Luhmann leaves one with a feeling of deep compassion as well as hope for people suffering from mental and emotional problems, on the basis of the recognition of shared humanity, Glasser is resolutely solution-oriented and reveals the creativity of symptom-formation. Both see drug-management of mental health problems as a cultural strategy that involves powerful vested interests colliding with the reality of the *placebo* effect as well as the persistence and efficacy of the recognition of the dynamism of human psychological functioning.

The title itself of Luhmann's book alludes to the entrenched nature of two very different models of illness in the world of mental ill-health that subscribe to different ideals: on the one hand, "there is the scientist, the fearless investigator of truth"; on the other hand, "there is the psychoanalyst, the wise wizard of insight" (2000:158). Research science is the backbone of biomedicine, and, as Luhmann puts it, researchers in psychiatry are its "secular priests" (2000:159). The ideal according to science in biomedicine is knowledge in the form of the truth of the functioning of the body, including the human brain. At the same time, science is not a linear process, its truths are contingent, and, today, it is a business that constrains the leads scientists follow (Luhmann 2000:165, 166, 179).

Conversely, psychodynamic approaches, as they were embodied by psychoanalysts and continue in the form of much psychotherapy, are based on nonfalsifiable hypotheses including the role of intention in psychic life, is driven by the desire to understand the patient, and requires practitioners to *care* (Luhmann 2000:176, 182). The self of the psychotherapist is important from this perspective because of the assumption that healing proceeds from *relationship* (Luhmann 2000:185). The focus of therapist/patient interaction is the construction of meaning and the nature of the emotions involved, all intangibles until they are spoken or acted out (Luhmann 2000:189–191).

This process is not necessarily cost-effective in the short term and cannot guarantee results, but rests on ancient assumptions about the power of love and nurturing in human relationships to create happiness and well-being (Luhmann 2000:175, 200–202).

Whereas Luhmann clearly defines the philosophical issues underlying contradictions in the advances and delivery of mental health services, Glasser points to a way out of the conundrums that appeals to me on the basis of my own experience as a psychodynamic psychotherapist: much like Alfred Adler, he maintains that symptom-formation is a creative enterprise arising out of deep unhappiness about unmet basic human psychological needs, such as the *need to belong* (2003:94–95, 112–113). He argues that people need to take responsibility for their own emotional well-being and that everyone is naturally equipped to do so. His tone is not moralistic but optimistic, and he finds that to see the human condition only in terms of material realities of the brain and to infer that drug management is necessarily the best solution to problematic emotional and cognitive states can be to deny the power of human meaning-making and creativity which extends even to how physiology expresses itself (2003:103–107). Indeed, symptom-formation may protect society as the affected individuals come to terms with the sources of their unhappiness and find more constructive ways to get their needs met (Glasser 2003:123–124).

Glasser also describes major flaws in psychiatric science, such as the assumption that brain abnormalities precede dysphoric states; rather, brain chemistry changes continuously as behavior changes (2003:17). He argues that to conclude that the brain generates such states as depression and anxiety independently of human consciousness is “about as scientific as me taking your heart rate when you are calm and then pointing a gun at you, shooting a few bullets past your ears, taking your heart rate again, and then telling you that you have heart disease” (2003:17). From this perspective, the DSM is a compilation not of mental illness but of symptoms of deep unhappiness; rather than

attesting to brain disease, it lists creative and intentional attempts to rebalance disturbed interpersonal relationships (Glasser 2003:14–15, 26, 38). Glasser believes that the term mental illness should be reserved for “real” brain pathology such as “Alzheimer’s disease, Parkinson’s disease, epilepsy, brain tumors, or multiple sclerosis” although these too may involve unhappiness (Glasser 2003:14–15). Furthermore, research on brain drugs, as Glasser calls them, is mostly carried out by the same companies that produce the drugs, which obviously begs the question of the validity of the research findings (2003:19). Then, there is a real possibility of serious and lasting side-effects which include not only psychological addiction but permanent neurological disorder such as tardive dyskinesia, formerly attributed only to antipsychotics; it now appears that the very popular class of drugs known as selective serotonin reuptake inhibitors (SSRIs), “as exemplified by Prozac, Zoloft, Luvox, and Paxil,” can cause this disorder too (Glasser 2003:33).

The significance of human perception

In 1972 Kaplan and Manners wrote that “Man is preeminently a conceptualizing and symbolizing animal.” Today, it is increasingly being recognized that all human perceptions are mediated, down to the cellular level (Lipton 1997), and that the interpretation of events is carried out through the use of cultural materials, particularly language. However, based on the recognition of the Semiotic Principle or “irreducibility of the sign” (C. S. Peirce), anthropology has long been committed to a “fully intentional conception of meaning” (Goddard 1994:7), one that has effects in the world.

The mind-body problem resurrected, or, can psychological anthropology be a science?

Unlike anthropology, biomedicine in the United States has been characterized by a narrow focus that has concerned itself only with the strictly empirical. No symptom or perceived condition could be admitted as having medical salience unless it was measurable on the basis of natural science methods. This meant that the body alone has been its purview, and no phenomenon identified by a patient could have significance

unless it was “objective,” meaning perceivable by another, or quantifiable. It is for this reason that psychiatry, with its emphasis on mental illness, has always been regarded with a certain kind of ambivalence within the scientific community, and why it continues to be dominated by the search for physical causation in its understanding of mental illness (see also Whitaker 2002). So-called behavioral medicine, existing as a sort of institutional bridge between general medical practice and psychiatry, is a recent addition to biomedicine and focuses on behavior, at least nominally, because it is observable.

However, as Maretzki points out in his description of the innovative medical discoveries and treatments devised by the early twentieth-century German physician Georg Groddeck, “the restoration of health involves changes of states in human awareness and functioning,” and “this process defies a clear delineation” (1992:379). In other words, although there may be observable symptoms of illness or disease and different levels of functioning biologically, there is also always *awareness*, and there is no clear line to be drawn between these phenomena. Whereas “allopathic medicine implies a preference for the utilization of chemically synthesized pharmaceutical substances to act curatively on cell structures and organ systems . . . in order to achieve a reversal of detrimental processes,” so-called alternative methods “involve healing through assumptions or recognitions of events which cannot be explained by simple reductionism and are, therefore, often referred to as ‘natural’” (Maretzki 1992:379). A “challenge,” as Maretzki calls it, for allopathic physicians, is the “transposing” of certain illness complaints “from the reductionist model of the natural sciences to other levels” (1992:381). In the West, this entails dealing with “psychological processes,” which include “the abstraction and interpretation of symbolic constructs” (Maretzki 1992:381). Yet, “in historical traditions of the West or other cultures parallel illness phenomena were resolved through more integrated interpretations and treatments of equilibrium-based or ‘holistic’ medical practice” (Maretzki 1992:381). So, it could be said that the interpretive

structure of these medical traditions were broader; they incorporated a wider array of phenomena as pertaining to sickness and health and looked to the reestablishment of balance, however that was to be defined.

With these observations, Maretzki aptly designates what I perceive as the main problem that has pervaded biomedicine and threatens the effective treatment of mental and emotional balance in the United States: it is what he describes as the “bifurcation of body and mind in current or ‘modern’ thinking,” which then “leaves to the individual practitioner (as a conforming or nonconforming professional) the challenge of applying suitable interpretations that do justice at all levels of significance” (1992:381). Much ethnomedical analysis itself can be seen as arising out of the struggle to “conceptually integrate phenomena which appear together only through the language use of hyphenation or by other devices . . . employed to attempt to overcome the conceptual distinctions, which often yet remain (e.g., mind/body)” (Maretzki 1992:381).

What makes the work of Georg Groddek interesting is that he was “an example of a physician sensitive to the complexity of illnesses, complexities which cannot be resolved through reductionism” (Maretzki 1992:381). Instead of ignoring what today would largely be defined as psychiatric disorder along the lines of somatization, he took patient complaints as they presented them seriously and devised ways to alleviate their suffering which included older naturopathic methods such as the use of hot baths and massage. It is also interesting to note that Freud became intrigued by Groddeck’s approach because he seemed to be working in a conceptual gap within the emerging biomedicine of the time, positing dynamics or forces “linking mind and body” which he called the *Es* or *It* (Maretzki 1992:388). This is the term that Freud later “adopted” and called the *Id* (Maretzki 1992:388).

Groddeck believed that “psychological treatment is not only required with nervous patients, it is the beginning of all medical treatment” (Maretzki 1992:388). Furthermore,

“the *Es* was the object of the physician’s medical work and of pursuit of knowledge about illnesses; it was vegetative and psychic existence” (Maretzki 1992:388–389). I find these propositions particularly intriguing because it would make psychiatry and mental health practice of primary importance in the alleviation of suffering, rather than dispensable in the face of psychotropic medication. Indeed, if Groddeck turns out to be correct in his assessment of the significance of the state of one’s awareness to one’s overall health, then present biomedical practice could come to be seen as inverted: the body’s state is largely a reflection of the person’s mental and emotional state, not the other way around. Put another way, the state of an individual’s awareness and physiological expression could more readily be acknowledged as the source of the feedback loops that constitute disease. And the “split” between mind and body, then, would be revealed as a cultural illusion, which Groddeck came to see (Maretzki 1992:388–389).

Psychosomatic medicine began to emerge during Groddeck’s time as the significance of Freud’s discoveries became more well-known, and has continued to exist. But it has never gained the status or appeal of other branches of biomedicine. Maretzki explains this in the following way: “The question of empiricism against systematic knowledge and specialization becomes significant for medicine because systematization occurs within a relatively narrow natural science paradigm, poorly equipped to handle psychosomatic illnesses” (1992:390). As I go on to elaborate subsequently, science has been constrained by philosophical prejudices which have significantly affected the ability of biomedicine to address much of the true suffering of human beings.

However, for psychodynamic psychotherapists and students of human nature, the most interesting scientific development of recent times may well be the discovery of the neuroplasticity of the brain, made possible by brain imaging technology. Ordinary encounters with volition and desire, either taken for granted or in some quarters dismissed as illusory, turn out to exhibit remarkable properties, such as the ability to effect

structural changes within the brain. As a result, interest in the nature of human consciousness and thought has revived, and there is a return to philosophical debate about the materialist perspective on reality.

An interesting proponent of a renewed view of human subjectivity - one which takes it seriously, by which I mean as an aspect of the ground of being - is Slavoj Žižek, a Slovenian philosopher. As Adrian Johnston describes Žižek's work (2008), "a thesis making possible the articulation of what could be called a transcendental materialist theory of subjectivity, is that the choice between either a disembodied subject or an embodied self is a false dilemma" (2008:xxiii-xxiv). This proposition is highly relevant to the practice of psychotherapy given its cultural context of the supposed *psyche/soma* split. Through a unique synthesis of German idealist philosophy and Lacanian psychoanalytic metapsychology, Žižek makes it possible to respect human subjectivity scientifically by suggesting that this transcendental subject, meaning the human sense of self, "is genetic as formed over time through an ensemble of mechanisms and processes" (Johnston 2008:xxiv-xxv). These "mechanisms and processes" include biology, historical situation, and "socio-psychical variables" which, according to Žižek, make it possible for subjectivity "briefly to flash into existence at those moments when the disharmonious conflicts between these multiple-speed temporal tracks become audible" (Johnston 2008:xxvi). Žižek's perspective, then, although comparable to the work of other emergentists (who see mind as an emergent property of the brain) is highly complex, and, given his inclusion of sociological conditions in the formation of subjectivity, of use to anthropologists.

Žižek's view of the subjective dimension of human nature seems to imply that it is itself a process; when all is "stripped away," there remains nothing to be found but a "void, absence, or 'empty spot'" (Johnston 2008:9). Indeed, he believes that it is nothing more than "the permanent tension between the phenomenal, experientially constituted ego

and the quasinoumenal, unrepresentable *manque-à-être* (lack of being) in relation to which every determinate identity-construct is a defensive, fantasmatic response” (Johnston 2008:9). However, recognizing that once subjectivity has arisen it cannot be reduced again to the material base from which it emerges, not unlike other organic developmental processes, makes his theory more defensible against the charge of idealism, anathema to the materialism that has dominated modern science and psychology (Johnston 2008:275). At the same time, Žižek has been known to admit that ultimately his interest does lie in “reactualiz[ing] the legacy of German idealism,” and that psychoanalysis is simply a tool for doing so (Johnston 2008:126). As I shall elaborate, this is where his work intersects with my own interests, given that I contend that consciousness, which can be taken as subjectivity, ought to be naturalized, by which I mean given a place epistemologically in our concepts about the natural world, even in its materiality but not necessarily solely on the basis of it.

As Adrian Johnston also points out, a transcendental materialist theory of the subject can indeed be usefully included in more scientific discussions about the brain and consciousness (2008:275). In this context, I see Žižek’s work as an elaboration on the nature of subjectivity as it is revealed by the perspective known as *dual-aspect monism*. Mark Solms and Oliver Turnbull demonstrate how the objective self in the form of a human body, as the material ground of being, can be viewed as the outside of a phenomenon in the world that also has an inside: the subjective self (2002). From a philosophy of science point of view, then, the world continues to exist as one kind of thing, referred to as a *monist* perspective (as opposed to a *dualist* perspective) - in this case, matter - but it is capable of exhibiting awareness. Self-awareness, then, is merely the view from inside matter, and matter is seen as having two aspects, hence *dual-aspect monism*. How matter could be capable of generating an inside view still cannot be explained, which Žižek also admits (Johnston 2008:279), but dual-aspect monists believe that it does.

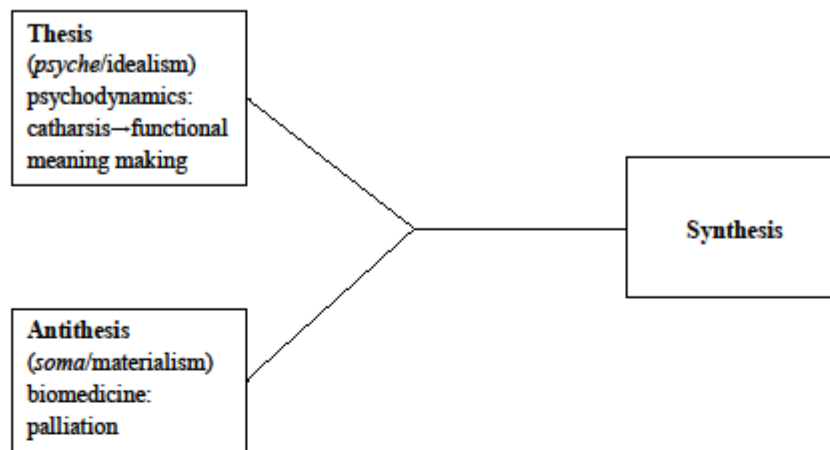
Solms is trained in both neuroscience and psychoanalysis, making it possible to see his work as a kind of bridge between the different forms of science. He believes that in fact a synthesis “draws closer and closer” (2002:ix), one which will continue to produce “an explosion of new insights into the natural laws that govern our inner life” (2002:x). Solms and Turnbull refer to their enterprise as the interdiscipline of *neuro-psychoanalysis* and their hope is that it can become “a new intellectual framework for psychiatry in the twenty-first century” (2002:xv). In order for this to happen, however, psychoanalysts would have to become much more willing to engage in wrestling with the *mind-body problem*, or, as it is now known, *the problem of consciousness* (Solms and Turnbull 2002:45–46). Again, specifically, at issue is how consciousness is able “to emerge from the brain” (Solms and Turnbull 2002:46).

This problem may be divided into the “hard” and the “easy” problem, according to David Chalmers, an Australian philosopher devoted to this question (Solms and Turnbull 2002:47), whose work I also note. The easier problem can be seen as understanding “the specific neural processes that are the correlates of our conscious awareness” (Solms and Turnbull 2002:47), the bulk of the neuroscience findings of the last couple of decades. They have, however, not brought anyone substantially closer to understanding the “hard” problem which John Searle, for example, defines in the following way, “How does the brain get over the hump from electro-chemistry to feeling?” (Solms and Turnbull 2002:50). I am suggesting that the way in which scientific inquiry itself has been constituted, through the use of, for example, the “closure principle” - one of the metaphysical principles of materialism - has limited our ability to successfully answer this question (see also Wallace 2000:25). Nonetheless, given the technological advances in the field, Solms and Turnbull believe that it may be possible soon to address the “hard” problem experimentally (2002:50), with the result that “in the long term, a comprehensive neuroscience of subjective experience will be developed” (2002:314).

METHOD

Given my interest in the extent to which the biomedical model of healing has permeated the mental health field and how affiliated practitioners negotiate their way within and through it, I framed my inquiry in the following way, shown by the Hegelian figure below:

Figure 1



The meta question

How do practitioners make sense of the philosophical and cultural contradictions, some of which I believe can be argued to be regressive, in a climate of practice increasingly dominated by biomedical strategies and thinking? Whereas Luhmann (2000) delineates the philosophical contradictions at issue, I investigated how practitioners navigate between them and come to workable solutions. As a practicing psychotherapist, I have my own thoughts about this and my own approaches to help-

seeking individuals, forged on the basis of both training and experience, but I observed that other practitioners do not negotiate or resolve these issues in the same ways.

However, I discovered that there are patterns to the resolutions or syntheses, based to some extent on the *status and role* of the person negotiating this particular field of practice or social institution; but one of the patterns stood out in terms of its radical departure from the status quo, and it may represent a viable and alternative future.

The biomedical model in mental health services organization

The biomedical model of healing is based on linear models of causality, insists on positivist methodology as the standard for acceptable research and commendable findings, and is reductionist in outlook. It tends to reject the admittedly often tautological findings of social science as nonscientific despite the demonstrated relevance of cybernetic perspectives on behavior. So-called behavioral science is marginally acceptable, so long as linear causality in relation to physical health can be established. Advances in neuroscience are making inroads into these long-standing cultural and philosophical divisions between *psyche* and *soma*, but disease as a body or brain phenomenon is also economically important. It is fair to say that so long as acceptable science cannot explain how thought or *intention* functions (see Anscombe 1957:51–53) to influence bodily states, *psyche* and its dynamism must or will retain the status of “folk psychology.”

The mental health field is organized hierarchically in terms of a so-called “clinical” continuum, with psychiatrists at the top in terms of authority, influence, recognition, and status (see Rhodes 1992; and Luhrman 2000). The modern psychiatrist, who is also a medical doctor, functions largely in the capacity of drug management for psychological distress. All other workers in the field tend to defer to the psychiatrist, despite the fact that in general he or she spends the least amount of time with the client/patient. The status of the psychiatrist seems to derive largely from a culturally

driven perspective that accords outstanding reverence to scientific knowledge of the human body (Foucault 1973:146). Within a community mental health agency, a psychiatrist may also be attended by psychiatric nurses, who may spend a little more time with patients. Next in the hierarchy are the psychologists, who view themselves as grounded in a scientific perspective of mental conditions, meaning that they tend to espouse, or at least pay lip service to, positivist explanations of brain function. If they have a doctorate in the field of psychology, so much the better for them in terms of status. Then there are the psychotherapists, who like to claim parity with psychologists but depending on the nature of their licensing may or may not have the authority to administer certain types of tests, regarded as a mark of scientific competence. The general function of psychologists and psychotherapists is to establish a relationship of rapport with client/patients in order to facilitate the reorganization of distressing thoughts and behaviors on the basis of communication. Traditionally, this is known as engaging in “the talking cure” (Hedges 1987:39).

Social workers at various levels of training comprise the next level of the hierarchy, although there is also a so-called clinical social work degree that permits the same status and function as psychologist or psychotherapist. People with a social work degree can find work as “case managers” within the mental health field, and can advance to managerial positions within such organizations as community mental health centers or hospitals. Usually, the function of case managers is to assist a client/patient directly with the organization of his or her life, including seeing to it that appointments are kept and that drug protocols are adhered to.

Finally, there are the occupational therapists, who often literally occupy the basements of the buildings in which mental health services are housed. They tend to have the least education, receive the lowest pay within the system, and are involved with the most seriously ill people. Yet, together with case managers, they tend to spend the most

time with client/patients, and it can be argued that of all the workers they come to know them the most thoroughly. Occupational therapists teach life skills and constructive spare-time pursuits, as well as sometimes being required to make home visits and assist a client/patient personally with chores.

Well-managed community mental health facilities conduct regular case management meetings to which all workers involved in a particular client/patient “case” are invited. Although everyone is typically welcome and even expected to contribute, the workers defer to each other on the basis of their perception of each other’s role and status within the organization. Biomedical knowledge is regarded as the final authority when a treatment decision needs to be made, and all other types of services tend to be regarded as peripheral. In a curious twist, case managers and the occupational therapists, who often also have case-management type duties, are made to feel somewhat responsible for a client/patient’s adherence to the medication protocols, and thus bring the biomedical influence within the system full-circle.

There is a wild card in the management of mental health now, comprised of general medical practitioners, who have come to be an important and, from the point of view of some in the mental health field, unregulated, source for prescriptions for some of the most potent mood managing medications that presently exist. Moreover, there is in general no ritualized or standardized expectation for mutual cooperation in the management of client/patients who happen to be seeing both a psychologist or psychotherapist and a general medical practitioner in relation to mood issues such as depression or anxiety.

In a world all its own is chemical dependency treatment, which deserves its own study in terms of philosophical, scientific, and cultural issues often at odds with each other (see Erchak 1992). The larger field of mental health treatment tends to regard client/patients as not amenable to psychological treatment if they are actively addicted to

illegal as well as to some legal drugs. Ironically, the move towards what I perceive to be increasing reliance upon prescription drugs to manage psychological distress seems to be at philosophical odds with the ideal of living a drug-free life.

From my perspective as a practicing psychotherapist who has also worked in community mental health centers, including in one as a case and “day treatment” manager for a period of half a year, the status of the psychologist or psychotherapist is the most ambiguous within the mental health field, because of the increasing dominance of the psychotropic management of mental and emotional distress. This approach seems to bring with it the assumption that ultimately the chemical state of the brain alone is what determines wellness. Yet, it seems to represent a worst-case scenario of linear and reductionist thinking, even a regression, when, from a social psychology point of view - instantiated in the diagnostic procedures of the DSM itself - it is quite well understood that individual and collective well-being is multivariate and includes social environment, perception, and attitude in highly significant ways, at many levels of analysis. There is even reason to believe that environment acts in triggering if not causal ways. I believe, therefore, that this assumption is ripe for research from a *cultural* point of view, since it differs radically from long-standing ideas within the culture about responsibility for emotional well-being as well as new findings about the force-like nature of mind. To that end, then, it seemed useful to engage in a series of interviews with numerous representatives of every level of the mental health service delivery system, including general medical practitioners.

Research design: Anthropology by appointment

Specifically, I carried out twenty-seven major interviews with mental health workers and general medical practitioners, usually on site and at their convenience. Of this number, two people warranted interviewing further, in a second round, for the purpose of my obtaining greater depth and clarity of insight into the issues. One of these

individuals is a medical clinic executive director and the other is a licensed psychologist. I found research subjects through word of mouth, on the basis of my existing professional contacts. However, several of the interviewees were recommended to me by my research subjects. I did not exclude any mental health practitioner who expressed an interest in being a part of the project, which is to say that I was not consciously seeking practitioners with a particular bias. Apart from demographic information, structured aspects of this project included a request for a verbally given official job description, as well as years of service. The latter information helped to provide some historical context. As a general medical practitioner had informed me before I began this project, I could expect to find generational differences of opinion, which did turn out to be somewhat the case but not significantly. Then, I also asked about the day-to-day realities of the work setting, and whether it is different than expectations developed during the years of academic training. In my own work as a psychotherapist, I had discovered, for example, that accepting clients who carry low-income medical insurance means maintaining a case load of clients whose distress is often intricately interconnected with issues related to poverty. Graduate training in psychology did not directly prepare me for this, yet it has opened my eyes to how social environment can be conducive to the production of mental and emotional distress. Perhaps more significantly, it has meant occasionally being more open to short-term management of problems, including referral for drug prescription, than training would have indicated.

The major focus of the interviews was on perceived *causality* as well as *efficacy*, which is to say that I asked questions in relation to what the practitioner believed is “really” causal in client/patients’ distress symptoms, as well as what his or her experience and training indicated as effective in alleviating symptoms. Questioning of a philosophical nature such as this involves some level of rapport having been established between an interviewer and the interviewee, given that institutionalized fields of expertise

are replete with their own forms of “political correctness,” and I did find myself at times in situations where the interviewee edged into defensiveness. A current example of such correctness in the delivery of mental health services includes the requirement to write up so-called “functional impairments” in strictly behavioral terms; in other words, a client’s perceived distress does not necessarily count towards “impairment.” This runs directly counter to symptom lists for many diagnostic categories, including mood disorders and several so-called personality disorders which are, in turn, largely not physically definable but cause real distress to afflicted persons within our culture. Third-party payers (i.e. health insurance companies), however, may refuse to reimburse a practitioner unless “distress” can be defined in observable terms.

Interestingly, although practitioners are compelled to develop workable models of practice in their minds in order to function professionally, it is my experience that client/patients will sometimes voice frustration concerning the points of view to which they are exposed in their treatment at the hands of multiple practitioners. Whose point of view counts? Whose point of view is more representative of “reality”? Is it that of the psychiatrist or general medical practitioner, who offers only drugs as an intervention, or is it that of the psychologist or psychotherapist who does not necessarily readily endorse drug management for “faulty cognition”? It does appear that there are practitioners who manage to walk the middle of the road, suggesting or condoning drug management as a short-term strategy, but this still frustrates some client/patients who are tempted to believe that they are being manipulated. And if a pill can “fix the problem,” as they will sometimes say, what is really the point of talk therapy?

Design rationale

My rationale for this methodological approach can be described as “postpositivistic empiricism in keeping with a contextual view of knowledge” (Cottone 1989:225). (See also Jacobs, Kissil, Scott, et al. 2010.) Implicit within this approach is

the recognition that conclusions are “tentative in a dynamic system of thought and ideas” (Cottone 1989:232), which is another way to describe the open-ended nature of signification or the reality of *semiosis* in human affairs, including in the production of knowledge. Furthermore, rather than *meaning* having been regarded as a confounding subjective variable, interviewees’ interpretations were central to the project, on the basis of a replicable method.

Questions

My goal was to find answers to the following questions, which gave rise to a protocol to which I adhered consistently (see appendix):

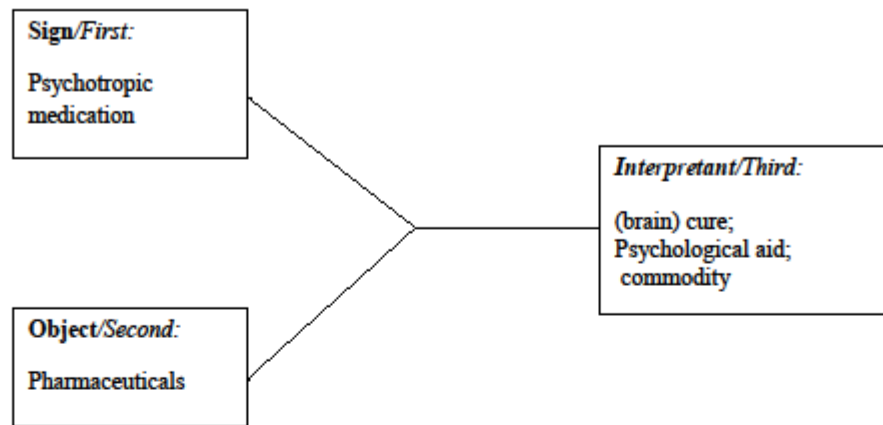
1. What, in your opinion, is the cause of your client/patients’ problems?
2. What, in your opinion, works to alleviate the suffering or the difficulties of your client/patients? How do you define success in your work with client/patients?
4. Which theoretical or philosophical parts of your training have you retained? Why?
5. Which theoretical or philosophical parts of your training have you let go? Why?
6. What is your opinion of psychotropic medication?

After completing the bulk of the interviews, which I conducted over the course of approximately eighteen months, I used a Peircean semiotic approach to analyze the responses, concentrating on *modes*.

Analytical application

Using the example of psychotropic medication, the application of a Peircean analytic scheme can be modeled in the following way:

Figure 2



Interpretants can become new signs, in a system that proceeds coherently but non-deterministically and also potentially infinitely (Buchler 1940). Viewing signification in this manner can help to account for epistemological change or divergence over time as interpretations themselves are used as, or become, *firsts* or *seconds*. For example, a student helping himself to his roommate's Ritalin might constitute the chain of signification in relation to this pharmaceutical substance in the following way: sign/first = study/concentration aid; object/second = pharmaceutical; interpretant/third = academic success. Moreover, signs or firsts tend to be governed by *modes*, meaning tendencies towards certain types of interpretation, known as *iconic*, *indexical*, or *symbolic*. So, in the case of psychotropic medication, the mode of interpretation biomedically trained workers take may be described as *indexical*; that is, the interpretation will tend in the direction of the pharmaceutical substance as contiguous with something natural, such as a receptor site on a nerve cell.

Interviewing of mental health workers for this project, then, using Peircean semiotic analysis, did reveal the nature of the signification process as they tend to employ it, including dominant modes. I had suspected that it is the modes that are at issue in the philosophical conflicts within the field and as they affect client/patients and this can be seen as the case.

SUMMARY

Using a postpositivist empirical method with *meaning* as central, I conducted a series of interviews with mental health workers and other professionals involved with or impacted by mental health concerns. At issue was the extent to which the biomedical model of human functioning has coopted the mental health field especially as it affects the practice of psychotherapy. I believe that this question is important because of the disablement one can observe in patient/clients and others, as well as the philosophical dilemmas confronting practitioners, as a result of their collective exposure to the idea that people may be essentially powerless in the face of their own biology. This perception appears to contribute to the vested interests of the pharmaceutical and insurance industry but it flies in the face of developments in the fields of psychoneuroimmunology and neuroscience which validate a force-like dimension of mind or focus and intention, and which stand to free people from dominance by external agents including psychotropic medication.

THE HEART AND SOUL OF THE MATTER

“The foundation is the soul, Judas.”

“The foundation is the body - that’s where you’ve got to begin. Watch out, son of Mary.”

(Kazantzakis 1998:204)

INTRODUCTION

Does matter have a soul? Not that I asked this question directly. I was interested in how practitioners perceive the relationship between the mind and disease and was hoping that this configuration of one of the oldest questions in the world would elicit modern insight. After all, since mental health practitioners purportedly deal with the mind, especially when it is distressed, I assumed that they must have working models of what it is they are dealing with, including definitions of illness or disease. But the general medical practitioner sitting in front of me was at great pains to explain to me what the mind might be; even though he is also a professor of medicine, he indicated that he was not accustomed to the type of questions I was asking. He took his time exquisitely, asking me to go ahead and give my own definition first; I felt he was buying time.

With impeccable logic, however, he slowly began to piece together how since much of the mind seems to be found in the brain where it uses resident structures, and since the brain is part of the body, none of the phenomena associated with disease can ultimately be separated from the mind. In other words, he said, of course there is a relationship between the mind and disease. Indeed, he ceded that the mind may sometimes even be “etiologically related to the disease, as in causative.” In a nice turn of phrase, he concluded that the mind is “nested” in the brain, and from that perspective also is the brain and the body.

He went on to delineate the impact of perceived stress on the body, as endocrine and neurophysiological structures and processes throughout the brain and body are triggered over and over again, implicitly describing an impact of mind on matter that

notably includes the neurotransmitters implicated in those most common of ailments general medical practitioners are asked or feel compelled to treat today: anxiety and depression. In a different interview, the executive director of an upscale medical practice in the Twin Cities estimated that seventy-five percent of the patients in her practice are given medication prescriptions for those conditions alone, a finding that has been confirmed as common by one of the biggest medical insurers in the United States, Kaiser Permanente.

As I asked this same pivotal question over and over again, the answers began to fall into patterns that seemed to be related largely to the nature of the training the practitioner had undergone, but also to their often long-term experience as practitioners associated with mental health. Although my conversation with the medical school professor stands out in terms of his conscious desire to avoid the reductionism in which the body and the mind are conflated categorically, a known side-effect of standard medical education, and whose intellectual commitment to the reality of consciousness also has him practice elements of psychotherapy with his patients, most of the practitioners acknowledged at least a reciprocal influence between the mind and the body. What is significant here, however, is that “disease” was generally equated with the body; in other words, despite my question as to the relationship simply between mind and disease, the interviewees generally went ahead and equated disease with an embodied condition, thus more or less unconsciously falling into the Western cultural distinction between *psyche* and *soma*. Practitioners’ answers, then, revealed a cultural intellectual prejudice which despite the advances in mind-body medicine is alive and well.

PRACTICING UNDER THE INFLUENCE

How does this question relate to the practice of psychology? In a follow-up question, I asked practitioners what the term “mental illness” meant to them. When the answers to both questions are correlated in a semiotic frame, patterns emerge that can

help to elucidate both the treatment consequences for client/patients as well as the style of psychological practice by the practitioners. What follows are descriptions of the data in aggregates that happen to break out roughly into quarters of the body of interviews. At the same time, it is important to point out that in true kaleidoscopic fashion some of the subjects' responses could be categorized in more than one way; this affects approximately a quarter of the responses given by practitioners who also happen to work in the most highly medicalized settings. It seems to me that this finding reflects contradictions inherent in their work environments that have their own implications.

Disease as largely of the body

Eight of the twenty-seven respondents interpreted the sign “disease” as properly applying largely to the physical body, although practitioners in general tended to be quick to point out that there was probably a reciprocal influence between the mind and the body. Keeping in mind that in the chain of signification a so-called Third or interpretant can also become a new sign or First in what is essentially a potentially infinite meaning-making process from a Peircean semiotic perspective, the sign “disease” was arrived at conceptually in two ways: either on the basis of the body as the First, and the symptom as the object or Second; or the mind as the so-called First, and the body as the object or Second. In the former case, “symptom” (their term) or “disease” was simply implicitly conflated with the body with the explanation that mind itself cannot really be separated from the body. Either way, the overall impression given by these responses could be described as exhibiting a form of holism in most cases, but they rest on a fundamentally dualistic perception of human nature as consisting of *psyche* and *soma*.

Signification can also exhibit *mode*, which is to say that the meaning-making may tend towards certain types of interpretation, known as *iconic*, *indexical*, or *symbolic*. In the case of “disease as largely of the body,” the interpretive process as revealed by the respondents could be said to be governed by an *indexical* mode, meaning that they

assumed that the sign “disease” is contiguous or intrinsically to be associated with something natural, in this case the human body.

Demonstrating the first kind of chain of signification, practitioners gave such graphic responses as the following: “I don’t separate the mind from the physical body” because it is “one big ball of clay or bag of skin which includes everything,” explained to me by a licensed clinical social worker. A nurse practitioner said, “although bacterial and other pathogens may be involved, the strength of the immune system counts, and this is impacted by *attitude* [sic]”; and a licensed psychologist put it this way, “to help with physical disorder, pay attention to mental and vice versa.” And a professor emeritus, who had also been a consulting psychologist specializing in educational psychology for close to fifty years, said, “it’s an artificial kind of parceling out to say that the function of a human being can be divided into those that are physiological medical conditions and those that are related to the mind.”

Examples of the second kind of signification chain include these: that the relationship between the mind and disease is “limited” and certainly “not linear,” given that “people of perfectly sound mind and body can get cancer,” stated by a licensed psychologist highly trained in behaviorism; or, that, conversely, although the relationship is “a strong one,” subjective states are not real; indeed, they are “nonsense.” This latter, highly conflicted perspective was espoused by a multiply licensed practitioner who also directs several mental health clinics in a major city and refers to his employees and practice almost exclusively in the medicalized terms of “behavioral health.”

What did the term “mental illness” mean to these practitioners? Essentially, they believed that it has no meaning in any intrinsic sense; that to the degree that it exists, it is comprised of sociological *myth* governed by convention in its application. This was borne out in such comments as since everyone, according to a social worker, “can be found,” so-to-speak, in the DSM (the diagnostic source book for mental health

practitioners), the term can't have much meaning; that it essentially pathologizes widespread and therefore ordinary human behaviors and perspectives. As a behavioral psychologist put it, "when I think about using, say, the DSM for diagnosing, by rights everything in there really is mental illness." However, she and several other practitioners expressed dismay at essentially having to label as "ill" what they claim should more accurately be described as "problems of living." As such, one practitioner flatly declared that "most referrals to psychiatrists are nonsense." Along the same lines, a very long-term practitioner, now retired, said that in his opinion everyone actually has "demons" that could "overwhelm" them. And one very efficient and affable psychologist who has also taken on a management role in the practice where she is employed put it more pragmatically: "Unfortunately, most of the time it means whatever the DSM says so I can write it on a piece of paper and submit it as a claim," since "if you cannot diagnose, you cannot get reimbursed." Another response in this category was that "mental illness" simply denotes an "inability to cope"; that, in other words, the diagnostic system is really just trying to characterize behavior rather than disease or illness. As I shall describe below, the perspectives taken in relation to "mental illness" have rather specific treatment and perceived success attribution consequences for client/patients, which are not necessarily predictable on the basis of licensing.

Disease as applicable to mind

Seven of the twenty-seven practitioners readily took the sign "disease" to be applicable to mind. They arrived at this conclusion by designating the symptom (their term) or behavior as the object or Second, and "disordered" thought or mood as First; in other words, thought itself could be unwell, and this was inferred from both physical symptoms and/or behavior (which from this perspective included the spoken word or self-report). Again, there was an acknowledgement of a relationship between these phenomena (between First and Second), but they were still held to be distinct, indicating

that the *psyche/soma* distinction was also in evidence. In general, there was an accent upon the phenomenon of mind in this aggregate, which set these data apart.

The mode of interpretation tended largely in the direction of *indexicality*; again, this means that practitioners assumed that when or if the sign “disease” applies to mind, and they believed that it could, then it probably also has a somatic underpinning. At the same time, a *symbolic* mode of interpretation is also in evidence here, as practitioners use the conventional terminology and form of explanation of psychological thinking to describe the suffering of mental health client/patients.

This structure of signification shows itself in the following examples: that thought or mood disorder is related to “organicity” (this from a retired psychiatric nurse); that the “inability to cope” or, on the other hand, “positive thinking,” seems to correlate with conditions such as diabetes, possibly explainable on the basis of how bioamines are shared between the immune, endocrine, and nervous systems (nurse practitioner); and that “your thinking has a huge influence on your physical health not only directly in terms of the distress response but also more indirectly, like hope [sic],” as stated by a cognitive behavioral and forensic specialist. A behaviorist said, “disease itself can affect the mind, but how one looks at the problem they face also affects outcome of disease”; and a newly minted psychiatrist who also holds a doctor of philosophy degree in neuroscience explained that the relationship question, from his perspective, should be between mind and “symptom,” because to talk about “disease” is to make it “primary.” He proceeded to explain that “symptoms are a consequence of how a mind is out of synchronization,” and that although mind and disease are “intimately related,” how they are related is “tricky.” “We have two theories we haven’t reconciled,” he said, although it is quite clear that in any case the body functions “chemically and electrically.” He was explicit in his belief that mind is not simply an emergent feature of the brain, because “you’d have to deny experience.”

Mental illness, then, he went on to say, is “a distortion in mental function.” How did the other practitioners in this set see it? Examples include thought or mood “disorder,” “ability to cope gone awry,” “behavioral, emotional, cognitive dysfunction beyond what you would expect for one’s situation,” and “strange ideas.” To these practitioners, then, mental illness is a real phenomenon, whether or not it can be accounted for theoretically. It is interesting to note, however, that implicit within their definitions is the assumption that *something does the thinking*, and that thinking is amenable to change. At the same time, most of these practitioners alluded to the idea that there is a social context to thought and mood which can be helpful to practitioners in determining whether or not the label “disordered” is justifiable. A cognitive behaviorist in this set expressed it this way: “Somebody comes in with visions, I’m not automatically going to assume, oh, mental illness; depends on the context of the vision, that sort of thing.” And another behaviorist said mental illness can be thought of as a way of “operating” that is “a problem to society.”

Disease as unease

Eight of the twenty-seven practitioners could be described as holding a view of the human condition that is holistic in a very broad sense, one which I believe has interesting and unusual theoretical implications. Whereas the term “holism” carries a dictionary definition of “tendency in nature to form wholes that are more than the sum of the parts by creative evolution” (Fowler 1965:581), these practitioners tended to refer to what I would like to describe as an *energetic* dimension of human being that lies largely outside of present scientific terminology, namely *spirit* (their term), or what I think could more usefully be named and incorporated theoretically as *consciousness*. These practitioners also see themselves as practicing somewhat outside of the professional mainstream, but they believe that their perspective is the wave of the future, and that it is implicit in advances in mind-body medicine. Leaving aside for now the broader

theoretical implications I perceive in this perspective, the meaning-making strategy employed by these practitioners took the following form: generally, they were aware of the conventional *psyche/soma* split but were loathe to engage in it; that is, they saw human nature as integrated at a level perhaps beyond any dualisms. This revealed itself in the form of what could be described as an accent on *being*, in which the idea of symptom (their word) could apply to either the object or Second, or to the First. When “symptom” was used as First, it included a reference to “spirit” in conjunction with mind. So, there was still a nod in the direction of the idea of mind and body as distinct entities, but they tended to be adamant that such splits are indeed mere convention. They saw the Third, or new sign “disease,” then, as more accurately a description of, as they put it, “unease,” or “dis-ease.”

The mode of interpretation for this aggregate can be described as largely *symbolic*, meaning governed by convention; however, in this case, it is the convention of what has traditionally been defined as religion, but which practitioners glossed more in terms of awareness of a larger picture of being. As I will explain further below, these practitioners seem to be tuning in to a growing awareness in healing professions of the role that consciousness plays in the human condition.

Here are some outstanding examples of how they saw the relationship between mind and disease: “that body, mind, and spirit work together. So if people are mentally or emotionally distressed - experiencing unease or disease - it means that things may show up in the body or sometimes it does show up in the body. And I think that that can work the other way, too, that people can have a physical illness that impacts their emotions. . . . I don’t think that the two or three, if we include spirit - I don’t think that they can be compartmentalized” (contributed by a psychologist who describes herself as a holistic practitioner with a particular interest in mind-body medicine); “disease . . . becomes ‘dis-ease’ . . . disease is being out of balance. . . . my entire therapeutic role is to

teach people how to find their own balance, and then the disease disappears” (by a psychologist who is a yoga and meditation practitioner); and that there is “a tremendous connection between the mind/body/spirit,” such “that if you don’t believe that things are going to get better, they’re not.” This particular practitioner, a psychologist who may be described as eclectic in her approach, went on to explain that “I think that we do have the power to some degree to heal through the connection to mind and the body, and what we tell ourselves, and how we behave,” which she feels amounts to “the ability that we have to change the chemical response.” And a psychologist who has dedicated her whole practice to the teaching of mindfulness-based approaches, said this: “mind and body are one entity. . . . What happened in the disease process is body and mind, thought and physiology. . . . mind is an amazing filter that either helps us to prevent disease or to heal when the body becomes ill.” Lastly, one of the nurse practitioners put it this way: “Any physical manifestation has within it the component of mind, which includes multiple concepts”; in her experience, “cognition affects the expression of the disease,” and she felt strongly that practitioners should be aware of the possible involvement of so-called “spiritual issues.”

How do these practitioners view mental illness? Generally, they believe that it exists but that it deserves a more inclusive or broader definition, as well as that it exhibits social dimensions. So, answers from this set include this very typical response: “serious and persistent illnesses that are rooted in like organic issues of the brain, or chemical issues like schizophrenia and bipolar illness personality disorders, too, I think it is an illness that has a biological base reinforced by the person’s environment, by the family environment, and the community at times.” The same psychologist who practices yoga and meditation elaborated on the same idea, saying, “there are people who are schizophrenic and psychotic, and if there was anything that would be a ‘mental illness’ to me, that would be it. . . . my understanding of the severity of those psychoses is that they

are organic in nature, and they haven't been able to figure that out yet. They haven't been able to solve that except by giving medications to subdue those uncontrolled impulses or functions of the brain that aren't being modified by the amygdala or whatever else is going on in there." However, in that expanded spirit of holism, he went on to point out that "most of us are delusional" in the sense that "we live in this delusion that life should be a certain way. . . . it's the world within that has to change, and that's the difficulty. The impaired delusion is that somehow we're going to change what's going on out here. . . . Everything is made up."

The mindfulness psychologist said that she hates the term "mental illness," and believes that it is "applied to people from whom we wish to segregate ourselves," perhaps because it is "a shadow side we don't want affecting us." She is particularly concerned about how the label makes client/patients "wince," and finds that it is still "not seen as an illness in the same category of illness as we would see diabetes or heart disease or cancer." She doesn't use the term; instead she simply denotes "the specific name," such as "anxiety disorder." And along similar lines, a nurse practitioner felt that the term is "antiquated" in view of the emerging field of mind-body medicine.

Behavioral health

Six of the twenty-seven practitioners took an approach to the question of the relationship between the mind and disease that can best be described as flattened out or fairly strictly referential, meaning, from the perspective of Peircean semiotics, that a tripartite form of analysis is more difficult to apply, not because it is not also in evidence, but because these practitioners, for both philosophical and economic reasons, want to or have been trained to play down or simply deny the existence of a phenomenon that most people experience as real but is also notoriously difficult to capture scientifically. This is the mind itself, especially as it manifests in the form of subjective experience. This is, of course, extremely ironic, given that most practitioners with this perspective can and do

still call themselves “psychologists.” As will become evident, however, this term may actually become passé, and never was accepted in a certain circle, depending upon the future of psychological practice in its relationship to medicine in our society.

Practitioners with this perspective are either directly associated with the practice of medicine or see themselves as an arm of medical practice. They describe their work as adhering to the goal of being “evidence-based,” and as such, phenomena they treat as well as any outcomes must be objectively measurable. Any states or conditions described by client/patients that do not conform at least to this empirical criterion are regarded as not “real.” This means that subjective states tend to be viewed as not real, and behavior is simply the outward manifestation of a brain state. Brain states are potentially measurable, and as such, they are regarded as having some reality. This reality is believed to be based on chemical and electrical properties of the material substrate of the brain. So the practitioners in this set tended to discount the notion of mind altogether, with the exception of those with some exposure to psychoneuroimmunology (PNI) who, however, must still conform to the practice of what is now called evidence-based medicine.

When asked about the relationship between the mind and disease, meaning-making by these practitioners tended to flatten out into disease as strictly of the body. The Third or new sign “disease” was derived directly from an object (Second), the body, which constitutes a referential form of meaning-making. It also of course did not conform to the underlying dualist notion of *psyche/soma*, especially in those practitioners who could be described as true believers of a strictly materialist perspective on human nature. This did not mean, however, that no First was ever in evidence. As one practitioner put it, there is indeed the “nonsense” with which psychiatrists are obligated to deal, and which, he claimed, largely occupies their time.

Far from merely being interesting semiotically, this pattern of signification has serious consequences for client/patients, as I shall elaborate on further below. Suffice it

to say for now that it has to do with a certain turn in medical practice governed by two extremely powerful vested interests, the insurance and pharmaceutical industries, in whose interest it is to discount the subjective side of human nature and experience. This dimension of being human happens to include an enfolded and powerful potential: that of self-healing.

The mode of interpretation, then, in what is also the field of behavioral health, can be described as strictly *indexical*, based as it is on a materialist philosophy that excludes any phenomena that cannot be apprehended in a scientific laboratory. All findings, when they are in evidence, are interpreted as natural, and therefore real, from this perspective.

A psychiatric nurse and licensed practical counselor who manages a mental health emergency response team had this to say in response to the question of the relationship between the mind and disease: “the mind is biological, and the regulation of the body affects the mind. . . . for example, nutritional problems can affect dopamine production,” which he said can be observed sometimes in the situation of people who have had gastric bypass surgery and who are having difficulty absorbing enough protein, a precursor of dopamine. The executive director of a medical practice who sits in on the board meetings which include discussions of clinical issues said that the relationship is “not a discussion . . . that doctors don’t want to deal with emotional issues”; it is her impression that doctors are “body technicians,” who generally do not feel competent to deal with mental health issues. And a psychiatrist declared that the term “disease” applies only to the body.

Mental illness, then, from a widespread current medical and medicalized perspective, becomes not a disease but dysfunctional behavior, a common response in this set, and, as the psychiatric nurse and counselor described it, anyone is only “a hair’s breadth away” from it, depending, for example, on your nutritional status. To the degree that it exists, it is an organic problem of the brain, as in “outer-edge” conditions such as

bipolar-polar disorder (clinic director); therefore, as a strict cognitive behavioral psychologist who defines himself as a behavioral health worker framed it, for a client/patient to say “‘yeah, I’m feeling better’ . . . to me that means nothing. I want to know what symptoms are better.” And symptoms have to be measurable in some way, he explained, as part of a method of practice that ought to reflect “an application of science.”

The human person

All this is not to say that these practitioners and several others with a more behaviorist orientation could, from my perspective, be described as lacking somehow in humanity; on the contrary, they often attested to the burden of having to deal with suffering in an environment with few perceived treatment options. As I shall elaborate below, their personal opinion of the human condition, as it expressed itself in other moments in their interview, was sometimes strikingly at odds with what they also admitted were institutional pressures to conform philosophically in their particular environments of practice.

However, when one looks at the Third or new sign “human/person,” to which a third of the practitioners alluded in the course of, for example, also describing how it is that people heal from mental disturbance, the *psyche/soma* distinction arises again, as well as a definition of being human that I believe carries particular significance: that of a *social* being. And this characterization, based on the data, can be applied both to these practitioners and to how they view their client/patients. Again, the process of signification tended to proceed in the following way, with the body and disease designated as the object or Second, and the mind, with its symptoms and role in behavior, as the sign or First. And the mode could be described as *symbolic*, given that this form of interpretation rests upon such nonempirical but conventional phenomena as moral sentiment, especially in the form of compassion.

A social worker who had trained extensively in Gestalt theory but who also takes a very pragmatic approach to the plight of her clients spoke of the importance to people of “feeling connected to another human being.” In a similar vein, a young psychiatrist spoke of the importance to people of interpersonal trust, which was echoed by a medical doctor who believes that the nature of medical practice lends itself to the creation of such trust if doctors are willing to practice in this way. And the clinic director talked about the pervasiveness of both anxiety and depression, which the doctors in her practice feel obligated to try to treat on humanitarian grounds alone, that is, apart from other practice concerns. And a committed behaviorist in private practice who is willing to retain chronically mentally ill clients on medical assistance in his case load despite the notoriously low rate of reimbursement for services affectionately describes them as “great people” whose presence he enjoys and who followed him after he resigned from a community mental health center. “In here,” he said, “you’re just who you are; the whole [diagnosis] thing is left outside as far as I’m concerned.”

But the now-retired practitioner who moved me the most in this regard spoke of his early years in educational psychology during the 1950s when he worked with children with “attenuated mental development,” in a climate of practice that he described as not having “changed much from a hundred years before.” Every state had hospital-like institutions for handicapped children, so that, he said, “if a child was born with some kind of stigmata that indicated that they were, you know, handicapped - if they were born with Down’s Syndrome - they’d be advised to send them to an institution, and I have memories - almost haunting memories - of these little children in these big pens, you know, of children, and it was a terrible time.” He said that today “it’s almost with embarrassment to think about what we thought, and the practices.”

The DSM

I never asked practitioners directly to discuss the meanings they assign to the diagnostic source book of so-called mental and emotional illness, but more that half of them voiced their opinions about it anyway. Given their job descriptions and their training, their attitudes toward the diagnostic standards would probably surprise people not associated with mental health professionally. Most commonly, they regarded it as a parsing of in many ways normal human behaviors and approaches to life that perhaps ought not to be pathologized in the medical sense. Generally, these respondents see this code as a necessary evil, so to speak, which permits them to make a living through reimbursement by third-party payers.

The chain of signification that seems to be in evidence in this practitioner attitude towards the DSM proceeds in the following way: the Third or new sign consists of human behavior as sickness - the DSM - arrived at on the basis of the human organism as the object or Second, and the acting agent or person as sign or First. The *psyche/soma* split exists fairly obviously in this configuration, and the respondents consider illness or disease of all kinds to be a normal part of being alive. They tended to seriously question the validity of this institutionalized view of human nature and described their work with the distinctions mostly as a professional requirement rather than on the basis of a commitment to its philosophical claims. The mode of interpretation here is clearly *symbolic*, since these practitioners see the use of the DSM as an example of a conventional practice in environments influenced by biomedicine which creates, sustains, and applies diagnostic heuristics.

A clinical social worker said, “from the DSM point of view, everyone is a whack job, and could be found in there.” A psychologist said, “it’s an artificial construct [representing] the current state of the art to describe stuff.” And another psychologist saw it as part of what she refers to as the “medical model,” which requires practitioners to

“really look at what is the diagnosis, document their symptoms, what is your treatment plan, and setting specific goals and objectives, and trying to measure people’s minds in that way.” She went on to describe how as this approach has taken over in mental health, driven by the insurance industry, “we became compartmentalized toward seeing people as parts, or as this illness or that illness.”

Sometimes there was a poignancy in practitioners’ comments showing personal struggle with having to label people with illness, as when a psychologist said, when I think about using the DSM for diagnosing, by rights everything in there really is mental illness. . . . But I’m reluctant to say - let’s say somebody comes in with some depression or something like that - ‘problems of living’ as we sometimes call it - to label that mental illness. Of course, the flip side is I’m billing for that, so I, you know, I guess I should be calling it mental illness.

And the psychologist who sees mental illness as a question of personal balance said that it is when imbalance becomes habitual in people’s lives that “they fit into those little DSM IV categories of depression, or anxiety, or stress, or OCD, and all that stuff, but that isn’t what I focus on when I’m talking to them. I just have to have that stuff for the insurance companies; makes people feel good though because they have a label on something.” And the retired educational psychologist and professor asks himself these days, “labels on human beings are convenient myths. . . . we’re not like that. And we used to make all kinds of predictions based on some kind of indices [sic] that now looking back you say it’s ridiculous. Why did we ever do those things?” He has concluded that, “it’s just not that simple. I’m through with . . . making absolute predictions based on some kind of measurement.”

A doctoral-level psychologist with over forty years of experience took an approach that was essentially beating the medical model at its own game when applied to the DSM, when he said,

when you read the literature nowadays, the scientific literature, they'll say all kinds of things are diseases somebody pointed out that this thing gets called disease all the time, mental health problems, but if you look at a medical definition, it has to have etiology, it has to have laboratory studies that confirm and validate the diagnosis, etcetera. . . . [Mental illness] was interchangeable with 'mental disorders.' But now since it's gone into medicalization, as you know, since it's become medicalized so much, then it gets mixed up with 'disease,' which is for most mental illnesses there's no laboratory study . . . that meets the criteria of a medical disease. So medicalization is . . . taking a medical model and applying it to personal problems which may be called mental or psychological disorders, and then forgetting that it's a model and start treating it as if it is real. So, it's actually only a model.

The multiply licensed psychologist and clinic director would agree with the foregoing psychologist on this point, when he says, "if you ask most people, are they depressed? Yes; have you ever sought treatment? Most will tell you, no. Why? They'll tell you the symptoms weren't severe enough. In other words, they had something without it impacting them; so is it an illness? I would tend to say no. It's part of the reality of being on the planet, on the north side of the grass versus the south side."

Then there is the issue of the context of people's lives and how they make meaning individually. The psychologist who is also a college instructor and forensic specialist is careful with diagnosis because "there are plenty of people who have their own unique way of coping, you know, so I think it transcends even the specific race or ethnicity or cultural kinds of things. It's their own little microculture that one has." The behavioral psychologist feels strongly that one has to look beyond "the clinical definition . . . the standard way of defining," because "if someone's doing really well from their

perspective, and society isn't having a problem with the way they're operating, then . . . to me that's not necessarily a mental illness at that point anymore. It may be a mental illness to me if it was me experiencing it, but if they're OK with the way their life is, OK, great!"

Treatment modalities and rationales

Given the divergent perspectives on human nature and mental illness by these practitioners, what is treatment at their hands like, and how do they justify their methods? Using the first four of the aggregates described above, the picture that emerges is one of specific exigencies of practice often in sharp contradiction to the practitioner's understanding of the client/patient's real need and how to meet it. Psychological practitioners' ability to move freely philosophically depends largely on the conditions of their employment; more specifically, unless they are self-employed, they must more or less at least nominally pay lip service to the one modality that is believed across the board to have good empirical backing in terms of treatment effectiveness: cognitive behaviorism. However, even self-employed practitioners must generally claim to be doing cognitive behaviorism if they want to be reimbursed by third-party payers, meaning medical insurance. Medical practitioners, on the other hand, are taught that the most effective method of treatment is medication, if not surgery, and the industry perspectives known as "best practices" and "evidence-based" medicine constrain them, and those practitioners who align with them, too.

Disease as largely of the body

Practitioners with the perspective of the sign "disease" as having to do more with the body tended to practice psychotherapy with an eye to what most of them defined as "problems of living." In other words, they seemed less preoccupied with definitions of mental illness and more concerned with the in-the-moment and on-the-ground needs of their client/patients as both presented themselves. Their treatment modalities run the

gamut; in other words, they do not in actuality confine themselves to what is known as the “gold standard” in behavioral health circles, according to one of my informants, namely, cognitive behaviorism. They use any or several modalities, often even with the same client/patient, if they judge this approach to be in the best interest of their client/patient. But treatment plans, which are often required by the insurance industry, must be written up in behavioral terms. This means that distress as a client/patient reports it, regardless of what kind, must be described in ways that could be observed. If one takes the example of anger, certainly it might express itself in the form of hitting or verbal assault (which, however, the psychologist would most likely at least initially hypothesize as a dimension of depression), but it also might not present visibly at all, and often does not, unless one works in, for example, violent offender treatment programs.

This can lead to highly artificial treatment narratives that often bear little resemblance to the felt inner worlds of suffering that clients/patients report. Another example would be the situation of a person suffering from dysthymia, a condition of chronic low-grade depression, which may not have outwardly discernible dimensions at all. The afflicted person goes about their daily duties but often struggles with an inner sense of the uselessness and meaninglessness of much of their lives. Or they may harbor a continual inner sense of anger or resentment that others are rarely able to detect. How, then, is the practitioner to write this up in behavioral terms?

This practice conundrum applies particularly in the case of the so-called personality disorders, treatment for which is largely not reimbursable with the exception of those which do indeed tend to involve rather obvious behaviors such as the self-destructive tendencies of borderline personality disorder or the delusional grandiosity or depression of narcissism. So, practitioners will often choose other diagnostic categories which are more reimbursable, but for which a reasonable case can also be made, such as dimensions of depression or anxiety in the case of the dependent personality, for example.

As to the accompanying narrative, psychotherapists will devise, often in collaboration with the client/patient, a list of desirable new behaviors, and then insert (or what I would describe as “back fill”) them as “pathologically missing” into the behavioral symptom list. These then become both treatment goals and outcome indicators.

So, from a semiotic perspective, the practitioners in this set can be described as practicing *symbolically* in an environment that often privileges an *indexical* approach, which is to say that the psychologists and medically associated practitioners in this set often intervene in their client/patients’ lives according to conventions that are clearly not contiguous with something in the natural world; on the contrary, such interventions and the philosophical approaches out of which they have arisen tend to be predicated on the recognition of the human capacity for awareness including of the self.

A clinical social worker who also happens have a master’s degree in divinity and who is self-employed, uses Gestalt treatment, which is known for its holism, as well as such spiritual techniques as sitting together with her clients in silence and meditation. She is also willing to self-disclose in the name of “being real.” She will talk with them about their concept of God, of heaven, and of hell, and describes some of her clients as “hanging on to the rope of Jesus,” which she says are clients’ words. She describes herself as directive at some times and cheer leading at others, “until one can retire into the background.” And when it comes to working with families, she teaches parents how to “see the world through the kids’ eyes.”

A retired psychiatric nurse who has also taught nursing at the university level, talked about the importance of monitoring the effectiveness of any medications being used, but also stressed the relevance of “looking at [patients’] support systems” and practicing awareness of and intervening if necessary in patients’ “interpersonal strategies.” Along the same lines, a nurse practitioner who demonstrated a strong interest in the relationship between thinking and the functioning of individuals’ immune systems,

includes in her treatment modalities, besides medication management, advice on diet, exercise, and nutritional supplementation such as calcium and vitamin D; referral to such modalities as biofeedback and psychotherapy; and encouragement to social involvement.

A psychologist who works in a hospital-associated mental health clinic lists cognitive behaviorism, family systems, psychodynamics, humanistic approaches, and behaviorism as her range of modalities, and says that “it depends upon the person” as to which she uses. In a similar vein, another psychologist who is employed by a community mental health center talked about how “to be able to join with the client is crucial,” and so,

part of the assessment initially is to find out what modality will work best with [a particular] client, so if I think that some more of a kind of a humanistic Rogerian approach is going to suffice, then that’s what we’re going to do. If it looks like good old rational emotive therapy, what have you I think I do use cognitive behavioral therapy more than I ever thought I would.

But, smiling apologetically, she also compares herself to “a little solo canoe that’s pretty good on lakes, pretty good on rivers, that’s not great at either, so it’s a good canoe that can do a lot of different things.”

A psychologist and clinic director who also espouses the behavioral health model on principle, claims cognitive behaviorism as his main treatment modality, although having also been on the faculty of a Gestalt institute, he says of himself, “I can switch into Gestalt mode with the best of them.” He also uses systems approaches and likes to employ metaphor, although he does not identify with the newer modality known as the narrative approach. He believes, however, that psychologists, like medical doctors, ought to be practicing in an “evidence-based” way, and that the only modality that currently fulfills criteria of this kind is cognitive behaviorism. Nonetheless, pointing to an elegant young tree outside his office window, he said, “if you take a tree here, if you look at all

those branches, the bigger ones out there, then it goes to smaller branches and then twigs, most of us in our lives have twigs, smaller branches, limbs, bigger limbs, and a trunk. What I try to do with people that come in for therapy is help them identify a trunk, 'cause they come in typically with twig or limb issues.”

And a retired educational psychologist and professor recalls his method in the following way: “I think my preferred way was always to ask them, ‘what do you think should be done?’” He said that in his experience, “people usually have a plan, and they know what they might do, and so mainly you’re supporting the individual because you’re on the sideline listening, and the person says, ‘why, I think if I did this and this and this, it would help me,’ and you say, ‘I think you’re right!’ And most of the time, people then feel reinforced, first of all because they’ve been able to say something that has been tearing them apart.” Clinicians, he said, have to be “smart” to “be able to deal with . . . to become involved in [clients’] lives.” The example he gave me is how he currently relates to a woman who is now in her nineties and whose family he knows very well; “it’s not playing therapist with her,” he says quietly, “it’s just talking to a person, another human.”

As to rationale, mostly they said that in their experience these are the ways that “work.” The clinical social worker says her methods “provoke” and “engage” her clients, who are “put off by the medical model.” The retired psychiatric nurse says it worked because it was “client-centered,” and the nurse practitioner talked about “equilibrium,” which includes physical health, but is also about “the psychosocial dimensions.” The psychologist in the hospital-associated mental health clinic added that her methods are “believable to clients and to me,” but it’s also about being “easy to write down,” and “to get reimbursed,” describing herself as a pragmatist. The psychologist from the community mental health center comes back to the importance of the relationship, and says, “how can I best join with this, you know, fourteen-year-old person dressed in black with thirty-five piercings who is cutting themselves, versus my seventy-six-year old in treatment who can’t remember how to find my office?”

The psychologist and clinic director, on the other hand, believes that psychotherapy should comprise “episodes of care,” much like visiting a medical doctor or a dentist or even a lawyer. He said, “I don’t want him [the lawyer] to play games with me and say, ‘what do you think about what you should do about that?’ I want their expertise, so I look at it when people come in they’re hiring me for my expertise.” Presumably, he is referring to his expertise as a diagnostician of the twig issues.

Disease as applicable to mind

Practitioners closely associated with or themselves practicing medicine tended to recognize the sign “disease” as applicable to mind as well as to body. However, in general, their perception of mind was dominated by how bodily states may impinge upon it. Practitioners highly trained in behaviorism tended to agree with this biomedical perspective, but of course their treatment modalities do not include prescription privileges. Treatment modalities in this group, then, conformed to both *indexical* and *symbolic* modes of meaning-making, reinforced by the particular licensing of the practitioner.

A retired psychiatric nurse mentioned not only the importance of monitoring medication, but of the use of group psychotherapy techniques on the hospital ward, which can usefully employ peer pressure on patients to conform with perceptions of what is real and what is functional in human interaction; a nurse practitioner talked about the relationship between chemical balance in the body and how certain states such as PMS can “drastically change [one’s] perception” such that patients can feel emotionally disturbed; and the young psychiatrist who also fits into this group, whose treatment modalities include psychodynamic psychotherapy and the use of some hypnosis, argues that the mind itself can be out of synchronization, although he prefers the use of the term “symptom” here to “disease.”

The behaviorally inclined practitioners in this group are aware of such phenomena as process, and its salience to how people think. One psychologist recounts how in the course of her training she was at one point pronounced a “spineless eclectic” by a team of supervisors because of her allusion to process, and was required to rethink her position on treatment method and rationale. She said that if pressed, today she thinks of herself as a cognitive behaviorist, although she was also exposed during one part of her supervision experience to a certified psychoanalyst through whom she learned respect for the psychodynamic approach as well. Her methods have included teaching clients to analyze their thought patterns and conduct and the relationship between the two, and encouragement to change for the goal of more effective functioning in the real world. Another psychologist who more completely identifies with behaviorism said that methods deriving from this approach really do comprise the bulk of his interventions. He describes these as consisting of “behavioral analysis,” but also said that “there are times when I have people that I think are bright and insightful and I will say something psychoanalytical [sic].”

The rationale for these methods included medical convention in relation to drug prescription in the case of the medical practitioners, pragmatism, and, as one of the psychologists described it for cognitive behaviorism, empirical support. The retired psychiatric nurse included “ethics,” which she saw as related to taking a client-centered approach. And a nurse practitioner said that she “likes to know the whole picture” of a patient’s situation. The young psychiatrist said his rationale included “what I was exposed to” in training, but that it also happened to appeal to him personally. He also believes, however, that “attachment and relationships are at the core of [patients’] problem formation.”

Disease as unease

Practitioners in this group perceived the sign “disease” as potentially applicable to both mind and body; however, what sets them apart is that they have what I want to call an expanded sense of the nature of being human. They invoke such concepts as “spirit,” awareness, and “mindfulness,” and allude to a form of holism in their thinking that includes as real the subjectivity of their client/patients. One can say that they take seriously consciousness itself, and that they seek to introduce their client/patients to the inherent power of this level of self-awareness. Semiotically, the mode generally governing their treatment modalities can be seen as highly *symbolic*; however, theirs are not only the conventional practices of psychotherapy or medicine. They draw their inspiration from Eastern philosophy and mysticism, as well as from the emerging science of mind-body medicine which recognizes the role of the individual’s state of consciousness in health at every level. Their methods, then, seek to help the client/patient become aware of their own awareness. I want to propose, therefore, that their mode of practice be defined as *indexical* as well, but in an expanded sense of the term, namely, contiguous with nature including consciousness, a position on which I shall elaborate further, below.

A psychologist from this group who is employed in a community mental health agency describes her treatment modalities as generally “solution-focused techniques,” and lists brief therapy, cognitive behaviorism, dialectical behavior therapy, and EMDR [Eye Movement Desensitization and Reprocessing], conceiving the latter two modalities as actually fitting into cognitive behaviorism. She said she appreciates the structured aspects of these treatment forms, but beyond that, “probably part of my orientation, I would say underlying, is more like existentialism. And that too is included in DBT [Dialectical Behavior Therapy], that the healing happens in the relationship.” When I asked her how she reconciles all these perspectives, she rhetorically asked, “Who is

controlling my brain? Who is thinking for me? Who is thinking for you? I am. You know, and so I have this brain and it has been habituated to react a certain way. I was born with a certain biological propensity, and I am still the - like George Bush - I'm the decider.”

A self-employed psychologist who himself practices yoga and meditation, defined his treatment modalities in the following way:

Well, it's narrative, it's talk, it's expulsion, it's discharge. . . . Letting things go. Letting emotions ride, learning how to ride the wave of emotions, rather than stuffing it. Journaling, practicing relaxation/breathing techniques; some people come in who are interested in Eastern philosophies, and I teach meditation and work with them on philosophies - the psychologies of Eastern thought - that's always refreshing because it's even easier to do therapy with people, even though it can get more complicated in a way, but I do a lot work with parents on parenting; I work with their kids, and so on. A lot of it is education.

Elaborating, he said, “It's how to talk, how to think, how to process. They're involved in the examination of the process that they're experiencing, and through that can teach them something that will help them through that [sic].”

Another self-employed psychologist said, “I use quite a bit of cognitive behavioral, just focusing. I focus a lot on what people say, what they tell themselves, and the way they tell themselves. I focus a lot on the inner critic or the tape they have running, and ‘what are you telling yourself, and of course you are feeling that way if you are that hard on yourself, or that punitive.’” This psychotherapist is also not averse to sharing aspects of her own life experience as a form of treatment, and believes it is important that as a practitioner, “you have done your own work so that you are able to more effectively lead the way.”

A psychologist who practices in a large urban center has reconfigured her whole practice to conform with what she perceives people really need the most in order to heal psychologically. This has meant dropping out of certain insurance company provider panels because of how she saw the philosophical collisions involved in being both a psychotherapist interested in the whole person and supposedly being able to predict the course of mental illness and its treatment. “I’m no longer a [particular insurance] provider,” she said, “and actually there are very few treatment plans I have to write, but [that company] in particular, I could no longer ethically say this is what I’m doing, because I didn’t have estimated dates for remission of symptoms. I don’t work that way; I don’t work with symptom reduction. I work with whole being transformation, and involvement to a greater level of wholeness.” Her practice modalities include

teaching of meditation, mindfulness practices, as they relate to emotional health I would say probably seventy percent of people that come to me come because they know about that I have a mindfulness-based women’s therapy group that’s truly become rich, you know, where we combine mindfulness practice and therapy in each session. I use lots of Buddhist psychology, basic ideas though, nothing very elaborate, but, you know, the basic idea of how the mind creates suffering. . . . Somehow the language with which it’s spoken, the tradition, people can hear that, where they can’t go to a CBT therapist [who] says you have ten irrational categories of irrational thoughts and we’re going to work to reframe those and change them, you know. The Eastern ideas of learning to be with suffering in a compassionate, allowing, accepting way, rather than trying to banish it, to transform it; to link ourselves to some source of love and kindness. I think that’s a powerful approach for many people.

A nurse practitioner who also practices psychotherapy uses interpersonal and psychodynamic approaches in treatment, as well as EMDR, some cognitive behaviorism, imago, and breathing techniques. She is also in a position to prescribe medication, but she explains that ultimately her purpose in using these particular methods is to gradually teach people to be “body-centered, having the client be in their body and know themselves.”

The rationales these practitioners gave include that healing proceeds from the cultivation of an “internal therapist” (nurse practitioner), and that mindfulness and self-awareness can lead to “emotional regulation,” since “a lot of struggles that people have . . . are rooted in the loss of [this] ability” (psychologist), elaborated as, “slowing down, calming down the system [which] can lead people to seeing what’s really happening, so getting out of those rigid repetitive thought patterns - these patterns are more open to clients when they learn themselves how to calm themselves down” (mindfulness-based psychologist). These practitioners also simply find that these methods work, although not for all (yoga and meditation psychologist), and they also allude to research results including those of mind-body medicine (nurse practitioner).

Behavioral Health

At base, practitioners in this group see their work and their treatment modalities as centering around physical symptoms, if not disease. Further, if a symptom is not measurable, then it is not regarded as real. Practitioners in this group may augment their treatment, which is mostly comprised of medication and medication management, with cognitive behavioral interventions, but they regard them as an afterthought to the management of physiological symptoms. The semiotic mode governing their treatment methods, then, is largely *indexical*, given that they perceive medications as contiguous with the “natural” conditions they treat.

A psychologist and clinic director in this group said that he uses mostly cognitive behaviorism but that he “can go into DBT or brief, ‘cause they’re all CBT anyway.” He believes that the practice of psychotherapy should be governed by “best practices” and should be “evidence based,” terms derived from medical practice which has sought to standardize care, and since CBT does have scientific validity, this ought to be psychotherapists’ main modality. At the same time, if “best practice” indicates drug treatment, then that ought to be dispensed as well. The arbiter is science. When I challenged this perspective by asking him whether he really believed that one could practice effective psychotherapy on the basis of a treatment manual, which would be an implication, he said,

well, we know that computers for instance do a better job than psychol-behavioral health people [sic] across the board, not just psychologists, at risk management identification. So, I have no problem with that. . . . It makes sense to me, because a lot of behavioral health people don’t think in terms of diagnosis, and they don’t read the literature as to what is the best practice. . . . I mean when we look at depression, for instance, these days, the jury is not out any more. It’s come in a long time ago. The best treatment: CBT and medication. A combination of those two. Now, some people get better on just meds, yes. Do some just with therapy? Yeah. But that’s best practices.

He also happens to be a paid educator for the pharmaceutical industry, and advises major insurance companies on psychotherapy practices, which role includes working to exclude scientifically unproven treatment modalities by refusing reimbursement to the practitioners. (Note that state regulatory psychotherapy boards have the same effect on practitioners and that non-licensed psychotherapists also cannot claim medical insurance reimbursement. Thus, the regulatory boards and the insurance industry work together in limiting practice.)

This same practitioner decries psychotherapy as “a soft science; it’s not as - like - the broken leg. We probably will never be as close. I really like the push [referring to scientific method], and I’d have no problem if computers could replace me.” His hope is that “at some point we can find something in the brain that tells us this is something that if you could just, you know, zap right here, and a person’s going to give up their addiction to whatever. It would make my heart soar.”

A psychiatric nurse with a counseling license practices cognitive behavioral and some psychodynamic methods of treatment, as well as medication management and nutrition advice. He also encourages his patients to be active physically and to maintain family and friendship relationships. His approach is very similar to that of the young psychiatrist, with the exception of advice on nutrition, and that he also practices some hypnosis.

The director of an obstetrics and gynecology medical clinic described her doctors’ treatment modalities of consisting of three things: medication, surgery, and education. However, education, meaning teaching the prevention of health problems, is highly problematic for physicians. As she explained,

prevention doesn’t get paid, or it gets paid very little. You know, for us, an annual visit - an average annual visit - we earn ninety-nine dollars. That’s not very much when you think of having to pay an employee, paying overhead, paying all of . . . the cost of running a clinic. Ninety-nine dollars for one preventive visit is nothing. If you then need to spend a half hour educating them, on smoking, on diet, on exercise, all of those things, you’re losing money. . . . the physicians are human, they want to get paid; are they going to spend half an hour educating a patient when they know they’re losing money as soon as the patient walks in the exam room? So, the financial incentives aren’t aligned for the prevention.

The doctors in this practice see approximately forty-four patients per day, three days per week, which is standard. Surgeries are reimbursed the most highly, and prescribing medication is both efficient and cost-effective in terms of medical practice.

This clinic director painted a vivid picture of the situation as it arises for the doctors in this particular practice:

A lot of times patients - they don't want to come in. In fact, we have a number of patients that say they're coming in for something and then in the exam room it comes out to be the anxiety and stress and all that kind of stuff. . . . I think the doctors kind of feel like when the patient's there they should address it, but I don't think - well, I know from what some of the doctors have said that they don't feel capable to address the issue. But if they send them away - for a lot of our patients we are the primary care doctor. Not like they can go - you know, it's not like they have a relationship with an internist or a primary doc where they can say, 'oh, I'm feeling down, I'm going to go to that doctor.' We are the primary doctor. So the doctors feel like they should address it, but I don't - I think they're just - they've been so inculcated with the use of meds. I think their first line of defense is 'use meds,' and if that doesn't work, then send them to a therapist.

She and a physician's assistant employed at the same clinic are trying to get relationships with psychotherapists established to whom they could refer; ideally, she said, she would like to hire one or more psychologists to work on-staff. But there is also physician resistance to this which has to do with the costs to the clinic.

To help these physicians to deal with the pressures involved in prescribing psychotropic medication, this clinic director brings in psychologists to educate them on mental health issues. She has also brought in a "pharm.D" (pharmacologist) occasionally to address the issue of polypharmacy and drug interaction, given that, as she said, "we have patients that have twenty meds! And, you know, how they all interact, and all of that stuff, is an issue, too."

A general medical practitioner from the East Coast whom I interviewed feels no compunction about treating psychological issues in his practice, and works to educate himself on psychological treatment so that he can use some of the techniques in his practice. He said he rarely refers to psychiatrists because “they [his patients] get their medications from me.” Implicitly, he saw very little need for referral to psychologists because “you know, they come back to see how the medication is working out . . . there’s a whole therapeutic context that will be similar, not identical to, but would be similar to them seeing a psychotherapist. So, there’s something about them seeing me - I mean, I do - in a sense, we’re just talking about what’s going on.”

He mentioned that in his experience a lot of people are not willing to see psychotherapists, and that when he has tried to persuade them, they have said such things as,

‘I’m just not into talking about’ it was someone [who said], ‘I don’t see how talking is going to help me,’ even though I’ll explain to them how it might help. What else might they say? They may agree and understand that that may be helpful but for them, it’s not part of their - it’s not in their comfort zone. There’s something more acceptable for them to talk about it with me [sic].

When I asked him what that something might be, he said,

I’m a physician and people rightly or wrongly seem to be a little bit more transparent or open to their physician. I’ve found that to be true. People tell me all sorts of - all sorts of things about their lives that I’m not sure that - I think it may take - it would take sometimes longer to develop the rapport with a psychotherapist, for them to get to that point, and in coming in for a history and physical, you know, it may come up. There just may - they may feel like this might be ‘relevant to my health,’ and so they’ll say things about their family life or about what they’re going through. How they’re thinking, what their fears are,

what their anxieties are. . . . I think people have a notion or an intuition that someone that does the kind of work I'm doing is actually carrying a more holistic picture of what's going on than a psychotherapist. . . . It includes mind and body, you know, and I think that's something that they don't necessarily get from a psychotherapist.

How do these practitioners describe their rationale for the forms of treatment that they provide? The psychologist and mental health clinic director sees his client/patients as "tough psychological nuts! [sic] And they've been trying to crack themselves, having difficulty, and they're coming to a professional nutcracker, that is, me, to help them develop some skills." There is also the usual pragmatic answer that practitioners give, such as "I have seen these things work," but also that these modalities "fit my nature," and that they use them effectively on themselves (psychiatric nurse and counselor). Along these same lines, the medical clinic director said that "half my doctors are on the meds themselves, so, you know, they have personal experience and have felt relief with the use of them." (When I asked her how she knew, she said, "they tell me.")

The young psychiatrist said that psychiatric practice today is "biologically and insurance industry driven"; he said that this is why and how it has come to pass that pharmacology comprises the bulk of treatment for psychological issues, and it is also why psychiatrists are no longer necessarily required to learn how to practice psychotherapy nor to undergo their own treatment analysis. It was his choice to study psychotherapy and it goes along with his strong impression that psychological issues are at their core problems of human relationship.

The East Coast general medical practitioner sees the treatment issue as the management of the biological stress markers that seem to accompany psychological problems. "Most of the people who are on psychotropic medications are on them not

prescribed by a psychiatrist but prescribed by people like me. We write more prescriptions than, you know - the total - the totality of prescriptions more written by primary care physicians than any other specialty [sic],” he said. Since this doctor is also a professor of medicine, I am inclined to believe that he may indeed have a reliable perspective on the situation. The “neurophysiological symptoms and signs” he encounters and which he interprets as the result of stress include “appetite loss, weight loss . . . extreme loss of libido, anxiety, palpitations, sweatiness, breathlessness, true panic attacks,” and he went on to say that, “I mean, stress is - there’s nothing I see - nothing in my practice that I see - that doesn’t have a stress component to it. I don’t think there’s a single thing that I see, whether it’s hypertension, heart disease, stroke, inflammatory bowel disease, diabetes, depression, anxiety, panic disorder - I mean, not a single - none of it doesn’t have some stress component with it.” He added that, “it depends how you define stress, but it’s more that relationship with stress that people have, rather than the stress itself,” which would appear to bring us full circle.

Defining and attributing treatment success

Practitioners’ definitions of treatment *success* were related to their treatment modalities with the attached proviso, however, of meeting third-party payers’ expectations to be able to prove success. In other words, regardless of how a practitioner actually did their work, medical insurer reimbursement entailed documentation along the lines of a treatment plan, goals, and outcomes. The attribution of success, however, included and followed quite a different line of explanation, including in the case of the medical practitioners and the behaviorally inclined psychologists, which gives rise to the most striking contrast in the meaning-making in which these practitioners engage: whereas success was often defined *indexically* in the standard semiotic fashion, meaning in terms of contiguity with natural phenomena such as, for example, an improved physiological reactivity, or in terms of phenomena one could physically observe, such as

different behaviors, practitioners largely ascribed success to subjective qualities of their client/patients. Semiotically, this cannot simply be glossed as *symbolic*, meaning conventional, since medicine and the behavioral methods of psychologists are predicated largely on a materialist view of science that discounts an efficient or causal role to individual's subjective states, including their thinking. At the same time, it could be argued that in the case of the strictly psychological practitioners, to ascribe success to individuals' effort is indeed somewhat conventional, and therefore does follow a *symbolic* mode of meaning-making. But my point here is that since even medical practitioners make another attribution, it calls again to the need, from my perspective, of an expanded definition of indexicality, namely one that includes the role of consciousness, and therefore thought, as an aspect or feature of the natural world. Using the same four aggregates as above, what follows are examples of practitioners' definitions of success in their work with their client/patients and of their perceptions as to the source of success.

Disease as largely of the body

Since the practitioners who comprise this group can be described as holding an indexicalized attitude towards the sign "disease," meaning that they tend not to see it as applicable to "mind," and since their treatment practices tended in the direction of healing the body, or, in the case of psychotherapists, attending to client/patients' "problems of living," treatment success was described largely in terms of compliance with treatment regimens and remission of symptoms.

A licensed clinical social worker defined success this way: "It all depends. . . . true success is defined by the client; for example, speaking up . . . getting up and coming in; coming in to connect; learning not to hit, scream, or yell; learning to say 'I'm sorry'; for the mousy ones, 'fuck it!' Learning to enjoy life; noticing things, for example, plants; being able to cry and laugh . . . the whole gamut of emotional stuff." Along similar lines, a psychologist said, "absence of meeting the diagnostic criteria," on the basis of

encouragement to “not be psychiatrically hospitalized this year,” or, “let’s not die this year”; meeting treatment goals, such as growth in assertiveness. (The hospital-associated clinic which employs her requires the staff to produce up-dated treatment plans on every client/patient every ninety days.) A psychologist employed by a community mental health center said, “a resolution of their symptoms, less distress, elevation of mood if they were depressed, improved coping With some kids it might be functioning better in their family, staying in school, staying out of trouble.” In the case of addiction, she added, success would be “if their quality of life improves and they’re maintaining sobriety.” And an educational psychologist described “improvements in independent behavior, social behavior. . . . being employable and earning some money that they didn’t exhibit maladaptive behaviors which were harmful to other people, things, to themselves.”

A psychiatric nurse defined success, at least on the hospital ward, in such terms as, “when they can deal with their lunch tray” on a given day, “when they are taking care of their appearance,” and simply all the dimensions of what is known as the “global assessment of functioning,” criteria that psychologists also use. And a nurse practitioner also used the term “functional,” but went on to describe “demeanor” as well: that it is “energetic,” and that their mood is “stable.” Also, that patients’ “relationships with the people in their lives are stable,” summarizing success as that patients “are feeling better about things in general.”

As to the attribution of success, a clinical social worker described it as “an awakening, which can be bodily, of the spirit or the mind - to themselves. Illness is a loss of connection to the self. It is shamanic: something happens,” and it comes about through, for example, crying, and “feeling connected to another human being.” A psychologist said that for some clients, it involves medication, which “gives them enough symptom relief to do the work of therapy”; however, although there also needs to be “a

good therapy relationship,” there has to be “collaboration,” and it is primarily “their hard work and willingness to take risks, to deal with the unknown.” A behaviorally inclined psychologist credits the following: “You know, I think sometimes the relationship is about as important as anything else; I mean, if the client is just showing up, and seeking healing - is healing [sic]. So there’s that . . . [also] how open they are, how much they’re willing to do things outside of the therapeutic hour,” and “it certainly is more about them than it is about me.”

The educational psychologist, who had also been a practitioner for more than fifty years, illustrated his answer to this question with an historical incident. He had listed education, psychopharmacology, rehabilitation, and habilitation, and then said,

it’s a mixed sort of thing and it depends on the individual. . . . What does any human being contribute to their own success or whatever? I don’t know. If you said why do some people prevail in terms of great hardship . . . there’s a lot of this written along this line, but anyhow, in wartime, some men under stress clearly come out of it without any damage to themselves and so forth. Some men exhibit . . . all of these psychological conditions that we used to talk about. One of the clear examples of that is there was research done after the Korean war, [during which] more U.S. soldiers were taken prisoner than almost any other kind of combat situation that we had. And the conditions were horrible in those prisoner camps, and the men that were described, they had a condition they described as “give-up-itis,” and men would go crawl into their caves and everybody knew that they would be dead in a very short period of time. After the conflict was over and they were able to retrieve the bodies of these men, they did extensive autopsies and they could not find any physiological condition that caused death for these men, so, anyhow . . . wherever that goes . . . I don’t know what conditions there are. Why does someone - why are people different? You know, I don’t know.

We can construct all kinds of language to describe that, and so forth, and - but why does some kid coming out of the, you know, the ghettos, the poorest possible conditions, emerge and surface, and it's not just cognitive powers, it's something else, and if we could quantify that and put it into the individual, that would be nice, but we can't. We don't know what it is; we're a long way away from that.

When I encouraged him to say more about why he thought we might be far away from understanding this phenomenon, he went on to say,

we can paint with a broad brush and describe it, but try to really talk about causal factor, we know that if you take a human being or almost any living creature and you physically abuse it, you're going to damage it. Now, there are certain kinds of physiological insults to a human being that cause unbelievable damage to their psyche and to their living, and yet that physical trauma that was inflicted on them - no bones were broken, nothing like that. . . . You know, it's all mixed up for me. It's not a clear kind of thing.

The psychiatric nurse credits success to the patient first, then the therapeutic relationship and a supportive environment, and finally medication for the management of crisis situations and the control of delusional states. And the nurse practitioner mentioned "the relationship of trust between self and patient" first, and then "the patient's desire to get well."

Disease as applicable to mind

As with the foregoing aggregate, the practitioners in this group describe success in terms of treatment compliance and remission of symptoms, and meaning-making is also largely governed by *indexicality* in the grounded sense, because although this group of practitioners sees the sign "disease" as potentially also applicable to mind, in that mind

itself can suffer from distortions in the way that it operates, they harbor a perspective of the mind as ultimately physically anchored. The practitioners in this group, therefore, are mostly medical practitioners and behaviorally inclined psychologists.

One of the psychologists found this to be a “tough” question because, she said, “my definition of success to some extent is going to be determined by the client’s definition of success, and what they’re looking for. So, it’s pretty subjective, client-dependent.” She went on to say that

I don’t think you have to have total . . . resolution of every problem . . . I think improvement. And without getting too touchy-feely . . . I think that if somebody has learned tools, and has skills, even if they’re not implementing them all the time, if they have that knowledge, to me that’s a sign of improvement, of success. . . . If they’re coming in with goofed-up thinkin,’ then their thinking is more clear, or if they’re not able to maintain community living because of whatever - self-harm or harm to others - then if they’re able to maintain community living . . . then that’s success. . . . If you can get Eeyore to just be a little more comfortable in Eeyore’s skin and not make everybody else miserable, then that’s success.

Another psychologist stressed the role of structure in trying to define success: If we’ve been . . . fairly clear at the outset of what the goals are, that would be one definition. But basically the primary definition in my mind is client satisfaction. If they feel they got what they came to get, and they feel like they’re ready to move on, then to me that’s a success. Now, of course, I think you have to have some forms of, you know, clear definitions [because of] insurance and all of that. You can’t just say, well, the clients are happy. . . . What’s really important is . . . they feel like they’ve got their wings back and they’re ready to move on. And you know what I just love is . . . when people figure that out for themselves. You start

having these pauses. You're sitting here and it's like, wow, there's nothing left to talk about! . . . 'You're ready to go make real friends, get out into the real world.'

A psychiatrist talked about the willingness on patients' part to do some things differently and to do different things. If "behavior patterns have been changed," even if only in the form of "small steps," that counts as success. Similarly, a nurse practitioner talked about improvements in "function," and "energy," including mood, and a psychiatric nurse referred to the "global assessment of functioning," a diagnostic dimension also used by psychologists which takes into account a client/patient's ability to interact with the external social environment.

How did these practitioners explain the success of their client/patients? A nurse practitioner complained that "a lot of patients want doctors to do something 'magic' for them," which she described as them having "an external focus of control," but that success had to do with relationship, specifically that between herself and the patient. But the patient also has to have "the desire to get well." And a psychiatric nurse said "the client/patient makes the difference." A psychologist put it this way: Although such "factors" as a person's biology, the nature of their thinking and behavior, social support and "learning community" are involved, and that "obviously, the therapy process is a collaborative process . . . that I would attribute success in part to the work of the therapist being able to lead, being able to provide the knowledge and the skills and attitude necessary to make changes . . . obviously the client is the major factor that I would attribute success to, their work, their effort." Even more succinctly, another psychologist said "success really is the power of the people. Them finding it, exploring resources that they have and they'd forgotten or don't even think of as resources, and, you know, their own will . . . that self-determination to be OK and think about their hopes and dreams again that they haven't for a long time and start pursuing them. So, it's really them."

And a psychiatrist talked directly about consciousness as having a role in the success of treatment. He said that first and foremost it is the patient's decision "whether to be conscious or not," and then, secondly, success follows from them "having a different experience" rationally, which includes that between them and himself. Success, then, follows from them "relating to me as a person, not just as an object," and has to be predicated on trust, which, however, they must "choose consciously."

Disease as unease

Remembering that the practitioners in this group make meaning not only *symbolically* but also in my expanded sense of *indexicality*, that is, indexically including consciousness, they are the ones who work with the concept of consciousness directly. Success with their clients, then, is certainly about symptom reduction but also about observing a certain kind of increased awareness in them, and their attribution is to the awakening within the client of an innate human potential, that of self-awareness.

A community mental health center psychologist defined treatment success as depending on:

wherever people start in their therapy, whatever the problem is, how do they define the problem? So, I will ask people . . . a solution-focused question: 'if this works for you, how do you imagine that you would feel?' Well, 'I will feel happier, feel joy,' some behavioral things or some sense that they are working on that already. . . . when they're following through with their own goals that they have defined. . . . I would also define success when those symptoms have alleviated [sic].

Similarly, a self-employed psychologist said the definition of success is

up to them pretty much Sometimes I'll have people who say, 'well, how often do you think I should come?' You know, "do you think I'm done?" . . . and I just say, well, you know, 'what do you think? Do you think we're done?'

I do try to establish goals and rating scales, and ‘when would you know/how would you know that you’re done?’

The yoga and meditation practicing psychologist said success looks like the following:

there’s not a lot of stress, if they feel balanced out to me, their tone of voice has improved, their expression on their face has resolved, and they’re not as anxious or painful, their demeanor has changed, they’re obviously more relaxed. You can see their mental-emotional-physical changes and improvements, and we talk about that, and I ask them questions about it to see if they are also observing them in themselves, and then we look at that every so often, like, ‘how do you think you have changed?’ ‘How do you think that this is making a difference for you?’

The mindfulness psychologist said she defined success “collaboratively with clients”; it is,

to live a life that has some satisfaction, while dealing with a chronic problem
to find work that is satisfying and relationships that are supportive, ways of coping For some people, you know, it’s transformation; really, there are some people that come in and just transform from very limited, very myopic kinds of just isolated people to people who love life. . . . I do a lot of work around purpose and meaning and clarifying what they want, and so that often transitions into what they define as success.

And the East Coast nurse practitioner/psychotherapist defines success as “client centered, so it can be very individualized. And it can be very broad, when a client feels for example that they have mastered a set of skills . . . that they have resolved issues of conflict. They’ve developed better communication skills, relationship skills.”

This same practitioner attributes her client/patients' success to "that building, trusting relationship with another human being. The therapist allows them to explore issues of trauma, or grief, or whatever, so I think it's absolutely relational." But she goes on to say,

I also think when . . . a client begins to be their own therapist, which may first begin with the client saying, 'I heard you in my head saying blah, blah, blah,' and when they really start to talk about their problems in a way that they are really using their own internal inner therapist, coaching themselves.

The mindfulness psychologist also largely credits the client, but she also attributes success in the therapeutic relationship to two very specific attitudes on the part of the psychotherapist, namely, "the compassion that they able to feel from us, and a lot - I mean, I hate to use this word - love, but I think that's part of the therapy relationship." She proceeded to describe the problematic nature of this concept for the practice of psychotherapy, including how a psychologist may be sanctioned for even invoking the concept in practice, but maintained that it is a dimension of effective treatment when appropriately acknowledged. She concluded by saying, "I think we're all underground a lot, a lot of us," in terms of both practice and what we perceive as useful to and effective with clients, with which I could fully agree.

The self-employed psychologist attributes success to "people have to really want to change. . . . people have to be really motivated to have their life be different, and they're just sick and tired of being sick and tired, or they've suffered enough or they've been in enough pain or enough distress that they really want it to be different. I think on some level too success is people that believe that it can be different." And the community mental health based psychologist described success as having to do with clients' "own beliefs and their thought and how it affects their feelings. So if they can

work at changing the thought or trying a new behavior and then they follow through I think that their own efforts brought success, and then the feeling that comes from that, ‘I can do this.’ but I really think that success comes from the client’s shift in their thinking.”

The yoga and meditation psychologist put it this way:

They have to be motivated enough to see the value of experimenting with possible differences and changes of behavior and attitudes, and so on. . . . some people just aren’t ready for change, even though they’re miserable. They don’t really know that it’s them, or they attribute their problems to physical issues or they’re blaming it on other people they’re so wrapped up into their problems mentally that they are not able to step back and make the observation of the mental and emotional process, so you have to teach that first. . . . And then they get to the point where they’re willing and able to make changes, and then it comes a lot easier.

Behavioral health

Recalling that this group of practitioners works mostly *indexically* in the grounded sense, attributing any symptoms or so-called disease to physical states, they define success in highly medicalized terms revolving essentially around medication management and behavioral dimensions. Three of the practitioners also practice psychotherapy, one exclusively, but success is measured in terms of compliance with drug protocols and the abatement of mostly physical symptoms or symptoms interpreted as having a physical origin. This makes their attribution of success particularly interesting.

The emergency response psychiatric nurse defines success in terms of a patient’s “behavior [when] it includes medication or different medication.” It also includes patients “looking at their techniques and doing or trying something different.” The young psychiatrist reiterates the behavioral dimensions, and the clinical director, speaking for

her doctors, said, “I think predominantly they assume they’ve been successful when they don’t have the patient come back.” When I asked her to elaborate on this, she said that this had to do directly with what they attribute any success to: “meds.”

A psychologist who describes himself as a behavioral health worker defines success partly on the basis of his own effort, given that many of his client/patients, for whom he coordinates care, are dementia-stricken and elderly, and who, he says, “are going to heaven with whatever they came in with, so, have I worked hard, and have I put together a plan for them that is reasonable? That’s one of the ways.” His other definitions of success are based on “outcome measures, and on symptom reduction, not on them just telling me, ‘but yeah, I’m feeling better.’” The East Coast doctor defined treatment success as “when they feel like they are in a position where . . . their life is being developed, either in the presence of their ongoing condition . . . or . . . that their condition is no longer - is going into remission. . . . And feel themselves less disabled or limited by the problem. Feeling a sense of well-being around the particular problem that we’re talking about.”

When it came to attributing success, the emergency response psychiatric nurse named “willingness to think differently,” and then his “connection” with his patients, which, he said, helps them “find the belief in their belief system.” He went on to say that “all have a potential for wellness.” By contrast, the behavioral health psychologist began his answer to this question with entirely external attributions - to the person of the therapist; success with client/patients can be attributed to their - the therapists’ - “great curb appeal and charisma,” he said. However, success includes another personal attribute: “if you’re curious about people, and curious about what is causing them the angst, the distress, downright curious about it, from a point of view like, I need to be really tuned in” He found it easier to talk about his own success from a business perspective, and attributes it to his own sense of curiosity, as well as, however, to tenacity.

But the East Coast doctor had this to say, with a rueful laugh:

It's kind of a mystery. Sometimes it's related to - it's very clear that medications really are the things that helped them. Sometimes it's just time; you know, the passage of time, I mean that they learn. Time teaches; they learn to cope with their condition. Sometimes it's . . . learning to see their condition differently, reframing and a shift in perception for themselves. Very often it's a combination of these things [including] personal work through work with professionals through them, actually it's really them attending to themselves in a way. Taking care of themselves.

THEORETICAL IMPLICATIONS

Is the mind real, or is it not? Is it merely a hum like byproduct of the gelatinous, machine-like human brain? Or does it actually have an efficacious existence? If it is not real, then what have psychological practitioners been working with, and what have they been doing? Has practicing psychotherapy been no different than the practice of magic in an earlier period of human history? But, if the mind is real, then in what sense?

And, if the mind is real, then why is psychological practice losing ground? Why are most psychiatrists no longer practicing psychotherapy? Why is “behavioral health” cooping psychology and offering psychotropic medication in place of insight? Why, indeed, from a medical perspective, at least in American society, does behavior count, and thought does not?

Practitioner view of mind

When one combines the foregoing data, it becomes clear that psychological practitioners, even when they are associated with medical practice, generally ascribe some kind of reality to the sign “mind”; they think and behave and practice as though there is something with which to work. Moreover, they attribute “mind” to themselves. Now, certainly the mode governing this meaning-making may be described as largely *symbolic*,

in that their ways of working with and relating to the phenomenon of mind is governed by conventions of practice. Many of these practitioners, especially those most closely associated with medical practice, also attempt to influence mind on the basis of an *indexicalized* approach; that is, they seek to affect mind by manipulating physiology, which is regarded as contiguous with the natural. But I perceive another or expanded dimension of meaning-making at work, one which could also be called *indexicalized*, but in a broader sense; specifically, it seems to include consciousness as a dimension of the real.

This expanded sense of indexicality is in evidence when practitioners attribute *self-aware ability*, or at least the potential for such ability, to their client/patients. It is actually in evidence every time they attribute *volition*, *choice*, ability to *change*, and *insight* to their client/patients, including not only in relation to their behavior but also to their thinking. It can be said that the whole practice of psychotherapy has been predicated on the existence of these capacities, and more like them, as part of human nature. Without them, the practice of psychotherapy would indeed be absurd, at best an outmoded practice not unlike magic and at worst a cruel perpetration in the name of further illusions such as hope, joy, and peace of mind.

The following is a list gleaned from my interviews with the practitioners of capacities that they attributed to their client/patients, which I argue depend on an assumption of a *self-aware ability* as an aspect of human nature.

Table 2

Assuming self-aware ability:

<p>to abstain from violence to abstain from violence to get out of bed in the mornings to speak up to come in for treatment to assert oneself to notice things deliberately to meditate to define one's problems to set goals to attempt to learn to choose hope</p>	<p>to take advice to take medication to comply to choose a healthy lifestyle to seek out/maintain positive relationships to desire to get well to observe self (thoughts, behaviors) to wake up to oneself (one's motivations) to deliberately change thoughts/behaviors to pursue goals to cooperate, collaborate to practice independence</p>
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Indexicality and scientific materialism

The clearest example of an indexical approach to meaning-making by a practitioner associated with the treatment of mental health is that provided by medical practitioners or others closely associated with them, who assume that they are involved with phenomena that are strictly natural, or associated with the natural world. As will become evident, this form of meaning-making can be aligned very readily with *scientific materialism*, which is a view and application of science resting on the following metaphysical principles: “objectivism, monism, universalism, reductionism, the closure principle, and physicalism” (Wallace 2000:21). The first of these principles, *objectivism*, “demands that science deals with empirical facts testable by empirical methods and verifiable by third-person means” (Wallace 2000:22). *Monism* in science refers to the belief that “there is one unified universe consisting of generally one kind of stuff, which can be described completely by physics,” and is closely related to the belief in *universalism*, “which asserts that natural, quantifiable, regular laws govern the course of events in the universe uniformly throughout all of space and time” (Wallace 2000:23).

Reductionism “declares that there is nothing that living or nonliving things do that cannot be understood from the point of view that they are made of atoms acting according to the laws of physics” (Wallace 2000:23). According to the *closure* principle, “the physical world is ‘causally closed’ - that is, there are no causal influences on physical events besides other physical events” (Wallace 2000:25). And, finally, *physicalism* “states that in reality only physical objects and processes exist. In other words, only configurations of space and of mass/energy and its functions, properties, and emergent epiphenomena are real. A closely related principle maintains that everything that exists is quantifiable, including the individual elements of physical reality, as well as the laws that govern their interactions” (Wallace 2000:26). These principles have ensured that, from this perspective, not a single subjective experience that a human being could name could be regarded as scientifically valid, nor could it even become the subject of scientific research (Wallace 2000:27–30). I believe they can also help us to understand some of the particular difficulties that medical practitioners and behavioral psychologists, whose training is explicitly grounded in scientific materialism (Wallace 2000:24), face in mental health practice. As already described above, this includes the creation of vast seas of documentation, necessary for medical insurance reimbursement, in which psychological states have been reduced to visible behaviors.

So, what is the practice world of a doctor like? How are medical practitioners compelled to treat patients? Examining the responses of those interviewees who work in medical settings sheds light on the mode of meaning-making that has progressively come to dominate psychological practice as well. Allopathic biomedicine with its particular standards and scientific outlook is taken as the paradigmatic form of intervention in human suffering (Myss and Shealy 1993:xiii). The very concept of intervention may be seen as derived from the notion that one cannot let nature run its course, unlike in the case of homeopathic and naturopathic medicine, which attempt to work with natural processes as they arise (see Murray 2000:1–2).

For some respondents, the prevailing biomedical approach seems to be a matter of belief in the sense that the way things are is indeed also how they ought to be; for others, it is merely how the system works presently, and is not necessarily ideal; indeed, it may be harmful. However, it appears that it is the medical insurance industry that drives several of the standards, using, I contend, a particular approach to science - *scientific materialism* - that is also profitable to the insurance industry, since it serves to constrain reimbursement to practitioners. To the degree that a psychological practice in the form of a community mental health center or hospital affiliation or even stand-alone institution receives medical insurance reimbursement, it must adhere to those standards, regardless of the impact on client/patients. So, for example, if a so-called “best practice” indicates the “prescription” of a particular form of psychotherapy or medication, then reimbursement will depend on this, whether or not this would be the best “intervention” for the particular client/ “patient.”

The executive director of a medical clinic said that, our busiest doctor sees forty-four patients a day. So, if you start talking about depression screening, that takes up a ton of time. So, one thing the doctors don't like is that it takes up a lot of time; some of the doctors in the board meeting have said they don't feel competent to deal with the depression issues, and because it's hard to get patients in to be seen quickly [by a psychotherapist]. You know, they feel like there's that gap of care, where they don't feel totally competent in dealing with it, and they know they can't get a patient to be seen quickly. . . . And then the third [issue] is that we've had a lot of discussions that the physicians are not bringing patients back appropriately after they've given them a med.

It is important to understand in this context that, as she went on to explain, “the reimbursement rate is different depending on which kind of patient you see and what you're seeing them for. So, different kinds of patients bring in diff- more money than

others [sic].” She implied strongly that bringing patients back in for medication management is not as profitable as certain other procedures.

The doctors in her clinic see patients three days per week, she said, and then, one day they have surgery in the hospital, and then they’re on call once a week night, and then every four weekends [the fourth weekend] for the whole weekend. . . . they could be called up two - three - times; being on call means also driving in to do deliveries [in their case]. So, you could be called in to do a delivery at four in the morning and then come back and do a clinic all day. Because you won’t cancel all those patients. So, you know, a lot of times they’re really sleep deprived, even when they’re seeing patients. And the other thing is, the stress - I mean, every time they go and do a delivery, they’re dealing with life-and-death situations.

Yet, recall that medical doctors, including in a specialty such as obstetrics and gynecology, deal mostly with stress-related issues, and write most of the prescriptions for psychotropic medications, according to the insurance industry itself. This is the psychological care that patients can expect at the hands of the medical profession and these are the conditions under which it is provided.

Both this clinic director and a general medical practitioner alluded to the problem of “outcome-based medicine” and “pay for performance”; the latter is essentially about incentives to deliver certain kinds of treatment. This doctor described the situation in the following way: There’s actually discussions looking at . . . pay for performance . . . the way that insurance is - including the federal government insurance, medicare - is looking at paying providers, medical providers - looking at some of this [supposed] underdiagnosis. . . . I have a little concern - underdiagnosis - when we begin to screen more and more people and make diagnoses, then what happens? I mean, then it would measure [doctors] by treatment, and treatment is easy on

claims data - is there a pharmaceutical - is there a psychopharmacological agent that is attached to that patient's diagnosis? And that - and that gets onto your report card for your pay for performance. Are you reaching the targeted number of percentage of patients with the condition? And are you treating a targeted number? These are the kinds of things where we are already being measured on in terms of antibiotic treatment prescribing, in terms of heart disease prescribing - prescribing certain agents for heart disease. If a person has heart disease, are they on x , y , and z ? If they're not, you're not providing quality of care.

I asked him if that was also about so-called "best practices," and he affirmed it, and went on,

Yeah. The circle of this under-diagnosis issue, because I think it will lead to even more probably overuse [sic]. I think there are other options, probably underused options in mental illness. I don't think it's a one-size-fits-all. I think my colleagues don't believe that either. However, knowing you're in the trenches overwhelmed by the amount of stuff you're seeing, and when you're pressured to, on performance measures that are measuring what you're doing, you know, it's awfully compelling to write a prescription. And when it becomes really easy with electronic medical prescription - easy! [he laughs] It's just a click, you don't even have to write anything on a piece of paper, you know. It goes right to the pharmacy.

A psychiatrist spoke of the insurance industry and "evidence-based medicine" as "a natural alliance" that is very "profitable." It works on the basis of "definable disorders that are measurable in terms of outcomes and fast removal of symptoms"; "insurance is the number one influence" in this system, and "we get paid for quick fixes." However, he

said, “people know better than to think medications fix things,” referring to his colleagues. He called the biological approach “terrible, of course,” for two reasons: there is loss to the clients in terms of psychological care, but also to the medical profession, since “much is psychosomatic in medicine.” Also, “medicine doesn’t have anyone to speak up for things psychological” anymore, which is also a “loss of vision for psychiatry.”

It would also seem that there is an alliance at work between the insurance and the pharmaceutical industry, as I address in the next chapter. For now, my point is that to the degree that an indexical mode denies subjective states as part of its meaning-making, which would appear to be the case where it is associated with a form of medical practice predicated on scientific materialism, to that extent psychological suffering has no place. It is how and why a psychologist, for example, who calls himself a behavioral health worker, described earlier in this chapter, can also claim to be a scientist and dismiss subjective states, the bread and butter of psychological practice, as “nonsense.” And why, when such states are begrudgingly acknowledged, they are dispatched with on the basis of what would appear to be an unexamined use of pharmaceuticals.

Stress and perception

Most of the practitioners made references to the role of stress in their client/patients’ lives. What seemed striking to me about this is that some of them also pointed out that it is the *perception* of stress, not the actual conditions under which it is felt, that plays the significant role in the client/patient’s health. This would seem to be a very fruitful subjective state both psychologically and physically, as well as theoretically, to examine for an improved understanding of the role of the mind and consciousness in human nature. Although this is no longer a new domain of inquiry (see Selye 1976), I contend that the implications are being underutilized medically and psychologically, and that this is due to the vested interests that have come to dominate these practices (see also

Creagan and Wendel 2003:xxiii). To write a prescription and send patients on their way is far more efficient than teaching them how to organize and approach their lives differently.

One of the psychologists remembered taking a “behavioral medicine” class in her graduate training which included learning about the relationship between medical conditions and mental and emotional health, but it also included information about the importance of stress management, including modifying “type A” behavior, given its role in cardiovascular health. Another one referred to the “insanity of the workplace” that is a reality in the lives of many client/patients, as well as the oppression, whether because of sexual orientation, gender, or ethnicity. However, clients seek out psychotherapy in order to learn different ways to think about and manage their situation, and it does help them. This is the point of such techniques as “reframing,” which is not simply a way to delude the self, but to take a different perspective on an issue that will not create the same emotional and concomitant physiological charge.

The yoga-and-meditation practicing psychologist believes that it is the perception of stress that leads to the “imbalance” that he treats, and it is when client/patients’ signs or symptoms of stress have abated that he knows they are on the way to recovery. Several practitioners mentioned the nature of people’s schedules as a major source of stress in their lives; people believe that they must always be doing something, if not several things at the same time. One of the nurse practitioners talked about adrenal burnout in this connection; one’s health is intricately connected to one’s lifestyle and to cultural expectations, which many people are translating into working themselves into physical exhaustion. Like medical practitioners, behavioral health psychologists are aware of the connection between stress and physical illness; one of these psychologists talked about this in relation to the very common disease known as irritable bowel syndrome, which he described as an example of “a chronic stress state.”

But it was the East Coast general medical practitioner who was the clearest on the topic when he described the list of neurophysiological symptoms which accompany chronic stress (see above) and which, he said, are involved in most of the conditions that he sees; that is, to reiterate, he said, “I don’t think there’s a single thing that I see . . . none of it doesn’t have some stress component with it.” And yet, he went on to say that it is “more that relationship with stress that people have, rather than the stress itself.”

It would seem that this finding alone could justify the whole practice of psychology. A clinical social worker described how thirty years ago psychology graduate students were learning about the uses and power of imagery and psychodrama, examples of treatment modalities that, as she put it, “came to be seen as hocus-pocus.” However, now it appears, she said, that “we may have thrown the baby out with the bath water.” A psychologist talked about how these days the area she feels she knows the most about is “stress, and the stress response, and . . . how that chemical response, and that through relaxation and through deep breathing and through just . . . mindfulness, can change the ability that we have to change the chemical response [sic].” Another one stated that “science . . . has proven that . . . visualization and relaxation techniques truly do impact our body.” And a nurse practitioner who works on the East Coast described what she hopes will become the standard solution:

I think the whole field of mind-body medicine as it relates to mental health, the use of yoga, meditation. . . what was once thought of as New Age and baseless, has really become more and more integrated . . . Also, in my area, where I work, medical practices are now incorporating psychotherapists within their practices. Folks that are coming to medical doctors for an array of symptoms are being evaluated [by] therapists to address the mind-body connection.

Consciousness

Consciousness is generally associated with living organisms, at least in modern Western culture. However, people debate about levels of consciousness and ascribe more or less of it to different kinds of organisms and sometimes to different stages of development of particular organisms. Although plants are living organisms, they are not believed to have any consciousness, and people attribute very little to such organisms as insects or fish. As to what it might be, people describe it in terms of *awareness* and, again, levels of awareness. So, an organism might be aware of its surroundings but not necessarily supposedly of itself; this is how many animals are viewed. Or an organism, such as a human being, might be aware of itself but not of much else.

Dictionary definitions include the term “awake” as a definition of consciousness, and certainly people will make that attribution as well. So there is an assumption that one is less conscious when asleep, and that “to wake up” can mean having become more aware and therefore more conscious. Scientifically, definitions have included the idea of a *state*, in the sense of condition, implying a specific balance or relationship between the components making up the object or organism; in other words, from the perspective of state, consciousness would be an emergent feature of an organism or potentially of an object. The idea of consciousness as a state also implies that when the components that make up an organism or their relationships with one another change, or if components are added or removed, then the state of consciousness also changes.

This is how we arrive at such descriptions as an individual being in a “comatose state,” or an “inebriated state,” or in an “agitated state.” In each of these situations, consciousness or awareness has been altered through the addition or subtraction of something that changes the basic condition of what one could also describe as *alert perception*. These general concepts about the nature of consciousness are also the basis of the idea that given enough complexity, supposedly, a machine too might some day exhibit an independent state of awareness.

What does this description have to do with the practice of psychotherapy? First of all, from the perspective of the philosophy of science, much of the foregoing description reveals a mechanistic perception of a characteristic of living beings that often, in fact, defies what the state of the organism would indicate. The mindfulness teacher Eckhart Tolle describes a chance meeting with the theoretical physicist Stephen Hawking at Cambridge University in the late 1970s, where Tolle was studying at the time and Hawking was teaching. Hawking, who suffers from amyotrophic lateral sclerosis, was already severely disabled and wheelchair bound. “As I was leaving the building,” Tolle recalls, “he was coming in, and when I held the door open for his electric wheelchair to come through, our eyes met. With surprise I saw that his eyes were clear. There was no trace in them of unhappiness. I knew immediately he had relinquished resistance; he was living in surrender” (Tolle 2005:212).

Tolle writes that some years later he ran across a lead article in a magazine about Hawking who had in the meantime become well-known internationally. “There was a beautiful line in the article that confirmed what I had sensed when I had looked into his eyes many years earlier. Commenting upon his life, he said (now with the help of the voice synthesizer), ‘Who could have wished for more?’” (Tolle 2005:212–213). One may well ask how such an attitude is possible. And yet, this is the human proclivity with which psychotherapists work every day.

Mind

To be more specific, what psychotherapists work with is a potential of consciousness, at least in the case of human beings, which is *self-awareness*. This seems to require enlisting the help of *mind*, which I would like to describe as *an executive function of consciousness*. In its turn, mind uses the brain to carry out all the characteristic behaviors and functions of what has often been described as *agency* in anthropology. As a model, this relationship could be depicted in the following way:

consciousness



mind



brain/body

In the course of socialization, mind becomes colonized with and uses encultured thought forms. However, it can and does, to varying degrees, remain open to spontaneous, new, or creative impulses from consciousness itself. This, then, I believe, is also the origin point of semiosis; that is, the open-ended quality of semiosis originates in a mind that is amenable to the spontaneity of consciousness itself. As to the origin of consciousness, it appears to me and I am asserting that it is a feature of the natural world. My perspective is not unlike that of David Chalmers, the Australian philosopher, whose “search for a nonreductive ontology of consciousness led him to what he calls *panprotopsychism*” (Schwartz and Begley 2002:47; Chalmers 1996). It is also much like that of William James, who, by proposing a radical empiricism that took subjectivity seriously, wanted to “reintroduce the mind, including sensory and mental phenomena, into nature, from which it had been divorced by the theologically motivated, mechanistic philosophy of Descartes” (Wallace 2000:68).

A case in point: OCD and expanded indexicality

Obsessive compulsive disorder is a psychological condition in the throes of which the afflicted person feels compelled to engage repetitiously in certain kinds of behavior seemingly beyond his or her conscious ability to control. These behaviors are often of a checking kind, such as going to make sure over and over again that doors have been locked, or that appliances have been turned off. The most well-known example is that of

compulsive hand washing. But almost any behavior or thought can become the target of repetition. People suffering from this disorder can become functionally disabled to the extent that they cannot lead normal lives; they find they cannot leave their homes, for example, or manage to control themselves well enough to stay employed or maintain reciprocal relationships with others. Theirs is a tightly circumscribed world which seems to constantly threaten to strangle them unless they obey their compulsions. Underneath the behaviors, or concomitant with them, there is crippling anxiety often compounded by compulsive and upsetting thoughts, and so most psychotherapists recommend an antianxiety medication to help in the management of this disorder and tend towards relying on it for alleviation, rather than on what have also been attempts at behavioral modification and, more recently, cognitive behaviorism. It is fair to say that this has been a disorder that psychotherapists have been discouraged about and that is often relegated to the category of severe mental illness. This means they have generally viewed it as a largely intractable genetically based disease which can only be managed, not cured.

During the late 1980s, however, the psychiatrist and neuroscientist Jeffrey Schwartz targeted this disorder, which he describes as “brain lock,” for his own research purposes, admitting that his interest was largely philosophical. He writes,

OCD, I thought, offered a wedge into the mind-brain enigma. Because symptoms are usually so clear-cut that patients can describe precisely what they feel, I realized that there should be no problem establishing the mental, experiential aspect of the disease. And since it was becoming clear even in the 1980s that psychiatric illness was rooted in the functional neuroanatomy of the brain, I was also optimistic that it would be possible to establish what was happening in the brain of people with the disease. Finally, the disease’s ego-dystonic nature suggested that although the brain was acting up, an intact mind was struggling to overcome it: the events of the brain and the state of the mind were, at least partly,

separable. Obsessive-compulsive disorder thus seemed to be the perfect vehicle for pursuing such profound questions as the schism between the mind and brain and, in particular, the distinction between active and passive mental activity: the symptoms of OCD are no more than the products of passive brain mechanisms, but patients' attempts to resist the compulsions represent active, mental effort (2002:60–61).

Schwartz believed that if he could “show that a cognitive-behavioral approach, infused with mindful awareness, could be marshaled against the disease, and if successful therapy were accompanied by changes in brain activity, then it would represent a significant step toward demonstrating the causal efficacy of mental activity on neural circuits” (2002:61). By 1987 he had set up an OCD psychotherapy group that was comprised of patients who were also willing to undergo successive brain scans through positron emission tomography (PET), “the noninvasive imaging technique that measures metabolic activity in the brain” (2002:62), willing to also teach themselves, and to remain medication free for the duration of the experiments (2002:88).

Teaching mindfulness meant helping the patients discern “the difference between an off-handed ‘Ah, here’s that feeling that I have to count cans again,’ and the insight ‘My brain is generating another obsessive thought. What does it feel like? How am I responding? Does the feeling make sense? Don’t I in fact know it to be false?’” (Schwartz and Begley 2002:78). This line of questioning, which works by inducing greater self-awareness, was the first step in what became a breakthrough treatment for OCD, the Four Step method, which begins with “Relabeling” (Schwartz and Begley 2002:79).

What Schwartz was essentially waking his patients up to was, “‘The brain’s gonna do what the brain’s gonna do . . . but you don’t have to let it push you around,’” as he put

it (2002:81). Relabeling was followed by the second step, Reattributing, which “also tends to amplify mindfulness. Through mindfulness, the patient distances himself (that is, his locus of conscious awareness) from his OCD (an intrusive experience entirely determined by material forces). This puts mental space between his will and the unwanted urges that would otherwise overpower his will” (Schwartz and Begley 2002:82).

The third step came to be known as Refocusing, and “evolved to become the core step of the whole therapy, because this is where patients actually implement the willful change of behavior. The essence of applying mindful awareness during a bout of OCD is thus to recognize obsessive thoughts and urges as soon as they arise and willfully Refocus onto some adaptive behavior” (Schwartz and Begley 2002:83). However, “Refocusing attention away from the intrusive thought rather than waiting passively for the feeling to go away is the hardest aspect of the treatment, requiring will and courage” (Schwartz and Begley 2002:83). At the same time, it is this step that produces the changes in brain structure that Schwartz was able to document through PET scans (2002:86).

The fourth and final step became Revaluing, “which is a deep form of relabeling”; Schwartz writes,

Anyone whose grasp of reality is reasonably intact can learn to blame OCD symptoms on a medical condition. But such Relabeling is superficial, leading to no diminution of symptoms or improved ability to cope. This is why classical cognitive therapy (which aims primarily to correct cognitive distortions) seldom helps OCD patients. Revaluing went deeper. Like Relabeling, Reattributing, and Refocusing, Revaluing was intended to enhance patients’ use of mindful awareness, the foundation of Theravada Buddhist philosophy. I therefore began teaching Revaluing by reference to what Buddhist philosophy calls wise (as opposed to unwise) attention. Wise attention means seeing matters as they really

are or, literally, ‘in accordance with the truth.’ In the case of OCD, wise attention means quickly recognizing the disturbing thoughts as senseless, as false, as errant brain signals (2002:88).

Eventually, by the early 1990s, when patients completed ten weeks of the Four Steps program, Schwartz was getting “encouraging results”; for example, in one study, twelve out of eighteen patients “improved significantly” (2002:88). He writes,

In these, PET scans after treatment showed significantly diminished metabolic activity in both the right and the left caudate, with the right-side decrease particularly striking There was also a significant decrease in the abnormally high, and pathological, correlations among activities in the caudate, the orbital frontal cortex, and the thalamus in the right hemisphere. No longer were these structures functioning in lock step. The interpretation was clear: therapy had altered the metabolism of the OCD circuit. Our patients’ brain lock had been broken (2002:89–90).

Schwartz’s work is a landmark in the treatment of psychiatric disease. It was, as he himself points out, the first study demonstrating that “cognitive-behavior therapy - or, indeed, any psychiatric treatment that did not rely on drugs - has the power to change faulty brain chemistry in a well-identified brain circuit. . . . Self-directed therapy had dramatically and significantly altered brain function” (2002:90). As a result, “there are now a wealth of brain imaging data supporting the notion that the sort of willful cognitive shift achieved during Refocusing through mindful awareness brings about important changes in brain circuitry” (Schwartz and Begley 2002:90).

Further, what continued to intrigue Schwartz was that his discoveries had real implications for theories of mind. He writes,

I became more and more intrigued by the idea that there must be a force to account for the observed brain changes. The willful effort OCD patients generate during treatment, I suspected, was the most reasonable way to account for the generation of this force. The results achieved with OCD supported the notion that the conscious and willful mind differs from the brain and cannot be explained solely and completely by the matter, by the material substance, of the brain. For the first time, hard science - for what could be 'harder' than the metabolic activity measured by PET scans? - had weighed in on the side of mind-matter theories that . . . question whether mind is nothing but matter. The changes the Four Steps can produce in the brain offered strong evidence that willful, mindful effort can alter brain function, and that such self-directed brain changes - *neuroplasticity* - are a genuine reality. . . . the Four Steps is not merely a self-directed therapy; it is also an avenue to self-directed neuroplasticity (2002:93–94).

Schwartz reiterates that,

In order to work, behavioral medicine (of which the Four Steps is an example) absolutely requires the use of the patient's inner experience, including the directly perceived reality of the causal efficacy of volition. The clinical and physiological results achieved with OCD support the notion that the conscious and willful mind cannot be explained solely and completely by matter, by the material substance of the brain. In other words, the arrow of causation relating brain and mind must be bidirectional. Conscious, volitional decisions and changes in behavior alter the brain (2002:94–95).

Finally, his work led him to,

posit a new kind of studyable force. I called it directed mental force. It would arise, I thought, from willful effort. What mental force does is activate a neuronal circuit. . . . that directed mental force is the physical aspect of the willful effort to bring healthy circuitry on line. With regular use of the frontal cortex, changes occur in the gating function of the caudate, and mental function improves (2002:95).

Over the years, Schwartz has tried to understand how mental force could possibly influence matter, the most contentious aspect of the so-called mind-body problem. Through collaboration with the physicist Henry Stapp he has come to believe that the answers lie at the quantum level of matter where attention can act to collapse the probability wave - the usual state of matter - into a particular and steadier state. In the case of the human brain and OCD, Schwartz applies this understanding in the following way:

The rules of quantum mechanics allow attention to influence brain function. The release of neurotransmitters requires calcium ions to pass through ion channels in a neuron. Because these channels are extremely narrow, quantum rules and the Uncertainty Principle apply. Since calcium ions trigger vesicles to release neurotransmitters, the release of neurotransmitter is only probabilistic, not certain. In quantum language, the wave function that represents 'release neurotransmitter' exists in a superposition with the wave function that represents 'don't release neurotransmitter'; each has a probability between 0% and 100% of becoming real. Neurotransmitter release is required to keep a thought going; as a result, whether the 'wash hands' or 'garden' thought prevails is also a matter of probability. Attention can change the odds on which wave function, and hence which thought, wins (2002:362).

Schwartz's work with OCD and theories of mind and consciousness matters to the practice of psychology because it indicates that far from thought being merely a passive byproduct of the brain's activities, which had generally been the contention of neuroscientists, thought itself shapes the brain. What we pay attention to has physical, material consequences in the form of neuron connections which then become habituated pathways within the brain. If consciousness in the form of thought and attention has this kind of consequence and power, then it ought to be acknowledged as a dimension of reality whether or not it can presently be explained further (Wallace 2000:81). And it is on this basis that I propose expanding our understanding of the *indexical* mode of meaning making, to include consciousness as a dimension of the natural. This is what many practitioners are already doing, whether or not they are engaging in metaphysical debate.

To acknowledge consciousness as a part of the natural world could also beneficially lead to the far wider deliberate use of attentional strategies in psychotherapeutic practice. As one psychologist explained, she had been fascinated by the use of "visualization, relaxation techniques, imagery" in graduate school, but "set that aside . . . because it sounded too flaky." Now, more than twenty years later, the possibility exists to begin to understand why modalities such as these have always had proponents and why they have also worked for many people. These are indeed effective modalities, not for all client/patients, and not for all conditions, but the same can also be said for medication.

Finally, to acknowledge consciousness and its uses as "real" is also to set people free from exploitation by an industrialized medical industry (see Illich 1976:39–124). It is to return people to an innate recognition that we are not born to illness and disease but to health and well-being. All organisms eventually die, but to assume that the course of a

lifetime must be drug dependent is to have succumbed to an illusion of our time, that of *being* as impotent matter without soul.

GETTING BY WITH A LITTLE HELP

“We’re in the midst of a huge experiment, without controls and without really good outcomes.”

Dr. Henry Emmons (2008)

INTRODUCTION

By the time people have decided that perhaps they could benefit from talk therapy and pick up the telephone to make the initial contact with a psychotherapist, they have most likely been taking psychotropic medication for some time, obtained from their general medical practitioners. This is part of the reason that they call: the medication has not necessarily been working the way they hoped it would. Although they feel less agitated or reactive, their problems persist. The underlying dissatisfaction about their lives is still there; the fear, the anxiety, the disappointment, the stresses - these have not magically vanished; these feelings have merely become muted, as though the volume has been turned down. But the dissonance continues, a shadow in the background, craving attention and threatening to break out, to disrupt, to make a scene. Something is still wrong.

They will tell you, the psychotherapist, that there really must be something wrong with their brains, since certain feelings are persisting. They will give you the story that both pharmaceutical advertising and medical doctors tell them: that their feelings of disease come from a sickness of the brain, from a “chemical imbalance.” This is the same story that psychotherapists are taught at their continuing education workshops, especially the ones sponsored by the pharmaceutical industry. This is not to say that this story is a complete fabrication; rather, it is only the highlighting of one part of a seamless coherence, a segment cut out of the middle of a symbiotic and reciprocal relationship between the way people live their lives, their particular circumstances, and, most

significantly, the *meaning* they make of their situation. In short, the brain and the body, which are not separate, do react, and may indeed become “chemically unbalanced,” but we are not asking a very basic question: under what conditions does this happen? And we certainly do not look to these symptoms, or signs, to point the way for change, whether personal or societal. To do so in the present climate of practice is to be “unscientific,” a position that a psychotherapist literally cannot afford; it is also to question and undermine powerful economic interests in a society that wants the “quick fix,” instant relief from the pains that come with being alive.

I asked long-term psychological and medical practitioners, the latter because they now provide the bulk of psychotropic medication prescriptions, about the changes they have seen in their professional fields, and how any changes have influenced their practice. I also asked them what psychotropic medication means to them as practitioners and what they thought about the involvement of general medical practitioners in mental health issues. What follows is a description of their responses, in the form of the four aggregates (see previous chapter) which emerged naturally from the data. All of the aggregates include some overlap, deriving from responses by professionals who work in medicalized settings, such as medical clinics, or who align themselves overtly with the philosophies and practices of modern biomedicine, and arises from the fact that several of these practitioners seem to hold more than one perspective and that these are in conflict with one another. So some of their responses fall into one category, while others fall into another. This seems to be the case either because they separate the mind and body phenomenologically or because they have reduced the mind to the body, sometimes as a perceived contingency of practice, as in the case of a psychiatrist whom I interviewed who sees this as merely politically correct in his work environment. Another way to describe the overlap is to say that practitioners in highly medicalized settings sometimes hold philosophically dissonant views on the human condition, such that some of what

they profess expresses one view, whereas other aspects express another, not reconcilable view.

It seems to me that these philosophical tensions contribute to the dis-ease of many of the practitioners, not only those in the specifically medicalized settings; it is just more pronounced there. In general, the psychologists and psychotherapists seemed to be voracious readers in their field; they also attend continuing education classes, which is a requirement of licensing, but their efforts seem to be go beyond the letter of the law. Every psychotherapist's office I visited had its packed book shelf. Sometimes most of the walls were lined with their books, and more were piled on the floor. They appear to immerse themselves in efforts to understand what they are dealing with, and yet it became clear to me from their responses that their graduate training was often at odds with the new so-called brain science as it is propounded by the pharmaceutical industry. Very few of these practitioners, however, named this discrepancy directly; that is, they do not describe the philosophical tension as such. They simply struggle to help their client/patients deal with their suffering in a climate of practice that reduces perceived suffering to brain function. They write the obligatory cognitive-behavioral treatment plans with goals and time lines and then set about being empathic, responsive, educational, and patient, artfully fielding whatever the client brings in, hoping always for the best.

OUR FRIENDS

The two overarching forces at work in the professional lives of mental health practitioners are the insurance and pharmaceutical industries. Medical insurance, like any other branch of the insurance industry, ostensibly seeks to contain cost for individuals by "spreading the risk"; the higher the number of people insured, which is to say paying into a particular system, the less individuals would, at least in theory, need to pay out in the event of a "medical necessity." However, also like any other branch of the insurance

industry, medical insurance seeks to control its own expenditures by limiting types and amounts of treatment. Since psychological practice aligned itself with biomedicine and to the degree that practitioners seek third-party reimbursement for their services, meaning payment by insurance companies, they find their practice methods constrained by that industry.

Mental health practitioners are inundated with workshop options in the name of continuing education which includes such examples as the following: “Coding and Billing for Mental Health Services: CPT and ICD-9-CM Coding Update” (Cross Country Education 2008). The lead description of this particular workshop offering reads, “Manage problem areas of documentation to avoid denials; handle denied claims quickly and effectively; gain strategies for optimal reimbursement from Medicare, managed care and insurance companies” (Cross Country Education 2008). The “What You Will Learn” section includes “Documentation necessary to support reimbursement”; a major section of the course is devoted to “Documentation Guidelines,” which includes “the treatment plan” (Cross Country Education 2008). Another section of the course consists of “Diagnostic Coding,” the first dimension of which is “ICD-9-CM and DSM coding”; from the perspective of the medical insurance industry, the DSM is part of medical coding. That is, the ICD (“International Classification of Diseases,”) which is the coding system used in medicine, subsumes the DSM. From this perspective, psychotherapy is structurally part of medical practice today. I contend that this is problematic philosophically, however, because psychotherapy deals with intangibles which practitioners are then at pains to try to make “real” from an empirical point of view. Mental health practitioners, then, find themselves in the position of needing training in how to obtain reimbursement for their services in the face of a medical industry that profitably seeks to exclude all suffering of an intangible nature. Ironically, medical practitioners acknowledge that much of what they deal with is actually psychosomatic

(Myss and Shealy 1993:6-7, 323–342); in other words, not only does disease seem to arise in concert with perceived psychological distress, in the form of stress reaction, but they are faced with amorphous conditions such as fibromyalgia for which no consistent treatment exists, other than, increasingly, the use of psychotropic medication.

The goal of the pharmaceutical industry, in contrast, is more straightforward. It is to create and sell effective drugs. The practitioners I spoke with do not necessarily perceive these two forces as deliberately working together, but they do see them interacting in the lives of their client/patients. The influence of the pharmaceutical industry would also appear to be the stronger of the two in terms of impact on people's lives. But this is also a function of the type of medical insurance that people have, since "mental health parity," meaning coverage for psychotherapy "equal" to that for physical health problems, is not a given. Most of the people who come to see mental health practitioners (the psychotherapists) are already on psychotropic medication, having obtained it from general medical practitioners; at the same time, all the practitioners are under pressure from the insurance industry to, as one psychiatric nurse put it, "whip them [patients] through and get them out." It may be easier, therefore, for many people to obtain medication of any kind than to gain access to psychotherapy. And these are merely the structural and economic dimensions of the issue, not the psychological aspects, such as the stigma of a mental health diagnosis. As several psychologists said to me, however, the consequence too often is "managed care casualties," over-medicated client/patients who have become the victims of "polypharmacy," more or less incapacitated by the drugs themselves.

So, a question that arises is whether medication management of client/patients is more cost-effective from the perspective of the insurance industry than psychotherapy; if so, then there would indeed be a *de facto* collaboration in place between these two forces, with help-seeking individuals unwittingly being steered in the direction of pharmaceutical

intervention for what many of the practitioners describe as “problems of living.” And psychotherapists are being undermined philosophically and practically as both they and potential client/patients are taught and come to believe that psychological problems arise from “chemical imbalance” of the brain which somehow just appears. This thinking, however, seems strangely magical in the light of the 1990s which were dubbed “the decade of the brain,” in homage to a neuroscience the findings of which include the salience of conscious awareness to optimal psychological functioning.

It should come as no surprise, then, that there is a movement underfoot for psychologists to be permitted to gain “prescription privileges.” In a society in which the professionally sanctioned solution to personal problems has become the use of mind-altering substances, there is great power to be had in aligning with this dimension of the medical model. One of the psychologists I spoke to, who manages a consortium of mental health clinics and is philosophically aligned with biomedicine, believes that this is indeed where the future of mental health practice lies: in the medication management of client/patients. “There is no money in behavioral health,” he said. And so he is about to start hiring physician assistants (nurse practitioners) as members of his team of practitioners. Several of the psychologists foresee this as the future of psychological practice; one mentioned that her psychiatrist brother, who is affiliated with a highly influential medical community, believes that indeed this really would be the best “use” of psychologists. As psychology continues its move “towards the biological,” as another psychologist put it, “we’re going to be doing - psychologists are going to be doing - fifteen-minute med checks, just as ineffectively as psychiatrists.”

Medicalization

“Drugs, it’s all about drugs, drugs, drugs, drugs. Very few people do I see who are not on drugs and very few people do I see who are not doing the polypharm. So, you know, we’re talking multiple medications” - spoken by a forensic psychologist. But this

could be the refrain of most of the practitioners I interviewed. Almost all of the psychological practitioners mentioned the term “medicalization” in reference to the question of what changes they had seen, and they all associated the same thing with that, namely, medication.

When asked to describe their understanding of how psychotropic medications work, almost all of the practitioners gave the same story, a rather straightforward description of neurotransmitters believed to contribute to mental and emotional health in the brain, and how the nerve cells of the brain may be influenced chemically to release more or less of these substances. Interestingly, the more education a practitioner had, the more likely he or she was to say that, in reality, no one actually understands exactly how these medications work. An outstanding example of a response that happens to encapsulate the continuum of understanding as well as the uncertainty is the following, given by a psychologist who occasionally also teaches psychology classes at a community college:

How I used to explain some things was what I knew then; we know more now. Five years ago I was telling stuff that was not true, so that’s kind of interesting. But I mean I would talk to people about things like neurotransmitters and do a very cookbook explanation of how an SSRI might work in the brain, and draw pictures on the white board or something, and I’m a little leery about doing so much of that because I’m a little more . . . I’m a little more removed; if I hadn’t had my hands in the soup as much I’d say even in the last couple few years but make attempts to talk to people [sic] about the role of various neurotransmitters and the role of various medications with those neurotransmitters or whatever

At this point in our conversation I intervened and said, “so, you’re more aware that there may be a more complex picture going on here,” and this psychologist went on to say,

I think it's more complex than I thought, and I think, it's like, we had the decade of the brain. We're starting to learn a lot more and there's a lot I don't know; I don't know why some medications hit the brain in a few hours but you don't experience the main effect for a few weeks - I don't understand that. . . . I mean, maybe hopefully some of the doctors do understand that. I got asked last week by somebody - they were talking about bipolar and they said, "Well, I have a friend who has bipolar but they're taking a seizure medication" - I don't understand that. That's the question. . . . The other thing is that where it all leads often is "talk to your doctor about this."

I asked her whether she meant a client's general medical practitioner, and she said, Your G.P. or your psychiatrist. I know a little bit; sometimes a little knowledge is dangerous. I mean, I can talk a little bit about things like neurotransmitters and things like that, but that's where they need to talk to some entity about, "OK, I have hepatitis; should I take an antidepressant?" You know, I'm not going to touch that.

It did seem to me as a result of the interviews that I conducted that psychologists are depending on the general medical practitioners, who are doing most of the prescribing of psychotropic medications, to understand and effectively monitor their administration. However, one year after this interview, a young, newly minted psychiatrist, who also holds a doctorate in neuroscience and who was just completing his residency and about to set up a private practice, said to me that much about the role, for example, of dopamine receptors in the case of delusional disorders is "fairly clear and convincing," but that how psychotropic medication works in the case of depression and anxiety is unknown; he said he himself had "no idea," and that "you'd have to understand how the brain works," and "neither my teachers nor myself understand how these medications or things work." This

admission was reiterated subsequently by four more psychiatrists whom I interviewed, three of whom are nationally recognized experts in their fields and teachers of medical students.

The insurance industry

Almost all practitioners mentioned the medical insurance industry in terms like the following, “the push for quick, quick, get ‘em in, get ‘em out, the fast food approach. Three sessions, go! Managed care kind of casualties; bean counters making decisions as opposed to clinicians” (the forensic psychologist). Another psychologist was even more blunt, and said, “pardon my French, but the damn insurance company’s telling us how to do our work, you know!” He went on to describe the problem in what turned out to be a typical fashion:

So . . . you see somebody and you go, “I’m going to help you but - but you have ten hours from insurance will pay you [sic], so somehow we’ve got to figure out how you can be better off after ten hours with me.” You know, well, what am I going to do with - and if I want to do more, then I’ve got to play the game. Because they’re going to say if I - if I say insight-oriented treatment for thirty hours is what you need, they’re going to say, “no, I’m sorry, we’re not going to pay for that” . . . so, the power’s taken away from me and you - client - to make decisions of treatment together.

“Playing the game” is a reference to having to seek “prior authorization,” which consists of constructing and submitting an argument to the relevant insurance company as to why a client/patient could benefit from more treatment sessions.

Another common example is the following: a psychotherapist may believe her client would benefit the most from a treatment plan that includes involving other members of the client’s family. Only one of the spouses in the family, however, has medical insurance, and that particular company does not reimburse for the practice of

“marriage and family” therapy. So, what is the psychotherapist to do? Learning how to “play the game” today includes what may be described anthropologically as an oral tradition, passed down from practitioner to intern, in the course of which the neophyte learns how to outwit a force that does not have the well-being of the client/patient uppermost in mind.

The most seriously mentally or emotionally ill client/patients, who often include geriatric patients in hospital in-patient units, may be affected the most severely, however, by the methods of the insurance industry. A psychiatrist who is a hospitalist responded in the following way to my question in regard to changes she had seen in the course of her practice:

Well, I think - just, you know, from my perspective - just being in the inpatient setting - you know, the elderly patients are mostly medicare patients and over the years I think it has gotten worse in terms of the reimbursement and so the bottom line is, you know, people don't get paid a whole lot for medicare patients. I think the same is true for other managed care or insurance companies, but medicare, you know, you just get reimbursed very little. But, so what is psychiatry or medicine - there's just a push for - to not keep the patients in the hospital longer than we need to, because obviously it's more expensive to be in a hospital. And so, you know, on the outpatient setting there's a push for people to see more and more patients, so that they can get paid more, right? And so that means less time for patients maybe, less time for clinical care, and so I think the result - and of course those are not the only reasons, but - the result is, at least now, what we're seeing is, we're getting a lot more sick patients in the hospital. Just, you know, it could be for example - maybe in the past you would get a patient that you think, “well, this probably could be managed as an outpatient, they're probably better or OK,” but now I think that the patients we get are really the ones that need to come

in to the hospital, which I think is also a problem, because when they come in sick then they need to stay longer in the hospital, you know, you need to do more tests, but . . . so, so we're dealing with more sick people. And they're just more complicated, probably more challenging to treat. I think we're seeing a lot more of the treatment refractory patients that have tried all kinds of medications but they're still having problems. And so, I think that's how it's changed.

Attribution

How did these changes in the conditions of psychological practice come about? What do the practitioners believe is the cause? Again, almost all of my interviewees shared a handful of the same opinions about this which many also summarized simply as "money." The following is a typical albeit somewhat caustic example that encapsulates these opinions, given by a licensed psychologist:

Money. The insurance companies want to spend less money on making people healthy. Back in the early '80s they began to do these preferred provider organizations - health maintenance organizations - which were just a cover for stock owners, and as soon as stock owners got involved in the mental health and the health care fields who were doctors, medical doctors as well, the stock holders became the primary target of the insurance companies making money, and they bought stocks, and they made their profits off of those pennies of stocks, and they began to limit access to healthcare services of all kinds: limit access to the doctors, reduce payments, all in the name of efficiency, and complaining about healthcare costs rising while the CEOs are making ten-million-dollar benefit packages every year. So, it's all hypocritical and self-serving and it's got nothing to do with anything else but politics, and our government is weak, and they don't have the willpower, and we sit back and we take it. And we don't do anything about it. So we are all at fault, we are. If we would rise up like we were back when we were all little hippies back in our twenties

They all identified the same vested interests which they see as the pharmaceutical and insurance industries; they also acknowledged, however, although often in a self-effacing tone, that they themselves contribute to the present climate of practice because complying with the demands of the insurance industry is also how they make a living. As one psychologist who is also associated with an addictions treatment center plaintively characterized it, “Well, we are working in a medical system, so we’re under that umbrella. If I was working out of a church basement, with, you know, bartering for chickens and eggs, I don’t care about diagnosis always, you know.” Of course, she went on to point out that “certainly, if someone came in with major depression, and they’re psychotic, that’s entirely different,” alluding to what is largely the consensus within the mental health treatment field that certain conditions such as suicidality really may benefit from the judicious use of pharmaceutical intervention. The point that many of the practitioners seemed to be getting at, however, is that diagnosis, as required by the insurance industry, is not treatment. And although testing may help with diagnosis, it may be more significant that, as one nurse practitioner phrased it in relation to colonoscopies, for example, “there’s a thousand dollars up there.” Moreover, many of them also stated that medication is not necessarily treatment, either. Indeed, it appears quite likely that the main reason mental health practitioners presently have psychotherapy client/patients is for precisely this reason; that is, medication is not treatment.

Disease as largely of the body

Briefly, this aggregate of responses, as I have described more fully in an earlier chapter, may be described in terms of *indexicalized* meaning-making, by which I am referring to the semiotic and interpretive tendency or *mode* of these responses to be based on the assumption that what is being described is contiguous or intrinsically to be associated with something natural, namely, in this case, the human body. The

practitioners whose responses fall into this category separate the mind and the body conceptually, and assign the term “disease” to the body; they are also highly skeptical of the autonomous existence of something called “mental illness,” and prefer such concepts as “problems of living” to designate the issues that they treat professionally.

It is in terms of their opinions of the changes that they have seen that their responses may be differentiated in certain ways from those of the other aggregates; so, for example, several of the respondents in this category talked about the health care system in our society as being “broken” due to the power of the two great forces, the pharmaceutical and insurance industries, impinging on their practices. Client/patients tend to be seen as the main victims from this perspective, but practitioners too become frustrated and discouraged in their ability to be helpful and to find their work meaningful.

A licensed clinical social worker in this group believes that the DSM is “useful for insurance companies [and] for medical people, [but] a waste of time for clients.” She points out that at the same time, “the medical boys look askance at psychotherapy because it’s hard to pigeonhole.” In her opinion, the DSM is “trying to make something sure that essentially isn’t,” and clinical debates are about “taking potshots at each other over things that essentially are not sure.” What we should be doing, she says, is asking, “what about the client?” As to medication, she remembers when there were only four or five available; today there are many more, and “nobody really knows how they work. The major problem: side-effects.” She is not sure whether this is an improvement on earlier times with fewer medications. She described the “wracked bodies” of some of her clients, including the problems of overweight and the development of a shuffling gait, in the course of which “thirty-somethings [are] looking like sixty-somethings.” She complained that psychiatrists do not discuss the side-effects with their patients, yet it has become “socially acceptable” to be on medication. “We know so little about the brain,” she said; “it’s a guessing game, and some admit it.”

These days, she says, “I talk about nutrition a lot more, focus more on their history, including eating and drinking, which are so easy to ignore.” She says she does not mention having been trained as a Gestalt therapist very often anymore, but feels compelled to claim cognitive behaviorism as her practice modality “because of insurance.” But cognitive behaviorism is, she says, “a bunch of hooey - it’s a way for the insurance companies to document.” By contrast, Gestalt therapy “is a way to document what’s going on in the room. . . cognitive behaviorism is not holistic; [phenomena] can be put in boxes [which] doesn’t tell you anything.” However, she said, clearly we are also “coming full circle - thirty years ago [there was] imagery and psychodrama [which] came to be seen as hocus pocus. We may have thrown the baby out with the bath water.”

A psychiatric nurse added to the changes she had seen “medicating kids and the acceptance of it”; she went on to speak of the wholesale “medicalizing [of] family situations,” in the course of which a child becomes the “identified patient,” a method by which a practitioner is able to both obtain psychotherapeutic intervention for a family and reimbursement for his or her efforts. She feels strongly that “kids should not be the IP,” since this has ramifications for their medical history. She also mentioned the problem of the influence of poverty under a “current administration lacking in humanistic values” (2007). So, while drugs may be more available and are being prescribed more readily, families cannot necessarily get more basic medical help. She sees this as an issue particularly for children and the elderly.

In the opinion of this particular practitioner, there should be much more “financing of studies on the healthy things.” She recalls being trained in nursing school to “treat the body’s - the person’s - response to the illness,” since “nursing is about wellness.” Instead, today the accent seems to be upon illness, which is then “medicalized” - treated with drugs. She finds herself “fighting hard to stress wellness,” and tells her patients to “eat an apple, and drink some water” for a change.

A nurse practitioner said that “medical professionals are providing much more psychotropics than in the past,” partly because they are “safer,” but also because they are “more accessible.” When I asked how she believes this has come about, she said as a result of “promotion” by “drug reps,” through whom “we get a lot more input.” Furthermore, the continuing education workshops available include free bipolar-annuals for healthcare professionals sponsored by the pharmaceutical industry “always featuring some diagnostic category seen a lot such as depression, anxiety, attentional problems.” It should be noted that these conditions used to be the province of psychiatry, not general medicine. Then there is the fact that “patients come in asking for what they see on TV,” she said, although she claimed that she herself “does not necessarily feel under pressure to prescribe.”

She is one of the practitioners who describes the medical profession today as “broken,” and sees this as a consequence of “relationship building [having been] interfered with between the doctor and the client,” implicating the direct-to-consumer advertising of pharmaceuticals. Along these lines, she also described problems surrounding “the continuity of care” brought about by a medical insurance industry under the auspices of which “patients are circumscribed as to access”; this is compounded by a medical delivery system in which practitioners see “a patient every ten minutes.” Although she identified some changes as “good,” such as electronic record-keeping and “pressure to keep costs down,” the “number of meds available has made it more complicated.” She also finds that “access to mental health services has improved,” and happens to be one medical practitioner who refers patients to psychotherapists, but that in general “there needs to be team effort between biomedical practitioners and therapists,” implying that this is not presently a given.

A psychologist who also carries out managerial roles in a hospital-associated mental health practice described psychotherapy practice in the past as having been an

“open-ended adventure, all relationship-based; then there was the painful over-correction” in the course of which “insurance companies became the devil for a while.” Now there is an “intermediate approach” in evidence, she finds, characterized by “a better understanding by doctors, etcetera,” which has come about as a result of practitioners ““bothering the rest of the system,’ the principal’s office, the doctors, the police, without longer-term therapy.” She seemed to be alluding to practitioners’ greater understanding of the many variables in client/patients’ lives that contribute to mental and emotional health and their greater willingness than in the past to enlist the help of other players in client/patients’ lives. However, she pointed out that “psychotic or bipolar [people] used to be the only ones on drugs; now most are on meds.” On the day of our interview, of the six clients still scheduled to come in for psychotherapy with her that day, all of them, she said, were on medication; moreover, three of the six were on “multiple.”

This psychologist attributes some of the changes to the hiring of many more middle managers by the insurance industry “to cut costs”; however, she said that it has become “obvious to everyone” that this approach “has become more expensive.” Along with this, there is the literal presence of the pharmaceutical industry in the form of representatives who cultivate what she described as a “soft-face presentation”: “they bring us new books, including DSMs; pens, lunches, free meds.” This industry has certainly contributed to “advancing neuroscience,” she said, but also to “feeding the animal.” The practice that employs her also has a nurse and a psychiatrist on staff, but the availability of medication has made the practice very “documentation intensive”; these substances are “under lock, signed in and out and noted when disposed of, rule-bound.” She describes herself, however, as having “no compunction about hitting them [the pharmaceutical company representatives] up for stuff for my clients, the women’s group,” since “they’re buying access.”

This psychologist believes that “drug companies have too much power and access; it’s like putting the compulsive over-eater in charge of handing out cookies.” And the “brokenness” (as she also put it) of the healthcare system from her perspective has to do with that “we are paying more money to manage the system than to pay the people providing the direct care.” She was referring to the cost of coding, billing, and managing client accounts.

Another psychologist in this group of respondents who works in an addictions treatment facility says, “we are seeing a higher incidence of abuse of prescription drugs”; she has the impression that she may also be seeing more “kids with problems” than in the past, and asks,

do we psychopathologize kids more, or, speaking of children, are there things going on in our society, like, you know, video games and computers - that very rapid stimulation, that instant gratification - and then we send kids to school and the classroom is totally “sit-and-git” style of learning, and it’s getting harder and harder . . . is it working for kids? So, we see kids acting out more and looking a little more disturbed . . . is there - say - more depression, or are we more aware of it, so more people are getting help? Is there more addiction, or are we more aware of it, so more people are getting help? . . . I sure hear about people being concerned about overdiagnosing every child and putting them on pills, and I hear that, and that’s in the pop psychology, but I also see kids who because parents hear that stuff who have bona fide ADHD and their parents do not want to get them help, and they’re afraid - “oh, if I put them on Ritalin they’re going to grow up and be an addict” - so then Johnny doesn’t do well at school, doesn’t have friends, their self-esteem is low. You know, some studies say some kids with untreated ADHD are fifty percent more likely to grow up with addiction problems because of all that comes along with untreated ADHD. . . . They’re always in trouble, so they start using.

She is more sure that she is seeing more eating disorder. Again, she attributes the causes to changes in society, including the desire for a solution in the form of a pill:

So we're coming up with a prescription for the symptoms, rather than looking at the . . . we're taking a pill, rather than looking at the causes. Which is kids eating high-fat fast food and watching TV instead of going outside playing kick-the-can late at night. . . . Diabetes and things like that - it's endemic. I listened to a doctor talking about prescribing some medication, and, you know, there's some side-effects, especially if you have a high-fat diet, and so she was talking about one of these teen-agers who unfortunately - they're eating high-fat diets so they have side-effects to a particular med. Well, my question is, did you talk to them about their high-fat diet?

At the same time, this psychological practitioner alluded to the sheer amount of work it can require to get well:

considering therapy and exercise and read something and go to a support group, and then it might not get better for weeks or months. And using kind of pain as an analogy perhaps, do I go to a chiropractor or a massage therapist? Well, my insurance doesn't pay for that; I try to exercise every day - it's a pain in the butt, or, I can go to my doctor and get Orotab. So, I think some of it . . . as a provider, I think sometimes that we get frustrated; we think we're not being helpful, we don't know what to do. I'm not quick to recommend medication for people, but I also know based on the presentation of their symptoms there are some people who'll have the need to march straight to their doctor's office. . . . it's easier. So I can go get that new weight loss pill and take it with my morning coffee.

But she decries what she describes as “the Western cut-and-paste mentality to fix it,” and does not believe that this is going to change any time soon. Addressing polypharmacy, she said she has been seeing this for a long time now, in the course of which

kids start out on this pill, it doesn't work, so let's raise the dose, and that doesn't work, so let's get another pill, and that didn't work, so let's raise the dose, so that didn't work, so let's add a third pill, so now I'm on three or four antidepressants, and that's not counting my blood pressure pills, and my cholesterol pills and my diabetes pills. So now I'm taking fourteen pills a day, and now I'm having memory problems. Am I having memory problems because of my depression or because of my medications?

This psychologist also mentioned that “some conditions just aren't very treatable” using psychological techniques, and that “sometimes we need symptom relief, no doubt about it,” professional opinions that many psychologists share, but, she said, “I think on a macro sense . . . we are a kind of a take-a-pill culture.” As a practitioner, then, she finds herself needing to have “some working knowledge” of the medications; she asks her clients whether “they know what they're on, and how much they're taking . . . so if my client comes in and says, ‘well, I'm sick of my patch so I quit taking it on Monday,’ and they're sitting in your office nauseous and shaking, you have some idea that oh, oh, they need to get in and talk to their doc. I need to know enough to send somebody to the psychiatrist for whatever reason.”

A long-time psychological practitioner who worked with handicapped children and eventually also became a professor, now retired, described the changes he had seen over time as “tsunamis.” “There were the poor farms, there were poor houses, and so forth. And so we treated people who were poor in that fashion; we institutionalized them,” he said, and went on to describe some of the details:

The institutions for the mentally retarded. The mentally ill, as we said; all of these things. And I think in fairness, for a lot of this, it's been a combination of changes in beliefs about the potential of human beings to recover from whatever they had,

and the development of course of the pharmacology. And psychopharmacology. That has allowed people to live in the open society. . . . Streptomycin changed the life for people who contracted tuberculosis - almost knocked it out. When I was working with children, children - young children - elementary aged kids - would leave school in June for summer vacation and I would see them in the fall - they would come in on litters, and they would have - they were victims of polio. So, you know, one summer Salk vaccine was given, and almost knocked out all of the polio, you know, all of the polio victims in that one summer! So, that changed that. The other is a change that occurred because there were some people in society who did not believe the professionals and said, "I'm not going to do this"; some parent with a Down syndrome child who said, "no, this is my child, I'm going to educate this child here," and so forth, and so they - this child with all the characteristics that we assessed at that time proved to be completely different than what the outcome was predicted, and that in the way that we - so it was changed. It was parents that did it then. You think of the association for retarded children. And . . . for my cohort now, I think of the AARP [a national elder organization], you know? And how that's changed things. . . . so, anyhow a single cause is not going to explain it. It's going to be an evolving panorama of changes imposed on people.

With deep feeling, he proceeded to give me his opinion of the changes, ending in puzzlement over what seems to him like a regression to a former socially sanctioned disregard for suffering:

My opinion now is almost a sense of guilt that I participated in . . . I wasn't a decision maker or decider, as our fearless leader says, but I was, you know, a student then. And I was just beginning, and my opinion now is how horribly

wrong [some of what we did] was, and if I participated I feel almost guilty for, you know, some of the experiences I had at that time will haunt me for a long, long time. Going into a nursery or with young children two - three years old, and the children coming up to cling to your hand, wanting human contact. And you'd pull away, and they would be left there, or . . . I could describe all kinds of things, but . . . you know, I could go on with that, but as an opinion, it was a terrible abuse of many human beings at that time; it was a degrading and debilitating kind of condition. And with that, you know, that's the way it was. It changed in my lifetime, thank God, you know, and that's all I can say. It would be like a lot of the . . . a lot of the treatment that leaves . . . that has occurred to people over time, and I stopped because yesterday I went to the . . . a lecture, by one from the physicians at the U, and he's also a HCMC [specific medical center affiliate], and he was talking about doctors participating in torture of people and . . . I thought, how far have we come? What has happened that our most, you know, highly educated people are now participating in torture? What the hell has happened?

Today, he said, children with handicaps are largely integrated with other children and practitioners view their potential in terms of contribution to society quite differently. But this retired practitioner is concerned about a political climate in which the gains made - the recognition of shared humanity - may evaporate, at the same time that a certain type of clinical attitude prevails in medicine.

Involvement of general medical practitioners

I asked practitioners what they thought about the involvement of general medical practitioners in the management of client/patients' mental or emotional symptoms. Most of the practitioners in this group thought that their involvement could be good and useful for client/patients, but two consistent themes that emerged in their answers were that it

depends on the individual physician, and that physicians today hardly have the time to really get to know their patients. This in turn seems to lead to lack of cooperation with psychological practitioners with whom they may share client/patients. At the same time, perhaps because this group of respondents tends to equate “disease” of any kind with the physical body, they seemed quite open to the involvement of medical practitioners in the lives of client/patients.

Indeed, a nurse practitioner said, “they have to be involved because you can’t separate the physical from the mental.” A psychiatric nurse believes that “generally, most of them have a great concern” for their patients, and that “they are doing their best.” However, she finds that doctors are also experiencing frustration as a result of the “reimbursement pressures,” which she believes are the cause of their lack of time “to really know their patients really well.” A licensed clinical social worker said she talks more to doctors’ nurses, and has “never gotten a call from an M.D.”; to her it appears that “medical people are on a treadmill; many psychotherapists too. We’re all enslaved to the insurance companies,” and so, again, doctors “lose out on knowing their patients.”

A psychologist employed by a mental health clinic associated with a hospital talked of “losing the person in a system” that has become so specialized that client/patients see it (rather than themselves) as “crazy”; thus, this practitioner gave the example of a client of hers who finds it strange that the hospital includes a “breast center.” She herself misses “the small-town way of collaboration with G.P.s” she used to experience, which included them asking her which medication type might be best for a particular client/patient they had in common. Ultimately, to her, however, “it’s about patient care,” and so she seemed to imply strongly that psychotherapists should seek collaboration with general medical practitioners and not fear “to disagree with specialists,” something she prides herself on being able to do.

A psychologist associated with an addictions treatment center said, “I think clients are more inclined to go there first often” in reference to the involvement of general medical practitioners in the treatment of emotional symptoms. In her words,

I sometimes see people that come trotting over from their G.P. after the first time they met that person and after a ten, fifteen minute appointment they’ve got a prescription in their hand, and ironically right away they have an appointment with me, and I’d rather have - see it the other way around; I’d rather have them have a psychological evaluation, and then they can go to the doc, and he can say, well, they have dysthymia. Or they seem to have a substance abuse depression, or what-have-you. You know, that concerns me a little bit.

She is not so much concerned about physicians’ involvement with mental health issues *per se* as that they are not specialists in the field. So if it appears to her that clients “need a medication consult,” she says, “I very often will try to encourage them to see a psychiatrist or a psychiatric nurse specialist because that’s all they do, you know.” However, there is no question in her mind that medication can be helpful to client/patients, and so she too works at trying to establish and maintain working relationships with local physicians and counts it as “wonderful” when she can have “seven or eight minutes” of conversation with them in relation to a shared client/patient.

The retired educational psychologist and professor mentioned above was clear in his opinion that the involvement of general medical practitioners in mental health “depends on the individual physician,” and proceeded to explain his position using a personal story:

I stopped going to male physicians . . . there’s something about the socialization, especially of middle-aged male physicians, in general, not all but in general, the ones that I came in contact with, where . . . the first thing that they would be you

would describe them as clinicians. They were interested in the clinical behavior. They have no concept, in my judgment, they didn't have a very clear understanding that I was the same kind of human being that they were. I was built pretty much the same. I wasn't, you know, this and that. I read a piece - the physician that I have been going to for a number of years and just now went to be a teaching practitioner for new interns and I sent her an article that was in one of the Harvard journals, and it said every patient should be, when a physician says, "I think this is wrong with you," should immediately ask, "what do you think is the worst thing?" Because you want them to extend their thinking, not to what they saw the first time, and down, but you want them to change their thinking styles. I asked him whether he was referring to something like "objectification," and he agreed, and went on to say,

My comment about gender is that maybe we socialize women in different ways than males, and so they're more open to looking at the person; that we have, you know, we've done something, and maybe it's always been that way, but I worked in Saudi Arabia and lots of other places where the socialization of women was very different than the socialization here. And so it's - I think it's cultural, and I think that we - our culture . . . of course it's changing - but I think that our socialization of women is different than for men and that when a woman physician in general - I've got another one, she's from South Africa - and it's the same thing. She listens better, she . . . is more likely to refer, more - she's more preventative - it's not interventions, it's preventative - and so forth.

The meaning of psychotropic medication

All of the practitioners in this group consider psychotropic medication to be a valuable form of medical intervention under certain circumstances, especially in the case of suicidality, but also for serious thought disorder. However, almost all of them also

stressed certain kinds of associated dangers with their use, including, according to some of the practitioners, that how they work is not well understood. In general, practitioners have learned about this type of medication in specific course work in their graduate training; however, they keep abreast of developments in the field by attending “continuing education” workshops, which, especially in the case of medical practitioners, are often sponsored by the pharmaceutical industry itself; reading books on the subject; and obtaining information from the internet.

A clinical social worker said, “sometimes they can save a person’s life; on the other hand, they can destroy people’s bodies. They are poison. They should be respected for [both] good and harm. . . . For some they work, and for some they don’t. It’s a crap shoot. Dope fiends won’t stay on them because the release they are seeking won’t come.” A nurse practitioner said that to her, medications meant “an adjunct to helping [a person] reach equilibrium,” and, along similar lines, a psychologist described them as “a tool for symptom management.”

A psychologist who is employed by an addictions treatment center, however, was also able to address the irony of the medical establishment’s tendency to quickly move to medication including in recovery programs, stating,

I think that ideally we would live a drug-free life, and then I also look at it from a kind of a harm-reduction model, and so if people are going to be out on the streets of, you know, Amsterdam or wherever with needles in their arms or robbing banks, or they can go down to the clinic and take a shot glass of whatever the latest opiate blocker is and they can go about their job, and they’re nice and they’re clean and they’re not hanging out in the park. . . . so maybe some medication like Chantix - I think that’s the latest if they can help with that transition with whatever’s happening, that’s a plus. . . . Philosophically, is it kind of odd to substitute one med for another? Absolutely.

I asked her how she thought the current situation, including the social acceptability of being on Prozac, for example, is different from the time when people carried flasks of alcohol in their back pockets, and she responded by saying,

I think that a greater understanding of some brain chemistry stuff has helped me a little bit. Wearing eye glasses helps me - is that artificial? Yes, it is. But if you look at the whole drug deal, my understanding is more people dying a year from smoking cigarettes than all the other drugs combined. And it's perfectly legal. I work in a treatment center and any given hour there's a couple counselors out back having a cigarette. It's very ironic. So, we're supposed to be helping people with their addiction and we're addicted. . . . And we can fly our airplanes down to Columbia to crop dust a cocaine field and probably do some harm to some poor farmer's family and if Columbia flew a plane up here to crop dust a tobacco field we'd shoot them down. But we are exporting our cigarettes to their country. So that stuff kind of makes me crazy. You know, if I was a small farmer in Honduras, or a small farmer in Afghanistan, the poppies, the cocaine - we ship well [sic]. We don't have to refrigerate them; it's economics. It's supply and demand, and we - I don't think we should be attacking the supply end of the equation. We need to look at the demand. . . . I took a big tangent, but I do think the drug wars have been all about interdiction, and it's been all about wiping out poor farmers' fields, and we haven't looked at what is the demand side, which is all about sociocultural issues, and children not getting good education and self-esteem and parenting, etcetera, etcetera. . . . I mean, it's a big . . . Afghanistan - I mean, a year after we were there, I think last year, opium production reached an all-time high. We talk about making them do something about that, but I mean it's - a certain amount - somebody's trying to survive. And we're buyin.'

But another psychotherapist mentioned to me how a psychiatric nurse of her acquaintance admits that alcohol may still be the best anti-anxiety medication known.

Another psychologist who is strongly aligned with the biomedical model of psychotherapy believes that “medications can be tremendously helpful.” However, he, like the psychologist above, alluded to the powerful influence on individuals of societal attitudes towards suffering, which are also heavily shaped by advertising and take a particular form in the United States:

We live in a society where the marketing to the public - I sometimes attribute it to garbage disposals and garage door openers. We live in a society of pop, pop, fizz, fizz, ‘oh, what a relief it is!’ This is why diet books sell by the zillions. Anything that is a quick fix Americans gobble up, no pun intended. Therefore, medication doesn’t take time out of your work schedule or away from your girlfriend or whatever.

To him, then, medications often mean a “quick fix,” which makes sense in a society that is not given to introspection to solve problems of disease.

The retired practitioner and professor expressed a different kind of concern in relation to the meaning to him of medication:

If it means that one human being dealing with another has only one arrow in the quiver and it’s a drug, what does that mean for interacting and understanding that person? What does that - it’s beyond me, that kind of an approach. . . . if it’s that this person says, ‘I can’t sleep, the demons are after me, this happened to me, it’s just something I can’t deal with’ . . . bad things happen, bad things are happening, and there is a drug that will relieve those symptoms, because this is a temporary kind of condition, and it helps, or, I’ve got a friend who has diabetes: he’s in a nursing home now. His life is in the pits; you know, it’s the twilight of the life, and so they’ve got him on some mood-elevating drugs. I say, what the hell!

When I pick up the phone and I talk to him, and I say, ‘how are you doing?’ and he says, ‘just great, it’s a wonderful day today,’ or something like that, that’s OK.

So, but if it were a thirty-year-old person coming in and they said some bad things have happened in their lives, both either imaginary or for real, and, you know, somebody said, ‘well, we can zone this guy out,’ or this woman out, by giving them drugs, and ‘we’ll see you in six weeks, come back and tell us how it’s working,’ that’s not the way it is with human beings, you know. Human beings are pretty social beings, and even . . . those who you see that seem withdrawn and isolated and don’t want any contact with human beings, that’s not always - and in fact I don’t think it’s ever [actually] the case.

Disease as applicable to mind

This aggregate of responses, like the one above, may be characterized in terms of *indexicalized* meaning-making, referring to the tendency to assume that what is being denoted is contiguous with natural phenomena. As also described in an earlier chapter, however, respondents took the term “disease” to be potentially applicable to “mind,” unlike in the case of the aggregate above, unconsciously validating the cultural *psyche/soma* split while reifying the mental dimension of human experience. This semiotic move then tends to give rise to *symbolic* meaning-making as well, especially when it comes to psychological interventions. From their perspective, then, the mind itself could be unwell, although this situation could be influenced by physical conditions, both of the body and of the social context of a person’s life.

Their opinions of the changes they have witnessed in the course of their professional lives are marked by negativity that centers on their perception of client/patients as being overmedicated including in part for purposes of *social control*. Although psychotropics are seen as indispensable for psychotic conditions, these practitioners see them as being overused in cases of less serious suffering on the basis of what they describe as a shortsighted approach to emotional disturbance. This has created a system of response that, in the words of a psychiatric nurse, is itself “not healthy.”

Given the salience of “mind” to the human condition which the practitioners in this aggregate acknowledge, it is perhaps not surprising that some of them also stressed the economic wastefulness of more recent trends in the management and treatment of distressed individuals, when by definition human beings are generally capable of making choices that have an effect on their well-being.

A behaviorally inclined forensic psychologist who is also a college instructor spoke of what she perceives as a “cheapening and devaluing” of psychotherapy:

People don't see it as a process that it should be; we know that learning should be effortful and it's much more effective, long-term, if it's effortful. It's more meaningful if it's effortful. So therapy should be about work and about commitment and investment, whether it be weight change, whether it be chemical use change, whatever. Personality, relationships - it's about the hard work, it's not about you do one quick thing and *voilà!* So I think our society's 'I want what I want, give it to me, Baby, now' - immediate gratification is - that attitude has really led to the changes, too. And also, we have - we have created the very monster which many of us are now complaining about. We tell people what they should want, and what they should expect, and what works, what they need. And what the source of their problem is. And then they believe it. Why wouldn't they?

She referred to the role of advertising in shaping public perceptions, including in relation to who may be regarded as an “expert.” Although this practitioner sees the increased acknowledgement by many people of having emotional problems as an example of a positive development in the midst of largely negative trends in the treatment of mental health conditions, she went on to say that even this, however, is suspect:

It's also a negative change, though; I think that they're overpathologizing their normal experiences. You know, I don't know how many people I have - students

who have a tough time paying attention saying “I must have ADHD” Or whatever. “I feel a little bit down, I must have clinical depression.” And on the internet, that’s another thing too in terms of change in treatment. Look at information resources and how people are making decisions about their experiences based on, you know, really uncontrolled information on various websites, info sites, and they have these bipolar disorder checklists and ADHD checklists and

She went on to mention the “Ph.D. approved” stickers on many mental health information websites of questionable scientific value, and described this situation as “appalling,” given that many consumers of this kind of information are not in a position educationally to critically evaluate the claims made.

I asked her whether her treatment methods have been impacted by these changes, and, in a manner that may be defined as typical for this aggregate of practitioners, said, Oh, yeah, definitely. In fact, you know, changes in treatment, primarily the treatment with drugs, continues to impact. There are some people that I see and they’re so doped up, so misedicated or overmedicated that that, in my opinion, is causing their dysfunction. Just on - one day last week they re-interviewed - they did a follow-up interview - this person I saw for a confidence-to-proceed and criminal-responsibility eval, when I saw her she just looked awful. I mean, she - I couldn’t tell what the hell - if it was some kind of psychotic condition - I couldn’t tell if it was some kind of brain injury - a poor historian - I had really limited data - so, I got a bunch of releases and went to [a local psychiatrist] and got records, and, you know, the person was on - she gave me a list of the meds she was on, and I thought, oh, that might be [it]. . . . So one hypothesis that I was passing around was she’s just way overmedicated. So, anyway, she ended up going off a few of the medications; one of them she was on: these whopping doses of Klonopin.

And she was having reactions to it and I saw her last week - much, much improved. And she recognized - she said, 'since I went off' - I don't remember the exact ones, but - she said, 'I'm much more clear' So, the medication piece certainly influences treatment, and not just the direct impact of the drug, for better and for worse, because I mean for some people that medication is helpful. It gets them to the point that they're able to benefit from the psychotherapy. If you have somebody who's severely depressed, they may not have the energy to invest in doing the work of therapy. Or, the same thing with anxiety or eating disorders, whatever. So you can have a positive impact of the medication on treatment, and also the negative impact, but not just the direct effect on the clients, but also the attitude of the prescribers. So, for example, I'm comfortable mentioning [a particular local psychiatrist] directly. So he has very clearly stated that drugs - that these people need to be on drugs, and given them the message that this is the treatment that they need. And then if anybody disagrees with that - another provider questions that So, for example, if somebody has just a tremendously severe chemical dependency history and they are taking various benzodiazepines and clearly abusing them, and they're also on these psychostimulants, and abusing those It's just craziness! [These substances are agonists.] And so providers like myself in doing evaluations have suggested - respectfully recommended - that this individual, you know, see what happens if they get off of these medications, and chemical providers saying 'we won't treat you if you're on .xyz medications.' [A particular local psychiatrist] will say, 'you guys don't tell me how to treat my patient!' And he will back stab and basically diminish any other provider's credibility, and of course the clients like him because he gives them what they want and he, you know . . . yeah. Well, and he doesn't push he doesn't confront, he doesn't challenge . . . he doesn't

question, so . . . it's a cursory assessments [sic], and they don't have to do any work when they go in. I mean, they can snowball 'im, whole bunch of things. So, his - it's not just [the particular local psychiatrist], there's been other psychiatrists too, but that kind of attitude undermines the integrity of other professionals, and so the treatment change with the drugs has had not only a direct impact but also in terms of the relationships among providers.

A behavioral psychologist who recently established an independent practice after having become disenchanted with the drift into the medical model of the community mental health center where he had been employed for over a decade admitted that the pressures to conform to aspects of practice, couched as "standards," remained the same. He describes these practices as often having little to do with furthering the relationship between himself and his clients, nor as contributing to healing as such, but they are requisite to being reimbursed. He said,

If anything, I probably am more careful to make sure that I do and say and pull more behavioral interventions in, and more behavioral measures, probably more importantly. You know, I'm much more prone - say, a depressed person - instead of just saying, 'how are you today?' I'd say, 'Out of one to ten, how's your depression?' So, I've got these numbers, 'cause boy, insurance just seems to go, 'hey (claps), good job! Keep those numbers!' And, of course, the reality is, from a scientific perspective, they're not that valid. But, you know, they're valid to the system, and they work. It's like the MMPI [the Minnesota Multiphasic Personality Inventory] - it's not really the most valid instrument, really, but it's accepted, you know, so we use it for a lot of things.

Involvement of general medical practitioners

The practitioners in this group have very real concerns about general medical practitioners being so predominantly involved in mental and emotional health treatment. Treatment, such as it is at the hands of physicians, generally consists only of the prescription of medication. Certainly, general medical practitioners “are acting well within the standard of the field” when they prescribe, as a psychiatrist pointed out to me, but the psychologists in this aggregate are concerned precisely about the lack of specialized training in the treatment of mental health. This may be compounded by non-recognition of psychotherapy as an effective form of treatment; as the same psychiatrist said to me, “don’t expect G.P.s to believe in psychotherapy.” In other words, psychological practitioners are concerned about the fact that general medical practitioners neither have extensive professional training in the treatment of mental health conditions, nor do they even necessarily believe in the relevance or efficacy of such training and treatment. They are, therefore, not likely to refer to psychologists.

This is not to say that general medical practitioners do not care about their patients’ emotional symptoms; on the contrary, one of the mental health practitioners was at pains to point out that “G.P.s want to make people feel better.” Furthermore, client/patients come in for appointments specifically to ask for medication; this goes along with what a psychiatrist described as that, “socially, we are into externalizing,” meaning that, in his opinion, client/patients seem to think that “‘it’s my brain chemistry.’” Or, as he went on to say, they “are not taking responsibility; [they say] ‘it’s not me, it’s my body.’” From this perspective, then, these psychological practitioners see the problem as one of the general medical practitioners lacking information about the context of the symptoms and being all too ready to medicate rather than to refer patients to mental health specialists.

A forensic psychologist expressed many of these practitioners’ concerns in detail when she said,

I think it's scary in the sense that they do such cursory assessment, and in my opinion the first step is accurate problem identification. I mean, duh! Your problem-solving approach starts with that you correctly identify the problem, and I think that so many physicians have no problem throwing out these very serious - what I consider very serious - labels like bipolar, like ADHD, like depression, like . . . inadequate personality disorder - I saw the other day! I mean, it's like what the hell! . . . So, they're poorly trained in diagnosing the problem in the first place, and then they do this cursory assessment and they don't look at all at the other factors that might be playing a role in this person's problems. So, and they're quick to just - just throw out the medications, which can complicate the problems. Another problem with it, the medication kick, and the change - going back to the question about the changes in treatment - medications undermine one's sense of personal responsibility and basically they're a barrier to empowerment, I think. So, when you have these physicians, these general physicians who do a cursory assessment, you go in, and oh, "yes, you have this clinical depression, this biological disease, this chemical imbalance," people start to think, "Oh, I have a chemical imbalance! It's just like diabetes, so I treat it with medications," instead of thinking, "OK, I have this chemical imbalance but I can change it by medications and I can also change it by the way I think and how I feel and my relationships and the behaviors I engage in," just like diabetes, because, diabetes, I mean, there is very much a behavioral and emotional component to the management of that, too.

Her concerns included not only incorrect diagnosing but also the social consequences of even labeling mental and emotional disturbance, a situation that psychological practitioners are usually overtly trained to take into account:

I think if I had to say, you know, is it more positive or more negative, I'd say it's more negative and it is scary. And they also don't appreciate that these labels have all kinds of implications, implications in terms of military service, implications in terms of jobs, other occupational kinds of things, implications in terms of the legal system. So you can have some general physician who's not trained throw a diagnosis of bipolar out and then a very savvy attorney from the Cities comes and picks up on that and they use that as a manipulative tool to mitigate sentencing or to get somebody - to attempt to get them - off. I mean, there's all kinds of implications that I don't think a lot of general physicians even think about. Because if you throw out a diagnosis on a medical condition, who cares? Unless it's HIV [human immunodeficiency virus] or something; you know, chlamydia, or, you know, whatever - that's not as big of a deal.

She included the potential problem of even finding housing under certain labeled conditions, naming this problem as that of "stigma."

A behavioral psychologist added to his list of concerns that general medical practitioners "seem to keep stocks of give-aways of certain pills." He wondered whether they are "really assessing that that particular antidepressant is really the right one, given all the variables." He wishes that there were a way for them to "assess complexity of client needs, somehow. So that it hits a certain number and, boom! It's - OK, that's - that's off to the psychiatrist for that."

The meaning of psychotropic medication

The practitioners in this aggregate generally perceive medications as an adjunct to treatment, "part of our arsenal for curtailing symptoms when they become too debilitating," as a psychiatrist defined them. Given the significance which they attribute to "mind," including the idea that the mind itself could be diseased, they regard medication as having a rightful place in the course of the treatment of certain

psychological conditions but that they should not take the place of psychotherapy. They seem to depend upon a notion of mind as forceful in its own right, mentioning such concepts as “psychological growth” and the fact that research has become capable of showing that talk therapy creates changes in the brain that are very similar to those which may be chemically induced.

A behavioral psychologist, who is in private practice, put it this way, which may be regarded as typical:

Generally, I think it’s an adjunct; you get some control of the majority of the symptoms and then get people to work on lifestyle and things to maintain and maybe not need, you know, long term. And of course, you know, the whole adjustment . . . I mean I guess it depends on the disorder, of course, but let’s say you have a person - it’s pretty clear they really do have bipolar disorder, let’s say. Well, there’s a whole major psychological component to that: accepting the disorder, lifestyle, monitoring, support systems, all that stuff that really a pill isn’t going to provide any of that [sic].

And a forensic psychologist, also with strong behaviorist leanings, meaning that one could have expected her to espouse a more reductionist approach, perceives medications as a source of “misunderstanding,” considering that “people do not have access to accurate and complete information about medications and about how psychotherapy influences you physically and mentally.”

A psychiatrist pointed out that a recent meta analysis of studies reporting on the use of antidepressants found that “much of the initial effect is placebo.” In other words, the meaning of medication may literally be that of an adjunct; it may have no more effect, at least initially, than any other form of consensual treatment. This practitioner also holds a doctorate in neuroscience, which has left him with a sense of the “complexity” of the issues more than anything else, and has come to the conclusion that what may be the most

important thing about medications is not *how* they work, but *that* they work; thus, for him, their meaning is a pragmatic one.

Disease as unease

This aggregate of practitioners may be characterized as holding an holistic view of the human condition which for them includes such nontangible aspects as *being* and *consciousness*. As described in an earlier chapter, this also predisposes them to *symbolic* forms of interpretation. Although they seem to be aware of the cultural *psyche/soma* split, they do not appear to organize their perceptions of people's distress along those lines; rather, their views stand apart on the basis of their perception of any illness as an integrated phenomenon involving the whole person and often the individual's community as well. Since their interpretations include the role of consciousness, however, their perspectives are both conventional in a methodological sense (hence symbolic) and highly progressive on the basis of alignment with developments in mind/body medicine. I have proposed, therefore, that their views may also be described as *indexical* in an expanded sense of the term, to include consciousness as part of the natural world.

What is the nature of the opinions that these practitioners hold about the changes they have witnessed? On the one hand, these practitioners are deeply, even passionately, concerned about what they see as a lack of integration of already existing knowledge about *wellness*. They observe that not only is such information not widely circulated in an integrated fashion as it might be, for example, through the medical profession, but there also seems to be institutionalized resistance to it on certain fronts including on the medical. On the other hand, several of these practitioners themselves seem to be a part of a backlash or of progress as they take matters into their own hands and treat their client/patients as they themselves want to be treated: as whole beings capable of health, but who may also benefit from support and encouragement occasionally, especially when confronted with psychologically overwhelming life circumstances.

The practitioners in this group are unique in another way as well in that most of them had a story to tell about their escape from conventional practice; that is, most of them have taken professional risks by asserting their own convictions about what a psychologist or other mental health practitioner is dealing with when attempting to treat mental and emotional disorder. An outstanding example is that of a psychologist who both practices and teaches meditation and related techniques to his clients, but who, twenty-seven years ago, at the risk of the loss of his license, was required by his licensing board to defend his point of view multiple times. Today, his methods can be described as “going mainstream” as a more progressive medical community is recognizing the role of consciousness in mediating stress, and clinical psychologists, many of whom both take cues from the medical community and have been practicing these methods themselves for many years, feel much freer now to integrate some of these techniques into standard practice with clients. In his own words,

Medicalization of therapy is self-defeating, counterproductive, and basically antithetical to mental health. And some day they’re going to have to wake up and realize that they need to focus on the realities [of] what mental health is really made up of. And it isn’t made up of chemicals and all that stuff, it’s made up of the ability of people to use their own inner resources.

Again, the “they” to which he refers is the biomedical industry with which much of mental health practice is now functionally and philosophically aligned.

Another psychologist in this group who is employed by a community mental health center laid out the following ultimate and consciousness-raising questions, which she sees as being avoided by both medicine and the pharmaceutical industry: “Who is controlling my brain? Who is thinking for me? Who is thinking for you?” She went on to describe both the changes she has witnessed and her opinion of them in the following way:

I think my initial training in graduate school was more about community counseling and relationship issues and people and how our personalities develop; less about the medical model. And then when I started working as a - licensed as a psychologist - I worked in a hospital, outpatient mental health in a hospital setting. So what happened early on was that the pendulum swung towards the big squeeze from insurance companies to really look at what is the diagnosis, document their symptoms, what is your treatment plan, and setting the specific goals and objectives, and trying to measure people's minds that way. And so I think we did - my opinion of that was - insurance companies began to drive all kinds of treatment. In a general way, we became compartmentalized toward seeing people as parts, or as this illness or that illness, and so some of my own personal journey as I was in graduate school I set that aside [sic], like using visualization, relaxation techniques, imagery, because it sounded too flaky. And so, just cognitive behavioral therapy, and it irks me that insurance companies put out - I saw this within the last two years - there's a letter to physicians saying that "here's what you do when your patient is depressed: first you talk with them, and then you give them this test, and then you give them an antidepressant, and then you make them come back, and then if they're still not improved, then you send them to therapy - psychotherapy."

From the medical perspective, then, psychotherapy appears to be the last resort. She added,

And I don't like that. I don't like that insurance companies drive that and that it's only a pill. It's that solution and delusion of a quick fix. And I also believe that if there is a depression, it's real; it can be aggravated by external situations and there are people who are just predisposed chemically to these symptoms, and so you take care of that and you get to have education about that and support.

This practitioner has effectively returned to using methods she was taught in graduate school:

As in our culture we have become more inclusive of other ways of thinking and other cultures and spirituality, I think that has impacted treatment, and so I think I'm more comfortable in teaching people like imagery and visualization. So, yeah, it's given some validation to some of the foundations that I started with. And I don't know if it was actually a change, but I think there's been so much research with the cognitive behavioral therapy . . . so over time in my own development I have really come to value how our thoughts affect our emotions and how our emotions then they impact our behavior, action. I think early on it was all about emotions - how do you feel? How do you feel? And then I moved to more "what do you think? What do you think?" And but you can't have that just be separate. . . . Those go together, and I think that has changed my treatment in the last five years. Those go together and we need to - we get to - take action. Behavior is important; take an action; do something. We can understand it for the next fifty years but it doesn't change anything.

An independently practicing psychologist welcomes many of the changes she has seen, such as the development of EMDR, thought field therapy, emotional freedom techniques, acupuncture, and yoga. She noted that "there's just been so much emphasis on how fitness and well-being . . . really goes hand-in-hand with mental health," and finds that "there's a whole creative force beyond that [of the insurance industry] of . . . people refusing to kind of be pigeon-holed." She believes it is essential to try to discover underlying causes for client/patients' distress; thus, instead of supporting "the immediate kind of quick fix," which she describes as the medication of symptoms, such as the

prescription of Ambien for problems with sleeping, she supports asking clients about such possibilities as “underlying trauma issues; do you have a sleep disorder? Let’s do a sleep clinic, let’s try - do you have sleep apnea?” In her opinion, the field of addictions treatment may also fall short at times in terms of looking at underlying causes:

You know, I can’t tell you how many people come in here, and on the surface they’re here, there, or at [a local halfway house for people in recovery], or they’re wherever, dealing with these chemical addictions, but if you start asking the questions, you know, “has anything ever horrific happened to you, or anything that you felt like a loss of control over?” whatever, and all of a sudden you just get this huge trauma history that - it’s like, “well, no one’s ever asked me about that,” and then all of a sudden it’s like, well, no wonder you would want like to drink yourself into oblivion, you know!

This practitioner concludes that,

I think you have to be willing to kind of step out of the way and let the client do the work . . . recognizing that people can heal more quickly than we thought possible. . . . that’s one of my basic premises, I guess . . . that the answers for the client are in the client, that I don’t have them [laughs] - very clear to put that out there - that I don’t know what’s going to work for them.

Another psychologist who reorganized her practice to specialize in the teaching of mindfulness and other related Buddhist mental and spiritual health techniques, came into the field during the 1980s when there were still many psychological practitioners who believed that psychotherapy itself could solve mental and emotional health problems. It was also, however, the beginning of what she describes as “the earliest stages of Prozac.” She found herself “watching two sets of colleagues, one set of colleagues that still

thought medication was unnecessary, and that all symptoms were explained by systems or cognitive dynamics. . . . And then of course working in an HMO [health maintenance organization], which I really wanted to do . . . I saw a lot of medication, a lot of belief in medication.” She talked about her psychiatrist brother who “believes that eventually we will have a brain cause for everything,” but who is “softening a little bit . . . over time.” He works at a prestigious Midwestern medical facility, and although he “still is really a medical doctor,” which she elaborated as “still king,” valuing psychotherapy only because “it makes people feel better” and because “therapists can help monitor medication,” she points out that in the meantime this particular medical facility itself has “a mindfulness-based stress-reduction program.”

Outside of more progressive medical establishments, however, which also cater to patients who can afford to pay out of pocket for services, this practitioner finds that “in the hands of internists and general medical practitioners . . . for the last fifteen years or more,” medications “have been handed out without recommendations for therapy, without even information about side-effects, without suggesting any lifestyle changes.” She says, “It’s astounding to me. My own doctor who is a wonderful doctor - every once in a while he refers someone to me - he referred a patient in to me who was really depressed on antidepressants - the man was alcoholic! I mean, really alcoholic! And doctor never even asked about his alcohol consumption.”

This psychologist explains these changes in terms of both the so-called medical model and Western culture:

I think that medical science is always looking for a way in that model, that traditional model that’s become Western medicine, and we patients want it too, we want the pill that will make us feel better. So, for a while when doctors had them, they were miraculous - they are miraculous sometimes. Of course they want to give them to people. And of course people want to take them. And then

add to that our culture that inundates us with the idea that the answer for every - all suffering - is out there somewhere in the right pill or the right relationship or the right car or, you know, the right vacation. . . . And doctors kind of like to play into that, I think. Some of them. They really like to be the - the person who can help that way, and some doctors are really I think attuned to the fact that people - I think it's common, it's really common, I was in the HMO and I worked there - wanting people to take responsibility for their own health, which is a difficult battle. . . . How many people are willing to do vigorous exercise three to five times a week? But, so they'd rather be on an antidepressant. They'll [some will] make changes in diet or changes in exercise or changes in their work schedules or where they stop commuting all or one way every day; we don't want to make - a lot of people don't want to make - lifestyle changes that could support them in getting off psychotropics. That's what I believe.

So, this practitioner alludes to both what may be a Western propensity for perceiving solutions as existing "out there," manifested in this case in the medical model, and the difficulty of getting people to take responsibility for their own condition. It would appear, however, that these phenomena could be two sides of the same coin, including enculturation into the idea that there is no such thing as an inner world or a potentially efficacious interiority to human nature. She concludes that "the pendulum has swung too far," but that "enlightened people are seeing that," encouraging her to persist in what she calls "a whole person approach."

A nurse practitioner from the East Coast who is also a psychotherapist described mind-body medicine as the most comprehensive and dynamic change she has seen since she began practicing. She finds that "what was once thought of as New Age-y and baseless has really become more and more integrated," to the extent that "medical practices are now incorporating psychotherapists within their practices. . . . Folks that are

coming to medical doctors for an array of symptoms are being evaluated [and sent to] therapists to address the mind-body connection.” She believes that some of these changes are being driven by the realization within the medical community that the success rate of treatment with antidepressants, for example, is “not high,” and that “even though the modalities that I’ve talked about haven’t been scientifically based, I think that there’s a growing body of evidence that they work. . . . If we get real, I think people are looking for modalities that work, that don’t have negative side-effects.”

When I asked this practitioner about her opinion of the changes she is observing, she replied,

I think it’s wonderful; I think it’s moving in the right direction. I think that the impact on our society as a whole will be positive, and I think many of the changes have to be lived and even on the level of the therapist. . . . the therapist prescribing medication instead of meditating, that’s a problem. Even in regard to the separation, “you’re the patient and I’m the authority,” because we all suffer from many of the same ailments that are cultural, and I think in order to be [a] therapist, you have to prescribe some of the same treatment, and recognize that partly what is ailing us is what’s cultural, cultural change that’s happening.

Another psychologist in private practice has come to believe, after more than twenty years of practice, that “mind/body/spirit - it’s all one.” Consequently, she finds that “our bodies get sick because we don’t take care of our minds.” The change she identifies as the most significant is that it seems as though “everybody takes medication for every blessed thing,” and that people have come to believe that “this is satisfactory, including doctors.” At the same time, due to the death related to psychological problems of a local client/patient, the insurance industry in the state in which she practices relaxed its restriction on the number of psychotherapy sessions available to individuals. Low-

income medical insurance, for example, however, has dropped its reimbursement rate by twenty-five percent. Thus, although the pendulum swings most recently have included the availability of more psychotherapy sessions to client/patients, this practitioner believes that societally many people now see medication as the solution, not psychotherapy.

Involvement of general medical practitioners

In general, when it comes to the question of the involvement of general medical practitioners in mental and emotional health treatment, this aggregate of psychological practitioners has serious reservations that revolve around the lack of specialty education of physicians in this area, the fact that the only treatment modality they have to offer is that of medication, and their apparent lack of an holistic view of patients and their lives. Other concerns include physicians' lack of referral to mental health specialists, careful titration and monitoring of psychotropic medication dosages, and collaboration with psychotherapists. These deficits and acts of omission, from the perspective of mental health practitioners, lead to the perception by the latter that physicians are generally not equipped to treat mental and emotional health problems effectively.

A psychologist in private practice summed these problems up by saying, "I don't think they know very much - their training is very limited" when it comes to mental health. She mentioned another problem, which she described as doctors having medication "favorites," for example, Prozac (or Effexor, mentioned by another psychologist). She believes along with most of the other practitioners in this group that "people ought to refer to specialists," such as, for example, psychiatric nurses.

Another psychologist in this aggregate whose office is located within a medical practice believes that this situation ought to involve a sense of responsibility on the part of medical practitioners:

Most people, when they are depressed, go to their medical doctor, and they want a pill right off the bat, and the doctor gives them a pill, but doesn't refer them to therapy. So, I think that if a doctor is going to be responsible, that everybody that they give an antidepressant to, has to be required to see a therapist. . . . Otherwise they're doing a disservice. They are creating an illusion that the pill is the solution, and that creates a dependency on the doctor and the pill to solve problems. That is not the way to go. So I object to that one hundred percent.

Another psychologist in private practice wonders whether there is an "ego component" involved for some medical practitioners, since, If someone came to me and I didn't have a competency in that regard, I would say, you know, I really . . . I could help you with a referral, but you really need to see somebody who deals with this or whatever issue, if I didn't have one. I think, you know, sometimes doctors just don't realize that they're [in] over their heads.

But she also alluded to client/patients' lack of follow-through:

And it isn't just the doctor's fault, either, because the clients . . . I don't see hardly any clients following up with their primary care physician. They get a prescription and that's it; they refill 'em, where with [a local psychiatrist] you check in with him, you do med checks, you're kind of always monitoring it, always on it . . . tweaking it. And I think the other issue is - I just have learned this so I don't know so much, but in terms of primary care physicians - the dosage level - they oftentimes don't give the appropriate - enough - and then just not . . . I think medication people really have to work hard to make them -get them - right. . . . And if the client . . . if the doctor isn't saying "come back and see me," or scheduling, and then the client is having like side-effects . . . we all see people who just like "well, I took myself off that," or the client starts playing around

[laughs] with their combinations [ironic tone of voice] and a whole other problem develops of side-effects, and yet the client isn't even sure that . . . they're not aware that it very likely could be drug-related. I just had somebody who had like kind of a psychotic episode, like auditory hallucinations, and people were like "oh man, maybe you have paranoid schizophrenia," and I sent them to [a local psychiatrist] and I looked up in the book where this particular medication, that was a possible side-effect. And [the local psychiatrist] thought it was, too. So, I mean, these are powerful drugs, they are.

On a different note, a psychologist in private practice who specializes in mindfulness techniques finds general medical practitioners to be useful for screening, given, as she put it, that "people will see a G.P. or an internist when they would never go to see a therapist." However, she went on to say that she believes that

they need to be educated. They need to work on - this is where I think health psychology is such a wonderful field - they need to work . . . ideally they need to work in conjunction with psychology, psychotherapy to effectively - to be good diagnosticians, and also to be good at prescribing the combination of psychotherapy and med management.

As to physicians referring to psychotherapists, she said,

They're really all across the spectrum, like my own physician, he's an internist. He refers all the time. Usually to people within his system that he can collaborate with. I know there are a lot of general practice doctors that do that, and there are numbers of them that seek out - I have a client, really, who is an internist, and he's done a lot of advanced training around anxiety disorders and depression accompanying diabetes, for example, so he's really an informed person, and he consults with the psychologist down the hall in his clinic. So there are some that

are fabulous. But they know their limitations too; you know, they don't just prescribe the same three drugs. They will refer to psychiatry when there's a case that's complicated. I think there are some people who run into a situation with a stress, and develop a complication and get depressed, and they need perhaps a quick fix-em-up, maybe meds, and they need counseling, and never have to have that medication again. And they need three or four drugs, and that works for them just fine. But they need to be more - they need to be trained to monitor the reactions of the patient.

Finally, a psychologist employed by a community mental health center invoked the industrialized context of medical practice when she said,

You know, the other thing I think is that because we work in a society - how is this medical model driven, but by insurance companies and money and reimbursement? And so if physicians only have five minutes or twenty minutes or half an hour and the patient wants help, you know, they are encouraged, you know - what's the treatment? The drug representative has just been around, OK, try this!

The meaning of psychotropic medication

The holistically inclined practitioners who make up this aggregate view psychotropic medication as at best an adjunct to treatment in much the same way as the foregoing group of practitioners. They differ from them, however, on the basis of their focus on the fact that no one actually knows how these medications work. They talked about how the "re-uptake inhibition" theory in relation to the SSRIs, for example, is changing ("ever-evolving," as a nurse practitioner described it), and discussion of the *placebo* affect is becoming more commonplace.

But the fluidity of this situation means that even medical practitioners are admitting to being awash in perceptions about these medications that could hardly be regarded as confidence inspiring. One of the mindfulness psychologists, for example, said,

A client will ask me, “How does this [psychotropic medication] work?” And I’ll say, “read [Emmon’s] book if you’re interested in these basic categories of medication. But you need to be educated by your physician about this because I don’t know.” And I don’t even think many of our physicians know. . . .

Actually, my M.D. internist [a client] yesterday sat right there and said to me, ‘you know, a lot of the time we don’t know what we’re doing.’ In a way, it’s always been true in medicine. . . . Now we just assume . . . that they really put these medications on the market when they’re completely understood, and they’re really not.

Behavioral health

The group of practitioners that make up this aggregate tend to view the relationship between the mind and disease in more or less strictly referential ways that are a conflation of the mind, the body, and disease; as I described more extensively in an earlier chapter, they generally do not find references to “mind” useful or illuminating. Instead, behavioral health specialists talk about “behavior,” meaning visible, countable episodes of action. This may be explained on the basis of the fact that the term “behavioral health” is a biomedical and insurance company invention and is, therefore, an outgrowth of *scientific materialism*, a perspective in science that does not admit to phenomena such as consciousness. According to “behavioral health” then, there is actually no such thing as “mind,” given that it is intangible.

It must be said, however, that although this group is made up of practitioners associated with biomedicine in several different capacities, the reduction of “mind” to

behavior and physiological states also comprises the correct stance politically in their work environments; in other words, some of the responses of these practitioners reflected splits along personal and work lines. An example of this is the practitioner who espouses the findings of psychoneuroimmunology but seems compelled as a physician and medical school professor to gloss them in terms of effects of stress rather than more broadly as reflections of states of awareness, although also admitting that stress is usually based on individual perception, and that it is, therefore, subjective. Meaning-making within this group, then, proceeds strictly *indexically*, with an accent on what is currently known as “evidence-based” practice. In other words, only measurable phenomena, including interventions, are admitted as possibly medically relevant or interesting.

Using the analogy of seeking help for a broken leg, a psychologist who also directs a consortium of mental health clinics strongly aligned with biomedicine described how he thought that client/patients ought to be able to expect the same form of treatment for their so-called psychological problems regardless of where they went, rather than what has existed until recently, which he characterized derisively in this way: “for behavioral health, you can get magnets put on your head, you can get dream work, or you can get cognitive behavioral.” The insurance industry, however, to whom he consults in a major Midwestern city, increasingly attempts to streamline psychological practice in the same way as medical practice, which he justified in the following way:

What’s happened now is, the research says certain things work better for certain disorders. Now that doesn’t mean you can’t sprinkle in a little bit of this, a little bit of that, but it had better have *x*, *y*, and *z* in it. And any clinician that has any lick of sense needs to understand the importance of this because as soon as there’s research that says best practices is this, and you don’t do it, or your patient jumps off the bridge, and they sue you - don’t ever forget the Tarasoff deal, what happened there. Nothing happened until it happened. And so this just in the past

year or two, this whole evidence-based thing. And when I sit in meetings [with] UCare, Blue Cross, Health Partners, Medica, everything is “best practices.”

What’s the best practices for ADD, ADHD?

This psychologist, who stood out strongly from the group in terms of his reduction of mind to the body, nonetheless depicted the *intention* behind the insurance industry’s attempts to constrain practices, using the notion of “best practices,” as ultimately consisting of the desire to avoid being sued.

When I asked him to describe the changes he has seen. He said,

When I started out, ‘75, almost nobody had health insurance for behavioral health. Then the state of Minnesota was one of the first in the country that if the insurance was written in the state of Minnesota, the employer had to provide it - [a] mental health benefit - in the health plan. But usually that was four hundred dollars max per year. Then it got up to seven hundred and fifty. But a lot of people [in Minnesota] - the companies - were national. Out of Omaha, whatever, and they had no behavioral health. Then ‘managed care’ came; well, when that came, new companies evolved: Health Partners, blah, blah, blah [sic], Medica, BHP. Then they got a mental health benefit, but they began managing the benefit. Because I was behaviorally oriented, ‘pragmatic’ as you say, and episodal care focused, I never saw managed care as a bad thing. In fact, I saw it as a good thing because it forced a lot of clinicians who I thought couldn’t fight their way out of an intellectual paper bag - it forced them to conceptualize what they were doing, and had to be able to tell other people. . . . What’s wrong with that? In my mind, that’s good. Well, what’s happened now, an example is, in these managed care companies, up until just the past several years, they were called care managers. Most care managers would say, you only get four sessions, or six sessions. Now the term, at least in Medica, is ‘care advocate.’ Not ‘care manager.’

Now, instead of a “care manager” calling him and asking, “Can you get that done in two more sessions?” he describes being asked, “Don’t you think you should be seeing them three times a week?” by “care advocates.” He attributes this to the rise of what he calls “evidence-based” psychotherapy, which he sees as deriving from “evidence-based medicine.” This, in turn, he regards as “an application of science.”

This psychologist feels that the changes he has seen are “all good,” and alluded in particular to what may be described as the demystification of things psychological when he said,

When I was first trained, we would write down ‘patient seen.’ [Whispering:] To protect the confidentiality of the client records, if somebody gets these records, you know. I’d much rather people get those records of mine rather than I got plaque on my teeth, or some rectal thing, you know. But oh, behavioral health, wooh! It’s like our thing is so sacred [derisively], you know, compared to everybody else. So, I think that the changes about documentation have been good. I think forcing people to write treatment plans so they had to think about ‘what am I treating? Am I treating major depression? Am I treating dysthymia? Am I treating a generalized anxiety disorder, or all three? And what’s my treatment plan?’

And his own methods of treatment, then, have changed to align with those of medicine in terms of not only documentation style and nomenclature, which includes the use of the term “behavioral health” instead of “psychology,” but also in fully accepting the use of medication if it has been designated part of “best practices” from the perspective of the insurance industry. As he put it, “when we look at depression for instance these days, the jury is not out any more. It’s come in a long time ago. The best treatment, CBT and medication. A combination of those two. Now, some people get better on just meds, yes. Do some just with therapy? Yeah. But that’s best practices.”

So, what are practitioners to make of the difference between people? This psychologist said, “It goes back to my premise that I said earlier, ‘cause of the cultural diversity. . . . I think that human beings are so unique in how they process things that we need guidelines to know what to do, just like a good physician.” At the same time, a philosophical split in his view of human nature seems in evidence when he says,

I do believe genetics plays a huge role in things; I think there’s a lot that we don’t understand. But I do believe, whether it be around creating financial wealth, asking a woman out for a date, or a woman asking a man out for a date, it takes some tenacity. It takes acting against your fear to get something that you want. And the more that we can have emotional muscle, and have a society that which I don’t believe we have right now [sic] - we have a soft society right now that says if you’re bored, watch a DVD and be entertained constantly - but at some point something bad is going to happen, more calamities, and people are going to get tougher again. And as a result they’re going to have greater tenacity to work on things that are important to them, rather than think the purple little pill or the little visit because Oprah said ‘go see a counselor’ is going to change their life.

A psychiatric nurse in this group who works on call as part of a mental health emergency team attributes the changes he has seen to “people higher up in the food chain not having the time” to handle all the cases, and having woken up that “they can trust” practitioners like himself “in relation to liability.” He sees these changes as beneficial, and describes the impact on his own methods as being “more willing to take stances than twenty years ago,” and having “grown personally more confident in [my] clinical judgment.” The young psychiatrist in this group, however, who describes psychiatry as “strictly medication oriented now,” due to the “natural alliance” between the insurance industry and “evidence-based medicine,” pointed out that people, meaning long-time practicing psychiatrists, “know better than to think medications fix things.”

His opinion of the changes are, as he put it, “a mix of things; psychoanalysis used to rule; there was arrogance [in that analysts] were categorically against biology. They were also detached from patients, and there was cruelty towards interns.” So, although some of the changes are also “terrible,” given that “much is psychosomatic in medicine,” and medication management is presently standard treatment, he seemed to be suggesting that perhaps the situation is no worse than in the past, if not even preferable in some ways.

When I asked the medical clinic director whether changes in the structure of health care have affected her management strategies, amending my original question somewhat given that she is not actually a practitioner, she responded in the following way:

Oh, hugely. I mean, it’s not related to depression so much, but reimbursement has been going down significantly for physicians, so what we’ve started doing is bringing procedures into the clinic that historically have been done in the hospital. . . . So, we - we’ve really changed our perspective when now we’re scanning the horizon all the time for procedures that can be done in the clinic rather than in the hospital. Because that is incredible - the procedures we’re doing have incredible reimbursement. But none of these relate to mental health.

“No,” I agreed, although the need to stay financially solvent as a practice seems relevant, and so I went on to ask, “why doesn’t your clinic or, in your opinion, clinics or practices like yours, have a psychiatrist or a psychologist on staff?” She replied,

We’ve - I’ve wanted that for many years and I’ve proposed it a couple of times. There’s a couple of things: the first is that the physicians have been concerned that we won’t have enough business to support that person, while I think that’s changing, but the second thing is the physicians didn’t want to have to be on call to deal with the psychotherapist calls. You know, they don’t want a patient

calling being suicidal. And I've talked to the physicians that these days there are - they've got other networks that - hotlines and stuff like that - but they're - you know, the physicians just are not keen on it. And that's part of my plan, with what we're doing right now, is to ease in to that, because I would love that. And I think it would be great for the patient, because then the physician and the therapist can talk, you know, and the physician can make more of the mind-body connection. You know what I mean? So that they're not dealing with all these issues so discretely. But I don't know any [specialty] clinic that has a therapist in the clinic.

So, although physicians may not relish having to deal with the psychological issues of their patients, at the same time they perceive themselves as under financial stress and perhaps not in a position to "lose" a patient to a different practitioner.

Involvement of general medical practitioners

From a behavioral health perspective, the involvement of general medical practitioners in the management of client/patients' mental and emotional health problems would seem natural, good, and even necessary, given the sheer numbers of patients whose distress is psychological, by admission of physicians themselves. The medical clinic director just quoted put it this way:

I think it's good only because I know how patients are. Like I said, patients do - you know, patients will feel like if they're stigmatized, you know, so - but what I think is best is an interdisciplinary team. So that the patient gets in the door with the physician and then, you know, the team can address it. And Kaiser Permanente does that; you know, they found that seventy-five percent of their primary care visits were stress, anxiety, depression-related, so they've created interdisciplinary teams to address it. And I think that's beautiful.

Medication management of emotional stress, then, also appears to be less stigmatizing to patients and it appears that many of them would rather take medication than work with a psychotherapist.

The psychologist who runs the consortium of mental health clinics approved of the involvement of general medical practitioners on a different basis:

I think it's fantastic. We know that physicians are less likely to be sued if they have good bedside manner. We know physicians that are rated best like in these magazines - it's bedside manner. And, you know, giving an injection is giving an injection is giving an injection, but how that person is made to feel when they come in for that is what they remember. So, I think that physicians, and I know that there a number of initiatives going on here in [a Midwestern city], and I'm certain across the country although I don't know for a fact, but I know it's a fact here, where physicians are being pushed more and more when they're doing an exam to screen for domestic violence, for depression, mood disorders, and substance abuse. And we now know in behavioral health, we - people like you and me - need to be doing not physical exams but a health history [asking about most recent thyroid check], electrolyte imbalance, all these kind of things [sic]. Medication regimen, because they can mimic psychological problems, and then the substance abuse. Have to be doing a substance abuse, not a full-blown evaluation, but close to it in every psychological evaluation. So the silos that used to be medical, CD, behavioral health, the health plans have really done a good job at trying to squeeze these together. Like all the CD programs now under rule 31 have to do the behavioral, the medical, and have plans for all those things. So I think it's tremendously important.

This practitioner went on to remind me that "most psychotropic medications are prescribed by primary care," and to say that "that's going to continue, that's not going to

go away.” Indeed, it was going to grow, and the reason, according to him, is “because of our psychiatry shortage here.”

The young psychiatrist in this group said that the involvement of general medical practitioners was “OK from a medical model perspective,” implicitly making an interesting distinction about possible ways of viewing the human condition, and he seemed to be elaborating on this when he went on to say that “socially, we are into externalizing”; [we say] “it’s my brain chemistry . . . it’s not me; it’s not having to acknowledge psychological issues.” When I asked him whether this might have to do with stigma, he agreed.

In the opinion of the psychiatric nurse, general medical practitioners have to be involved “because of the increase in medication management.” When I asked him whether it bothered him at all that general medical practitioners are not trained in psychiatry, he answered, “it bothers me more when [these] practitioners are not willing to ask for help - potential for arrogance.” He seemed to be acknowledging both a lack of expertise on the part of general medical practitioners and a greater need for the involvement of specialists.

The East Coast general medical practitioner and medical school professor offered a much more dramatic response when he said,

If it wasn’t for [the involvement of general medicine], the whole system would fall apart! . . . People would go without care. . . . It would be a huge access issue. There aren’t enough psychotherapists to take care of all the people that have [issues]. . . . there just aren’t - I mean - I’d say in my medical practice, oh, gosh, twenty-five percent of what I see is predominantly psychosocial. . . . That may be an underestimate, but I’m just thinking if I’m having forty-five hundred visits a year, for example, you know, that’s a lot of people. You know, when I have a patient panel the size of, you know, twenty-five hundred - three thousand patients

- so that if you just multiply that by the population in any kind of community, you just look at the numbers of things that are out there. I mean, there's an assumption - at least I read into that question - that . . . that there is some concern that general medical practitioners are handling

I responded at this point that there was indeed concern on the part of many psychotherapists, to which he said, "Well, wake up, I say. I mean it's like they [psychotherapists] may not understand the epidemiology of mental illness - what's actually out there. They don't - they may not appreciate the size of the cloth, if you understand what I'm saying."

The meaning of psychotropic medication

What, however, did medication mean to these practitioners? The mental health clinics' director describes them in terms of being "tremendously helpful," although he admits that there are problems associated with them, including the cost to client/patients:

I think psychotropics for thought disorders, first line of intervention. People with significant mood disorders, it should run very strongly concurrent with psychotherapy. Now, people with more mild symptoms, like Health Partners data, for instance: they have - what? - 1.3 million people in their health plan in the Twin Cities. It's either 67 or 72 percent - I can't remember which number, OK - but people that have Health Partners insurance when they start on an antidepressant never get it filled the second time. Now, the new SSRIs are downright expensive, OK? Now, taking them, they take four to six weeks; the first scrip is for four to six weeks, so nothing has really happened. Why do they stop? There's three reasons, people believe. One, copay; they don't pay for it. . . . They don't want to pay. The copay for the medications. Number two, side effects. And number three, the crisis is gone. They go in to their primary care physician, it's 'I lost my job, and now my boyfriend,' oh, here, would you like

some Zoloft? ‘Sure’; they take it. A month later, he or she is saying, ‘it’s the best thing in my life. Got rid of it [and] you wouldn’t believe the person I met.’ The crisis is over. So medications, I think, have their place; I think they’re given out waaaay [sic] too much. If you talk to most psychiatrists, at least psychiatrists that I know, they would say many of the referrals that they’re seeing are nonsense. In other words, it’s problems in living, or it’s a bona fide personality disorder - narcissism, or anti-social, or borderline - medications aren’t going to help that anyway. So, but, case workers, school: ‘you better go get on some medication.’ And we have a society where everything is get on medication. So, unfortunately, if I controlled the world, people that were doing anything in behavioral health would first [see] a behavioral health person, a non-prescriber, unless they were acutely suicidal or acutely psychotic; there would be at least five sessions before any medication could be started. And then they would have to remain with that behavioral health provider as they were receiving psychotropic medication. But that’s never going to happen, but thank God we’ve got a wide range of medications that are pretty darn safe. For instance, Elavil, you take an overdose, you kill yourself. You take an overdose of most of the SSRIs, you get an upset stomach. The atypical, antipsychotics these days, you can take ‘em, they’re pretty darn safe. In the old days, with Prolixin, lots of painkillers, Haldol - tardive dyskinesia. So, we have better medications.

It is interesting to note that this practitioner asserts that what he would consider the best-case scenario, namely, that client/patients stay with a “behavioral health provider” while they are on medication is “never going to happen”; rather, he foresees the future of the provision of mental health services as continuing to be dominated by biomedical forces, and although he is largely in favor of this trend, he is also concerned

about overprescription and societal pressures towards instant solutions to “problems of living.” But he seems to console himself with the notion that they are safer than in the past. When I challenged him on this, he responded,

There’s some psychologists that are kind of antimeditation. I’m nowhere near that group; I’m very pro appropriate use of medication, and I’ve done a lot of work lecturing and writing in the area of managing Alzheimer’s patients and those with challenging behaviors, basically axis II, from a nonpharmacological point of view. But I’m very quick in using medications and then focusing on minimum effective dose, which might mean a dose increase. Very much tracking symptoms.

Despite his circumspect rhetoric it did appear that he condones the use of medication for behavior control and proceeded to admit in relation to the pharmaceutical industry that “they often sponsor me as a speaker.”

The medical clinic manager, when asked what medications might mean to her doctors, laughed and said, “I think they mean relief to the patient and getting the patient out the door!” As I mentioned earlier, she went on to say at this point that, “I think part of it is that - I would say half my doctors are on the meds themselves, so, you know, they have personal experience and have felt relief with the use of them.” When I asked her how she knew this, she said because “they tell me.”

The young psychiatrist responded to this question by saying, medications “are part of our arsenal for curtailing symptoms when they become too debilitating.” This was echoed by the psychiatric nurse, who put it simply when he said they are “often part of the treatment of choice,” which seemed like a reference to “best practices,” the typical response and attitude of this group.

GETTING REAL

Unless a psychotherapist is “practicing out of a church basement,” as one psychologist put it, meaning not financially dependent on third-party reimbursement, the provider of mental health services is, according to the practitioners I interviewed as well as in my own experience, constrained by the prevailing medical model, which is, in turn, contained by the insurance industry. This containment is increasingly defined in terms of “best practices,” which are conceived collaboratively by biomedically trained physicians under pressure of the insurance industry. Because medical practice in the United States is organized along the lines of a for-profit industry and the provision of health care is brokered by insurance companies, the contingencies of practice for anyone associated with so-called standard medical care includes having to justify procedures; structurally, then, the focus of care is not on the client/patient but on cost for treatment. This may put practitioners fundamentally at odds with their training. An outstanding example in mental health practice has been the “brief therapy” model, based on behaviorism, as developed by Arnold Lazarus, for example, which was valued for its “unrivaled compatibility . . . with the goals and aspirations of managed care,” putting Lazarus into the position of having “probably contributed more to the clinical needs of individual practitioners and managed-care administrators than anyone else” (Franks in Lazarus 1997:xii). This is not to disparage the work of this contributor to psychotherapeutic method - on the contrary - but to reveal an aspect of the context of practice.

Since the 1990s, however, there has been a resurgence of psychodynamic practice amongst psychotherapists, in combination with the development of mindfulness approaches. This means a return to taking into account that although behavior is a part of human being in the world, so is intentionality and individual psychological development, neither of which can be conveniently predicted or coerced (see Healy 1990:xi). This return can also be seen as a reaction to the dysfunction that resulted from the tendency

towards directive, authoritarian, and mechanistic handling of the human problems that client/patients bring to their psychotherapists and other practitioners concerned with mental health, which included unacceptable rates of hospitalization and involvement of social service agencies from the perspectives of both the insurance industry and affected individuals (see Breggin 1991:299–300; 1997:33). From an industry perspective, it has turned out to be more cost effective to loosen somewhat the restrictions on the number of psychotherapy sessions a client/patient could have. Structurally, however, psychotherapy has become a branch of biomedicine, and this entrenchment is deepening.

Cutting across all these dimensions of practice is the pharmaceutical industry. Although bedeviled by the *placebo* effect (Silberman 2009), pharmacology is powerfully present as one of the two mainstays of biomedical practice, the other one being surgery. If one were to diagram these relationships, the result would be something like a Russian doll, with “medicalized practice” holding the center, surrounded by the “medical model,” further contained by the insurance industry. Although I did not find evidence for a literal collusion between the pharmaceutical and insurance industries, pharmacology is involved at all levels of practice and decision making in biomedicine of which psychotherapy is now a part. Simply put, every practitioner either prescribes or must take into account the role of psychotropic medications in client/patients’ lives; the medical model is predicated on the use of pharmacological agents (as well as surgery); and the insurance industry, in collaboration with biomedicine, generally regards the use of pharmacological agents as an important part of “best practice” and cost saving, especially of that associated with hospitalization.

The medical insurance industry - in person

I interviewed an executive of a major health insurance company in a Midwestern city and was able to ask directly whether medication management is more cost effective than paying for mental health providers such as psychotherapists. She responded in the

following way: “You know, that’s interesting because it really depends. It depends upon the medication and it really - so, it depends upon whether - you know, what the diagnosis is, or what the problem is that you’re treating.” At this point I mentioned that I had been learning about “best practices” and wondered aloud what she thought about them, and what their influence actually is, to which she responded, “I think that there may be - there may be companies or there may be organizations that look at that, that monitor that, might review and say, you know, you - this would have been or this is how you should have done it. That really is not something that we have done at [this particular company], but I do believe it does go on, because people may look at what is the most cost effective versus [sic].” Who are these people? I asked. “Well,” she said, “I think - like other insurance companies. It may be review organizations.” I mentioned that the practitioner from whom I had learned the most about the role of “best practices” was also a reviewer and that he seemed to be implying that some companies might insist on these. She replied, “They would - you know, that’s interesting that he would say that because what typically happens isn’t that you are forced to do it, but they may say you will not be in our recommended tier or you have to run your treatment plan by us if you’re not going to do this.” I was reminded of the work that psychotherapists often have to put into obtaining what are called “prior authorizations,” which amounts to permission to continue treatment. I asked her then whether the way to think about this might be in terms of a pressure on the practitioner, and she confirmed this.

But who is determining what “best practice” actually is? And how does it happen? She responded, “It appears to be the peers of the practitioner. Those people who are trained like the practitioner are put in a group or in a room, and they develop the protocols for best outcome. And they allegedly do a literature search, and - but again, how much of that is controlled by the government?” This seemed evasive to me, so I said, “And I’m asking, how much of that is controlled by the insurance industry?” “I really think very little,” she replied, and continued,

I do think very, very little. I think the insurance industry is simply a symptom of our culture. . . . I don't think that insurance - insurance chooses to pay or not pay. But the thing that most of the people don't understand is, a lot of what insurance pays and doesn't pay is really determined by the employer. Because a lot of insurance is purchased and is self-insured. When you think of big companies like a hundred or more employees, they're often self-insured. They really pay their own claims, so when they hire an insurance administrator, they are hiring their contract so that they get a discount from providers, they are hiring their medical management, which typically is applying some of the criteria for care, like, are we going to cover virtual colonoscopies as preventive? And, you know, what does the literature say about that? That kind of thing. They're hiring a formulary for the drugs, and they are having a place to bounce ideas off of how can we structure our coverage? So, if we want to pay this much, what can we get?

“Essentially, what can we buy for the money we think we have available?” I asked. She affirmed this.

So, what had she meant by referring to government involvement? I asked. She responded, “That doesn't apply to self-insured employers. The legislature does mandate benefits - we [this particular company] have one of the richest benefits in this state mandated by the legislature, but self-insured groups don't have to purchase that. They can get around that by” At this point I interrupted and said, “I got this impression that the insurance industry works together with legislators to constrain how much they'd have to pay out, how much an employer ought to buy.” “Well,” she replied, “I do think that the insurance companies do work with employers to help - to meet what the employers say they want.”

At the same time, providers are continuously negotiating for fair reimbursement for their services, as she explained in the following way:

When we look at healthcare reform in this state the company I work for has been very supportive of the provider saying, ‘this is how much it’s going to cost.’ And charging that to everyone, all the insurance companies. As opposed to having us spend our money on me and my staff, doing the contracting, having to work with the providers, having to do all of this. . . . And Blue Cross doing the same thing, and Medica, and Health Partners, UCare - everybody’s got the same people out there working with the [same thing] - so that would cut a fair amount of administrative expense, and it would also start educating the community about how much things cost. Because right now, what - if you go to Dr. X, Dr. X probably gets thirteen different payment rates, depending upon your insurance, your no insurance, your income, your whatever.

I confirmed that as a practitioner myself, this is exactly how it is, and that we do not really understand what governs this. “There’s nothing!” she said.

Trying to explain this to me, then, she said,

A lot of it ends up being driven by Medicare, or medical assistance, because they have the bigger block of patients, especially in the upper Midwest. We’re old up here. . . . So, when you see that Medicare pays a certain amount or pays a certain way, then the other health plans tend to mimic the methodology, not necessarily the rates, because as insurance people we do know that the Medicare and medical assistance rates in this part of the country are not very good.

I agreed with her, based on my own experience and that of the different types of practitioners with whom I had been talking. As practitioners, we felt quite conflicted about the fact that from the point of view of running a business, a perspective that psychotherapists are not always very comfortable discussing, the rate is so low that it does not adequately cover the costs of running a practice, even, as I pointed out to her, if you are working forty hours per week, which is unrealistic given the time required for record-

keeping. Meanwhile, compounding the problem, the rates of reimbursement have been declining. What was going on? She replied,

OK, so Medicare did just adjust what they call RVUs, the relative value unit. How they're paid works like this: all of the codes that a general practitioner, general practice, whatever, would bill, has a weight established to it, given it by Medicare. You know, the whole methodology is just like a crap shoot but somehow they've come up with some method - some way - to give each service a weight that is supposedly reflective of the amount of work, the overhead, and the liability insurance [that a practitioner has to carry]. . . . And that weight is multiplied by a conversion factor. Now, Medicare in its legal structure is supposed to have - Medicare is supposed to be a budget neutral. That's why the adjustments are always threatened. So every year they mess with the weights of the relative value units and they adjust the conversion factors. Now, just recently, Medicare has really increased the weight for primary care, and decreased some of that subspecialty stuff because they're seeing that this is taking more time and we need to reflect the payment. . . . So, when they say it was going down, it did for a while. And it is now on the trend up again.

I returned to the question of medication management possibly being cheaper than psychotherapy and stated that from some psychological practitioners' point of view it appeared that there might be a collusion between the insurance and pharmaceutical industries, to which she replied,

And from some of the medical providers feel it is, too! . . . I was just listening to email, from - to a voice mail that I just - I have to respond to, but it's so like ugh! . . . A manager of a neurosurgery group that does the trauma unit at [a specific hospital] and a couple of big Allina facilities called and told me that he really

needed to have a meeting because we needed to discuss the rates, because the rates that my staff had proposed to him were so ridiculous that no one was going to accept them. And of course just for a point of reference it was - I'm going to say it was about 23 percent higher than what our normal rate is, just because we know and we had spent a fair amount of time. Twenty-three percent. Now, from my perspective of my job, I am to give the best rate possible. From my perspective as a human being, I will say to him, just how the hell much money do these people need to make? What is enough? You know, because I look at anaesthesiologists, and, you know, certainly they think they have a lot of liability, they think they have all this, but is it really necessary that they make two-and-a-half million dollars a year? I mean, I know it is because it's difficult to maintain palatial mansions and a staff of four people to keep them up, I understand that need [ironic]! However, in the real world that the rest of us live, is it necessary?

Somehow the role of pharmacology was left behind again, and so when I protested instead that for some of us the reimbursement rates really were not viable, she described another aspect of how Medicare sets reimbursement:

They only underpay in this region. If you were in Florida, 'cause the way that Medicare's rates are established in by county, by sex, by age, and when they first set about this, there were a lot of billings from Florida and from New York. They have the highest reimbursement. Like in this market [the Midwest], the average family practice doctor from a commercial perspective is paid about 165 percent of Medicare. From a commercial. In the Florida market, they would be paid approximately 70 percent or less, because Medicare is so high that they don't have to subsidize their Medicare patients. They can pay a reasonable rate. Medicare is actually subsidizing commercial patients.

I commented that we really were not at all pitched in the direction of preventive medical care, and she agreed wholeheartedly:

Currently, we pay for symptom relief. We pay for chronic disease goings-on, we pay for trauma, we pay for transplants of people who take no care of themselves, we pay for transplants of people who take care of themselves. . . . What is taking care of yourself? How are you - you know, who is worth? [sic] I don't know that that can be a call that I make. But - so you have the patient with no incentive who goes to a provider who is currently the way it's structured is really - it's a business, and they aren't about taking care of people. They have gotten themselves into a small silo of 'this is what I do. I write prescriptions, I refer to a subspecialist,' or, if I am a subspecialist - if you come to me with a chronic shoulder pain and I'm an orthopedic surgeon, I'm going to evaluate you for surgery. I'm not going to say, 'gosh, Sylvia, you really need to do some exercise on this, and do this, and come back' - I'm not doing that. I'm looking - 'oh, well, maybe I could do this!' So you have the providers that aren't looking at the whole person because that isn't how it's structured for them. They're looking at their own situation. . . . and then they're looking to the payment, and so they look to the insurance company, because that's how it's structured here, which is really the employer of the person. . . . And the insurance company is of course trying to design as many programs as possible to reduce the cost of health care for the employer.

This reminded me of the question I had always wanted to ask about the medical system in this country but had feared was too simplistic, which was, why do we have insurance covering anything medical? I could see the application of insurance in case I

crashed my car or a tornado took the roof off my house, but wasn't insurance by definition a group bet? And how could that be applied morally to medical care? It appeared to me that we had the provision of healthcare set up on a kind of gambling foundation. She was happy to reply: "Well, in a way it definitely is, and I mean that was why when it started to get so expensive, you know, and when insurance first started, you know, it - the costs were so minimal, I mean really." But then there was legislation, I said, to which she replied,

I don't know if it's legislative intervention. I mean, I'm sure it's a contribution, but if you look at all the other people on the take in the stream, you see you have the medical device company. Now, they sell into the provider, to the physician or to the hospital or the surgery center or whatever, and they always get paid because the provider is responsible for paying them, and then the provider has to get the money from the insurance company. But the medical device and the supply people and the drug people they always get their money. So it is a very, very sick little system. And then you have insurance and when you have the insurance - the commercial insurance - you have the manager of the practice negotiating the contracts with the insurance, and that's a large part of what they're doing, so their livelihood has to come out of that insurance payment. And then you have little networks set up of groups that do this, and there's just all this money that is, you know, with the medical equipment you have the sales people, and you have all these people besides the manufacturer that get a piece of it. And so there's so much money dependent on you getting, you know, a new hip. How much money really gets paid out, and what's the real cost of that hip is probably a lot more than what anybody pays for it.

I said it sounded like a food chain to me, a whole series of profitable transactions. "Right," she said, "and it's not even, you know, linear." She elaborated further,

It's here, here [apportioning hand gestures], and then you've got this administrator who's buying this practice management system, and they buy this one because this particular management system will give them a little personal cut off of what the group pays. I mean, you've got so many deals like that, that it just is mind blowing. So how a person addresses all these issues I don't know. But I think it would really be great if we could figure out how to engage the consumer.

I countered that consumers as well as providers feel restricted by the insurance industry and tried to engage her in a discussion about the problems for client/patients at times of being confined to specific provider networks, but nothing came of this, other than the comment that "you would just have to personally pay" if you wanted to see a specific out-of-network provider. It seemed that we had gone around in a circle, although I did feel a little wiser for the wear.

The most important lesson seemed to be that although client/patients think they are getting the best care when they see a biomedical provider, in reality they may only be getting the treatment for which practitioners can be reimbursed. Treatment options are negotiated by employers through insurance companies who function as brokers for the medical industry; medical standards of health and care are not central to this process, nor are there incentives for the prevention of illness. How does this relate to the field of mental health? For mental health providers to be aligned with this admittedly cultural response to disease is to have sold out to an industrialized solution antithetical to best practice in psychotherapy, which is, I contend, and to appropriate Thomas Moore, *the care of the soul* (1992).

My findings fit in with those of the medical sociologist Peter Conrad who believes that during the last two decades,

managed care organizations have come to dominate health care delivery in the United States largely in response to rising health care costs. Managed care

requires preapprovals for medical treatment and sets limits on some types of care. This has given third-party payers more leverage and often constrained both the care given by doctors and the care received by patients. To a degree, managed care has commercialized medicine and encouraged medical care organizations and doctors to emphasize profits over patient care. But this is complex, for in some instances managed care constrains medical care and in other cases provides incentives for more profitable care. In terms of medicalization, managed care is both an incentive and a constraint. This is clearly seen in the psychiatric realm. Managed care has severely reduced the amount of insurance coverage for psychotherapy available to individuals with mental and emotional problems (Shore and Beigal 1996), but it has been much more liberal with paying for psychiatric medications. Thus managed care has become a factor in the increasing uses of psychotropic medications among adults and children (Goode 2002). It seems likely that physicians prescribe pharmaceutical treatment for psychiatric disorders knowing that these are the types of medical interventions covered under managed care plans, accelerating psychotropic treatments for human problems (Conrad 2005:10) (See also Koerner 2002:2, 5-6.)

Moreover, he also found that “Increasingly, managed care organizations are an arbiter of what is deemed medically appropriate or inappropriate treatment” (Conrad 2005:10).

The pharmaceutical industry - an overview

Medical research, particularly in the form of the pharmaceutical industry, is “a massive, corporate multinational enterprise” (Elliott and Lemmons 2005:1), the size of which is difficult to grasp or describe. As controversy and the cost of drug-testing has grown in the United States, drug trials, for example, have been moved abroad, to include large segments of unwitting low-income populations in such places as the developing societies of South Asia (see Kahn 2006). In the United States, the pharmaceutical

industry may be worth \$500 billion per year (Moynihan and Cassels 2005:1). It is easier to find figures on how much the industry spends per year on direct-to-consumer (DTC) advertising, which is “more than \$3 billion” (Moynihan and Cassels 2005:2).

Although the following quote is lengthy, it illustrates much about the scope of this industry and how it works, especially in relation to psychiatry:

Most of all . . . pharmaceutical makers seek to build word of mouth about a condition in the general public - the kind of water-cooler buzz that prompts people to ask their doctor about a disease, and the drug that might treat it. To that end, corporations have increasingly embraced patient organizations that work to publicize mental illness. One such group is the National Mental Health Awareness Campaign, created two years ago to eliminate ‘the fear and shame that is still strongly associated with mental disorders.’ The organization is particularly concerned with teen-agers A couple of weeks after the September 11 terrorist attacks, it released the results of a survey, which found that 30 percent of adults questioned felt their mental health had worsened since the tragedy. The group’s press release urged ‘parents and children traumatized by the recent terrorist attacks to avail themselves of the opportunity to speak to mental health professionals.’

The campaign’s brochures say it has received financial support from the Surgeon General’s office. The organization is less forthright about its ties to Fox Kaiser, a pharmaceutical lobbying firm whose clients include Bristol-Myers Squibb and AstraZeneca. Michael Waitzkin, a partner at Fox Kaiser, is on the campaign’s board of directors, and until recently the campaign was headquartered in Fox Kaiser’s Washington office. (It now operates from the office of the P.R. firm Health Strategies Consultancy.)

The National Mental Health Awareness Campaign wasn't the only group to step up its profile in the wake of the attacks. On September 26 the PTSD Alliance - the group headquartered in the offices of Pfizer's P.R. agency, Chandler Chicco - issued a statement warning that post-traumatic stress can affect anyone who has 'witnessed a violent act' or experienced 'natural disasters or other unexpected, catastrophic, or psychologically distressing events such as the September 11 terrorist attacks.' During the following month, according to the trade journal *Psychiatric News*, Pfizer spent \$5.6 million advertising the benefits of Zoloft in treating PTSD - 25 percent more than it had spent, on average, from January to June.

But the biggest presence in TV drug advertising after September 11 was GlaxoSmithKline, which in October 2001 spent \$16 million promoting Paxil - more than it had spent in the first six months of the year combined. In December, the company rolled out a series of new commercials, often broadcast during prime-time news programs and built around lines such as 'I'm always thinking something terrible is going to happen' and 'It's like a tape in my mind. It just goes over and over and over' (Koerner 2002:6) (See also Elliott 2003:125–126 for another similar example).

This, then, is an industry that uses advertising to prey on ordinary fear, is rife with conflicts of interest and questionable ethics, coopts patient organizations to create a consumer base, and reifies and then advertises obscure diagnostic categories to create or enlarge an existing market for pharmacological drugs. The latter include generalized anxiety disorder (GAD), social anxiety disorder (SAD), and premenstrual dysphoric disorder (PMDD) (Koerner 2002; Moynihan and Cassels 2005a; Conrad 2005). Historically, rare conditions have included depression and obsessive-compulsive disorder (OCD) (Elliott 2003:123–124). Today, however, "drug companies provide the backbone

of financial support for APA [the American Psychological Association] and for most of organized psychiatry” (Breggin 1991:345; see also pages 358-365).

Conrad describes the genius of pharmaceutical advertising as based on framing aspects of human suffering as “both common and abnormal, thus needing treatment” (2005:6). From this perspective, the general population becomes one large potential market (Moynihan and Cassels 2005b). How did this happen? Although pharmaceutical advertising is hardly new, physicians always having been targeted, Conrad finds that the situation changed dramatically after the Food and Drug Modernization Act of 1997, allowing for “a wider usage and promotion of off-label uses of drugs” and “direct-to-consumer advertising, especially on television. This has changed the game for the pharmaceutical industry; they can now advertise directly to the public and create markets for their products” (2005:5). The result is that “Drug companies now spend nearly as much on direct-to-consumer (DTC) advertising as in advertising to physicians in medical journals, especially for blockbuster drugs that are prescribed for common complaints such as allergy, heart burn, arthritis, erectile dysfunction, depression and anxiety” (Conrad 2005:5–6). This confirms and reiterates that arguably the most successful strategy of pharmaceutical companies has been to “sell the illnesses they treat” (Elliott 2003:123; see also Healy 1997:180–216).

History

The history of the creation and marketing of psychotropics in the United States, particularly of the anxiolytics, can be traced to a Czech physician, Frank Berger, who is supposed to have said that ““Most people get nervous and irritable for no good reason They flair up, do not differentiate between serious problems and inconsequential ones, and somehow manage to get excited needlessly”” (Elliott 2003:130). As bioethicist Carl Elliott tells the story,

When Berger took up a post as assistant professor of pediatrics at the University of Rochester in the late 1940s, he began to consult for a drug firm to develop a treatment of this kind of nervousness. In 1955, Wallace Laboratories introduced Meproamate, the drug treatment that Berger had developed, under the trade name Miltown. By 1956, in any given month, Miltown was being taken by one American in twenty.

Miltown was the first psychiatric drug developed to treat the anxiety and depression of everyday life. Like Prozac thirty years later, Miltown was both enormously popular during its time and the object of widespread anxiety itself. Newspaper columnists worried about the search for well-being in a pill. Intellectuals wondered why so many people needed tranquilizers to tolerate ordinary life in the most prosperous country in the world. News magazines carried headlines reading ‘Happiness by Prescription’ and ‘Peace of Mind Drugs.’ Despite all the public hand-wringing, however, the demand for Miltown far exceeded that of any drug ever marketed in the United States. In a way, Miltown represented an ironic twist on the legacy of Freud. When psychoanalytic theory began to make its way into psychiatry in the late nineteenth century, mainstream psychiatrists were concerned almost exclusively with psychotic illness. Psychiatrists spent time with patients who were floridly delusional, hearing voices, out of touch with reality. Psychiatry was considered a largely biological science. But Freudian analysis shifted the center of gravity for psychiatric practice. Psychoanalysts treated patients with neuroses rather than psychoses - the worried well rather than the inmates of the asylum. Increasingly, they saw middle-class patients in private clinics. By the 1950s, with the postwar emigration of so many European psychiatrists to America, psychoanalysis was well on its way to becoming the dominant force in American psychiatry.

Miltown reversed this trend. With Miltown, biological psychiatrists captured the terrain of psychoanalysis and made it the object of biological intervention. Anxiolytic medication gave the biological psychiatrists a treatment for the worried well, the patients on the analyst's couch. Miltown was only the first in a long series of treatments for the anxiety and melancholy of everyday life, from Valium and Atavan to Prozac and Celexa (Elliott 2003:130–131).

Since the 1960s, the history of the development and marketing of psychotropics has been deeply entwined with the establishment of psychiatric diagnostic categories themselves; in other words, rather than conditions of suffering drawing the attention of physicians and psychologists who then set about to seek a useful form of cure or relief, industry representatives or physicians or psychologists and others who are sponsored by industry have been inserting themselves into the development and refinement process of the diagnostic categories on the basis of what is now easily recognized as a profit-seeking motive. Elliott provides many examples in his work, including the following one:

Panic disorder, for example, was not even listed as a distinct psychiatric disorder in the second revision of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*. Until the 1960s, psychiatrists generally conceptualized panic as part of anxiety. In 1964, however, Donald Klein published an article (partially funded by Geigy and Smith Kline) suggesting that panic was distinct from anxiety, and that it could be prevented with anxiolytic medication. When the APA began to develop the next version of the *Diagnostic Manual* in the 1970s, Klein was part of the task force appointed to revise it. He persuaded other members of the task force that his views on panic were correct. When the *DSM-III* was published in 1980, it included 'panic disorder' as a distinct diagnosis, separate from anxiety, characterized by sweating, faintness, and

the ‘sudden onset of intense apprehension.’ The Upjohn Company soon began repositioning its new anxiolytic medication, Xanax (Alprazolam), as a treatment for panic disorder. Upjohn funded extensive clinical trials to demonstrate that panic disorder was an illness distinct from anxiety. By 1998, panic disorder had become so widely diagnosed that the National Institutes of Mental Health was reporting that it affected 2.4 million adults between the ages of 17 and 54 - 1.7 percent of that age group (2003:124). (See also Breggin 1991:347).

We may note that this dynamic also contributes to understanding the socially constructed nature of much of what is described as mental illness. However, as Elliott is quick to point out, all this is not to say “that drug companies are simply making up diseases out of thin air, or that psychiatrists are being gulled into diagnosing well people as sick”; rather, it is to reveal that, surrounding the core of many of these disorders is a wide zone of ambiguity than can be chiseled out and expanded. Pharmaceutical companies have a powerful financial interest in expanding categories of mental disease, because it is only when a certain condition is recognized as a disease that it can be treated with the products that the companies produce. The bigger the diagnostic category, the more patients who will fit within its boundaries, and the more psychoactive drugs they will be prescribed (2003:124; see also pages 232-233).

Prozac arrived on the market in 1987, the first of a new class of antidepressants known as selective serotonin reuptake inhibitors (SSRIs) (Conrad 2005:5). It has been estimated that “Prozac alone has been used by more than 22 million Americans since it first came to market in 1988” (Koerner 2002:2). These drugs were more effective than older antidepressants and appeared to have fewer adverse side effects (Conrad 2005:5).

During 2003, for example, sales amounted to \$10.9 billion, catapulting these drugs into the third-best selling class in the United States (Conrad 2005:5). Paxil appeared in 1996, when the FDA approved it “for the ‘anxiety market,’” and is now “one of the three most widely recognized drugs, after Viagra and Claritin . . . and is currently ranked the number six prescription drug, with 2001 U.S. sales approximately \$2.1 billion and global sales of \$2.7 billion. How much Paxil was prescribed for GAD or SAD is impossible to discern, but by now both Paxil and SAD are everyday terms” (Conrad 2005:6–7).

Today it is not only the adults who are swimming in mood-altering pharmaceuticals in the United States. Children and their problems continue to be a growing target (Conrad 2005:7). Although “Ritalin for attention deficit disorder (ADHD) has a long history,” it can be “seen as a pioneer drug for children’s behavior problems,” and “while the public may be ambivalent about using drugs for troubled children . . . a wide array of psychotropic drugs are now prescribed for children, especially stimulants and antidepressants” (Conrad 2005:7). Conrad quotes a survey which found that “spending on behavior drugs for children and adolescents rose 77 percent from 2000 through 2003. These drugs are now the fastest growing type of medication taken by children, eclipsing antibiotics and asthma treatments” (Conrad 2005:7).

Conrad predicts that “at the other end of the life spectrum, it is likely that the \$400 billion Medicare drug benefit, despite its limits, may increase pharmaceutical treatments for a range of elder problems as well. This policy shift in benefits is likely to encourage pharmaceutical companies to expand their markets by promoting more drug solutions for elders” (Conrad 2005:5–7).

A case in point: SSRIs, scientific method, and oversight

The class of psychoactive drugs described as selective serotonin reuptake inhibitors are among the most widely prescribed and “best-selling drugs in medical practice” (Lacasse and Leo 2005:2). However, no study has ever confirmed that a mental

disorder has been caused by a lack of serotonin, or any single monoamine, for that matter (Lacasse and Leo 2005:3, 5). There is no known “ideal ‘chemical balance’ of serotonin,” and “to propose that researchers can objectively identify a ‘chemical imbalance’ at the molecular level is not compatible with the extant science” (Lacasse and Leo 2005:3). Instead, what modern neuroscience shows is “that the brain is vastly complex and poorly understood” (Lacasse and Leo 2005:3).

To argue that mental disorders are driven by serotonin deficiency is also logically problematic as well as an indictment of the research methodology of the pharmaceutical industry, at least in the case of the psychotropics, since it constitutes *ex juvantibus* or “backwards” reasoning: it makes no more sense to claim that anxiety or depression are due to low levels of serotonin than to assert that headaches are caused by low levels of aspirin (Lacasse and Leo 2005:4). Rather, a meta study of clinical trials of, for example, antidepressants, revealed that “the placebo duplicated about 80 percent of the antidepressant response; 57 percent of these pharmaceutical company-funded trials failed to show a statistically significant difference between antidepressant and inert placebo” (Lacasse and Leo 2005:4). It is possible that even this result is inflated in the direction of efficacy when “compared to trials that use an active placebo” (Lacasse and Leo 2005:4). Finally, “this modest efficacy and extremely high rate of placebo response are not seen in the treatment of well-studied imbalances such as insulin deficiency, and casts doubt on the serotonin hypothesis” (Lacasse and Leo 2005:4).

Other challenges to the serotonin hypothesis include research demonstrating that other agents, such as the older tricyclic antidepressants, may be no less effective than SSRIs; that St. John’s Wort and *placebo* can outperform SSRIs; and that exercise can be as effective as the SSRI Sertraline for example (Lacasse and Leo 2005:4). Then, “although SSRIs are considered ‘antidepressants,’ they are FDA-approved treatments for eight separate psychiatric diagnoses, ranging from social anxiety disorder to obsessive-

compulsive disorder to premenstrual dysphoric disorder,” most of which psychologists would recognize as existing on a continuum of problems in the form of anxiety, implying that “serotonin regulation would need to be the cause (and remedy) of each of these disorders. This is improbable, and no one has yet proposed a cogent theory explaining how a singular putative neurochemical abnormality could result in so many wildly differing behavioral manifestations,” a problem increasingly recognized by prominent psychiatrists (Lacasse and Leo 2005:5). The *American Psychiatric Press Textbook of Clinical Psychiatry*, for example, “addresses serotonin deficiency as an unconfirmed hypothesis, stating, ‘Additional experience has not confirmed the monoamine depletion hypothesis’” (Lacasse and Leo 2005:5).

Perhaps no one is as vocal and pointed as to the shortcomings of the reigning and vested biological model of psychiatry as the American psychiatrist Peter Breggin, who has been practicing since 1968 and become known as “the conscience of psychiatry” for “his efforts to reform the mental health field,” beginning in 1972 with his organized effort to prevent the resurgence of the practice of lobotomy (2008: frontispiece). His overriding concern is with the safety of psychiatric practice. No longer alone in his critiques, he writes in the second edition of his psychiatric treatment textbook that

the concept that psychiatric drugs are neurotoxic is now a widely accepted principle in scientific research, especially concerning the antipsychotic drugs and mood stabilizers, and research has mounted up that demonstrates similar neurotoxic effects in all categories of psychiatric drugs. Many other medical experts have now joined in my criticism of the FDA’s failure to do its duty and my concern about the corrupting influence of the drug companies on the theory and practice of psychiatry (Breggin 2008:xxviii).

For a drug to be approved by the FDA, it must have been tested on animals and proceeded through “four phases of human experimentation” (Breggin 2008:349). However, almost all pharmaceutical research is “funded, designed, and conducted by drug companies or their close associates and allies, eliminating any hope of obtaining unbiased results” (Breggin 2008:352). During Phase Three,

controlled clinical trials are used to compare the drug to placebo and to previously approved, similar medications. At least two of the controlled studies must show a statistically significant positive effect from the drug. A few thousand patients are usually involved in the total database developed during the psychiatric drug approval process, but this number is misleading. It includes almost everyone who has taken even one dose of the drug. Only a few hundred patients may be involved in the Phase 3 controlled clinical trials that the FDA finds adequate for evaluating efficacy, and many of these subjects have usually dropped out before completion of the trials the actual clinical trials for psychiatric drugs usually last a mere 4-6 weeks (Breggin 2008:349; see also page 356).

It is important to note that a company “needs only to develop two positive studies, even if innumerable others are entirely negative”; however, Breggin believes that “this regulatory policy is not consistent with the canons of science or statistical analysis” (2008:350).

The next stage of testing, Phase Four, spans the entire period of time after the drug has been approved and entered the market. Phase 4 studies are implemented when the FDA requests a drug company to examine newly discovered drug hazards. In my interviews with FDA officials, they agreed that this crucial process tends to be given relatively low priority compared to the approval process. They attribute this to congressional and consumer priorities On occasion, drug companies simply neglect to pursue Phase 4 trials suggested to them by the FDA. For example, Eli Lilly never

conducted Phase 4 trials on Prozac-induced suicidality, even though the agency had required it and the drug company had agreed to it. The FDA, in turn, did nothing to force Eli Lilly to comply with its demand (Breggin 2008:350–351).

At the same time,

the American Medical Association lobbied Congress to make sure that after a drug is approved, physicians are not legally bound to follow the FDA guidelines. In the case of Prozac, for example, physicians quickly began giving it to children, even though it was not approved for them. Drug companies are not allowed to promote their drugs for unapproved purposes but often do so on the sly through their sales forces (Breggin 2008:351).

However, in Breggin’s forensic experience, “drug companies have defended themselves in product liability cases by arguing that only a controlled clinical trial can prove the existence of an adverse drug reaction,” which again he finds to be a “mistaken interpretation of the nature of science and scientific conclusions” (2008:352).

Breggin points out that the FDA has been aware of the limits of “premarketing testing” and of “the importance of the supposedly less scientific spontaneous reporting system (SRS) in which professionals like doctors and pharmacists, as well as concerned consumers, send in reports of possible adverse drug reactions” (2008:353). Thus, the FDA itself has in the past (1995) identified such premarketing clinical trial limitations as consisting of:

short duration - effects that develop with chronic use or those that have a long latency period are impossible to detect; *narrow population* - generally don’t include special groups (e.g., children, elderly) to a large degree and are not always representative of the population that may be exposed to the drug after approval; *narrow set of indications* - those for which efficacy is being studied and don’t cover actual evolving use; *small size* (generally include 3,000 to 4,000 subjects) - effects that occur rarely are very difficult to detect (Breggin 2008:353).

The point here is that once a drug is released into the general population, “there remains a 5 percent chance that the drug . . . might regularly cause serious, even fatal, injury to one in every 333 or so patients treated,” according to Paul Leber, director in 1992 of the FDA’s Division of Neuropharmacological Drug Products (Breggin 2008:354).

But there are even more subtle difficulties at play which may be seen as compromising clinical trial data (Breggin 2008:356). For example, “the treatment subjects in most controlled clinical trials used for FDA approval are not sequestered on a hospital ward”; “clinical experience and various studies have shown that patient compliance is spotty in regard to taking drugs at home”; and given that individuals who are willing to become research subjects are generally “desperate for money, desperate for therapeutic relief, or both,” their perceived “need to be in the experiment may influence what these subjects tell the investigators about their past histories as well as their responses to the drugs” (Breggin 2008:358). Furthermore, there are “very few blind studies, even when controls are carefully implemented,” leading Breggin to believe that this “may easily play into the patient’s or the investigator’s need to make a positive evaluation of the drug in regard to both safety and efficacy” (Breggin 2008:358). One can conclude, then, that “controlled clinical studies are not inevitably scientific. They may meet the canons of science, or they may not, depending on their structure and on how they are carried out” (Breggin 2008:359) (See also Helms 2002).

Breggin describes “other neglected areas in the FDA approval process” as consisting of, first, that “the FDA does not require drug manufacturers to demonstrate through animal (or human) research that the brain recovers from any of the various biochemical imbalances and other malfunctions produced by every psychiatric medication”; second, “the FDA does not require intensive neuropsychological testing of human subjects to document cognitive impairment or other brain dysfunction associated with drug treatment. . . . For example, it took independent postmarketing studies to show

that antidepressants . . . can impair cognition”; third, “the FDA does not require the drug company to show that any patients actually recover from their psychiatric disorders as a result of drug treatment. . . . Instead, all measures aim at demonstrating relative degrees of improvement in comparison to placebo or other medications”; fourth, “for a drug to be approved, there is no requirement that the patients rate themselves improved as a result of it”; fifth, “where there are known and even extreme risks in association with a particular class of drugs, the FDA does not require that the drug company specifically determine the new drug’s risk in regard to these known dangers”; finally, and perhaps most significantly, “the FDA does not conduct any drug studies on its own. It relies entirely on research produced, monitored, and financed by the pharmaceutical companies” (2008:359–360). It appears obvious that “drug companies have a strong financial incentive not to focus their attention on discovering or reporting adverse drug reactions that might threaten the approval of their product or cause future legal liability”; in fact, “they often fight hard against the passage of tougher FDA regulations and sometimes try to evade them after they are put into effect” (Breggin 2008:361). Breggin states that, in his forensic experience,

the methodology of the analyses may deviate drastically from the scientific process. In addition, if the conclusions seem to threaten the future of the drug, the conclusions may be modified or kept secret In general, drug companies have learned to employ many of what [have been] called tricks of the trade to make clinical trials produce exaggeratedly good results (2008:361).

If the FDA is compromised in its role of protecting the general public, what about the National Institute of Mental Health (NIMH)? Can the public feel more assured about the integrity of this federal agency designed to address issues of mental illness? Breggin served as a full-time consultant to the NIMH for two years during the 1960s. During this

time he found it to be “fundamentally a psychosocial and educationally oriented” institution, concerned with “ways to improve the nation’s mental health through psychological, social, educational, and economic means,” including “improving our schools and reducing poverty” (2008:373). He recalls that “biological psychiatry was relegated to a relatively small center in the larger psychosocial context. But then, with the shift in the political wind toward medicalizing psychiatry [as he has documented], NIMH was transformed in the 1970s into an institution for the promotion of biological psychiatry and drugs” (2008:373). Today, “NIMH conducts extremely expensive controlled clinical trials on behalf of the drug companies, trying to demonstrate the effectiveness of their products. . . . [For example] when the antidepressants came under fire, the direction of NIMH spoke out in their defense” (Breggin 2008:373). Breggin describes how the NIMH educates the general public through the use of “an enormous amount of literature” which is, however, biased in the direction of promoting “biological psychiatry and the drug companies”; he cites the example of one of its booklets, about schizophrenia, which, he finds, promotes “every myth of schizophrenia favorable to the use of drugs” (2008:373). Schizophrenia, however,

does not act like any other known brain disorder. It has no identifiable underlying pathology, it does not lead to deterioration in mental or neurological processes, and it responds to psychosocial interventions. That schizophrenia is a brain disorder is speculation, but one that biological psychiatry and the drug companies have turned into a battle cry on behalf of their authority, power, and economic success (Breggin 2008:374).

Breggin does point out that, to the credit of the NIMH and the possible surprise of readers “who are convinced that schizophrenia, above all other disorders, is known to be genetic,” the same booklet reports that “several of these genes are thought to be associated with an increased risk of schizophrenia, but scientists currently believe that

each gene has a very small effect and is not responsible for causing the disease by itself” (2008:374). However, he has come to the conclusion that like the FDA, the NIMH is an agent of the “psychopharmaceutical complex” (2008:375).

Holding down the fort

The mental health practitioner I interviewed who stands out the most vividly to me in terms of holding the tension of these great forces consciously is a former researcher in biochemistry, a toxicologist, a veterinarian, and, most recently, a board-certified child and adult psychiatrist. She also functions as an adjunct professor for medical students at a renowned regional medical treatment center near the location of her rural psychiatric practice. Although gracious in a casual, unassuming sort of way, she spoke bluntly about the state of psychiatry and the pressure that general medical practitioners are under to comply with demands that, in her opinion, compromise the integrity of medical practice. When one considers that most prescriptions for psychotropics are written by general medical practitioners and that they generally do not refer patients to psychotherapists, then the scope of the problem - the medicalization of psychotherapy - becomes clearer.

She began the interview by talking about the placebo effect. She said that when you take it into account in treatment, then “you really don’t have much of an effect. It’s very kind of minimal. . . . when I look at *placebo*, we have a huge effect for antidepressants but not so much for things like Ritalin or Adderall, those things that treat ADHD, which really are considered the most responsive in all of psychiatry to medication.” But psychiatry has, in her words, “gone biological,” despite all the intriguing questions that the placebo effect raises about the mind-body connection that psychiatrists are likely to encounter in such conditions as the somatoform disorders, hysterical conversion syndromes, and other “mind-body splits.” Then there are the culture-bound syndromes. She had spent time in Africa as a medical student and observed patients in states which they described as having “heat in their head.” She

believes that they may “really [have been] talking about agitated or anxious depression or bipolar,” although clearly culture affects the perception of the problem if not biological pathways of expression.

This psychiatrist had been trained to do psychotherapy, the two “evidence-based, so interpersonal psychotherapy, cognitive behavioral psychotherapy, and psychodynamic psychotherapy.” When I expressed surprise at her exposure to psychodynamic theory, she said that she thought this was indeed an emerging trend because “psychiatrists have realized that they’re putting out people who are trained in medications but not in the overall viewpoint.” She believes that what may be the most effective is “to look at the biologic with psychologic,” which takes one to the “biopsychosocial.”

When I asked her to try and address more directly the question of the relationship between the mind and disease, she said, “I think anybody who understands medicine - some of the older physicians understood medicine best - understands this huge connection between the mind and the body.” She went on to refer to an article from the 1920s by a physician named Peabody, entitled *The Care of the Patient*, regarded as a classic reading in the education of medical students. She believes that the importance of this article lies not only in understanding that there is a sacredness in the connection between a physician and a patient, but that “a person’s disease state is also related to lots of other things in your life. And that human disease can not only be created by our minds, but also perpetuated by our minds.” Attending to mind, then, had ideally perhaps always been a part of the practice of medicine.

This psychiatrist went on to talk about the role of depression, for example, in chronic pain, and of her experience with treating conversion disorders, which may include seizures for which there are no explanations possible other than, as she called them, unconscious motivations. In her opinion, these kinds of disorders require engaging the patient in talking about “the mind-body dichotomy,” in the course of which “physical

things show up with emotional distress” because “you’re displacing this on to your body.” Understanding of this kind of dynamic is growing presently as a result of the neural imaging being carried out at major research hospitals, she said.

I asked her whether one could invoke a role for consciousness in understanding some of the recent neural imaging findings, to which she replied, “I think so. They would call it something different - they may call it plasticity.” What, then, is mental illness, I asked her. “When you have an illness, when you have a problem with your mental state, it has to involve some sort of impairment. Occupational or social functioning.” So, although someone may exhibit signs that happen to occur in the DSM as symptoms, they do not necessarily warrant a diagnosis. She used the example of obsessive compulsive disorder, and put it this way: “If someone is OCD - like children have - and knows, [but the symptoms] are not ego dystonic to them, it isn’t an impairment!”

Elaborating on mental illness as impairment, this psychiatrist expressed appreciation for the DSM so long as one managed to avoid thinking about symptoms only categorically; she believes that a *dimensional* view is more holistic because, taking a case of so-called personality disorder, for example, “it’s not then about having necessarily a personality disorder, but having personality features that go along with the other stuff.” In other words, whatever the role of consciousness and even the flexibility of the brain, true impairment will probably have a biological basis. And yet, diagnoses, she concluded here, “have complexity to them that’s more than just meeting criteria.”

This psychiatrist will not see anybody unless they also have a psychotherapist or a willing to do some psychotherapy with her. She sees only about forty patients per week, which one should compare with more standard practice, including by general medical practitioners, consisting of seeing more than forty patients per day for what is then simply known as medication management. When I asked her about client/patients’ use of other forms of medicine, given the dissatisfaction that many of them experience with

biomedicine, she went back to the subject of the *placebo* effect: “Again, looking at that placebo effect, knowing that it’s therapeutic for patients to have all those people gathering, including the M.D. that’s not seen as some, you know, the person that’s going to be in opposition to all those things.” I admitted to her that I found it interesting that she thought of “alternative” medicine as a *placebo*, so she continued,

Well, I say that from the standpoint of that we don’t - look, we don’t know why a lot of things work, including medical. That’s the problem, you know, so we have a lot of people that go around saying, well, medicines are it, and psychotherapy is it. We know that there’s often just a special combination of things that work, and whether or not my treatments are placebo and my medications are placebo or somebody else’s are, I do know that it is generally therapeutic for the patient again - going back to Peabody’s paper - to feel that they’re cared for. And they’re cared for in a way that involves a whole network of people. So, if a patient comes to me and says, I’ve been using black cohosh, or, I’ve been using whatever, and it’s helping them - I’m certainly not going to be - unless I know it to be dangerous. Then I’m not going to be one to say, ‘no, I don’t think that’s the case.’ I may have my own scientific beliefs but I’ll suspend them for that patient. If a patient is going to a chiropractor, and instead of doing more than a manipulation, osteopathic type of a manipulation, which I’m very familiar with because our skills work together, then I will say ‘OK, they’ve opened up a channel for you and this is happening - hey, well, that’s great!’ And I have a lot of friends, they are massage therapists, and things like that. And I think that even just the laying on of hands - I mean, how do you measure that?

She went on to say that she includes her “own self in that placebo stuff,” because “we don’t know what we do. We just know that when it works, we’re happy about it.”

This psychiatrist believes that success with client/patients is largely attributable to the relationship between the practitioner and his or her client/patient. It is about the connection, and about “being genuine.” It is also about being willing to network, if necessary, with other institutions or aspects of the patient’s social system, such as the school district or the nursing home. It is about what she calls “synergy,” as it emerges from the combination of psychotherapy and the judicious use of medication; it is also about “being able to handle language,” as she put it, as it arises between herself and the psychotherapist “next door.” This seemed to be a reference to the meaning making about illness that ensues across practitioner lines which includes more or less of a biomedical perspective depending on the nature of practitioners’ training.

When I asked her about changes she is aware of in psychiatric practice, she became quite animated. Describing herself as a “purist,” she addressed the impact of the pharmaceutical representatives who seem very methodical to her about whom they visit. She will talk to them, but,

I’m not going to accept, you know, going to dinners or anything like that - I don’t do that. But I do take the samples because I have a poor population. . . . they really target primary cares in this area, because they [the primary care physicians] are naive and they don’t know how these medications are used, or which ones are better. And so I have patients come to me on Paxil which I absolutely hate - there’s a bad withdrawal from it - it’s not a bad drug in terms of efficacy - but people come in with medications and it’s because a detail man went to an office years ago and said, ‘this is the best antidepressant for anxiety.’ They all treat anxiety, except for Welbutrin. . . . and then I’ll have people with anxiety that are on Welbutrin What’s that about?

At this point I told her that I enjoyed seeing her puzzlement because we psychotherapists are certainly puzzled about all this, too! I also said that we do not understand why

patients are now often on multiple drugs, a situation described as polypharmacy, some of which appear to be agonists, according to our training. “Right, exactly,” she replied, “it’s just dirty medicine.”

She then described what she encountered when she first began to take over the rural practice where she is presently located, and that works in association with a team of psychotherapists, case managers, and occupational therapists. “I inherited a group of patients that were on three antipsychotics, and I thought, what in the world? Number one, the diagnosis - even a psychotic diagnosis - is PTSD. And they’re having dissociative symptoms all over the place. Hello!” (Dissociative symptoms may be understood in terms of defensively “leaving the body” or withdrawing awareness psychically under conditions of perceived attack.) She finds that polypharmacy is “a big thing,” and it is “terrible”; “I won’t even go to [the pharmaceutical companies’] demonstrations or their big meetings because, you know, there’s hardly anybody that’s untainted in terms of the way they do their studies. I have no connection with any drug company, but they’ve approached me.” Given her background in research, that did not seem surprising. “I said I would talk to the private carriers, but on my own time, without them buying lunch. . . . it bothers me when other psychiatrists do that,” she explained, alluding to the industry incentives to prescribe, buy, and sell.

I asked her what she thought about the most recent changes in medical practice; it seemed very different from Peabody’s “care of the patient” with its relational focus. I wanted to know what her theory was as to how it had happened that the pharmaceutical industry was so prominent, and she said, “I hate to say this, that big bad managed care has something to do with it, but I think that big managed care has something to do with dirty medicine.” She went on to explain that by practicing where she does, she has a level of flexibility, which, however, not all practitioners enjoy. Thus, some of her patients who happen to be physicians complain about the fact that “they have fifteen minutes to see somebody for medication for review.” She continued,

I know those people who are high producers, who see forty people a day, and, you know, when you do a fifteen-minute medication recheck, and you're allowing time for your dictation, and you have no time to make any outside phone calls, number one - that's out the window - your appointment time is now five minutes. You have a patient coming in and saying, 'yeah, I'm doing OK, my mood is OK, but by the way, you know, my mother is dying . . .' and the patient starts to cry, that's a problem. Now, your seven minutes has gone to ten minutes, and you've got to say, 'I'm going to give you something to take care of this, don't worry, Jo.' So, you know, they prescribe medications such as Klonopin and Ativan and all those. Which I really judiciously prescribe.

I brought up her reputation of working with patients to detoxify them, weaning them off multiple-drug regimens; indeed, I had gained access to her through a personal friend whose husband was in this psychiatrist's care for this purpose. She responded by explaining, "the important things again are the, I think, potentials for real toxicity, for having patients that we are not thorough with, that are primarily - it's two things: I think missed diagnosis is huge, and then with misdiagnosis comes missed treatment. Using the wrong drug for the wrong - sometimes you get lucky and they overlap, but I've seen a lot of that." Was it really a lot, I asked, to which she replied,

Oh, huge! Can't tell you . . . part of my job - one of the reasons why I take an hour with people and I see them personally - which is actually pretty short for me - I think that there's just so many people coming here with lots of diagnoses and lots of medications. Something just counterintuitive, like I've a kid coming from foster care, who has been beaten and sodomized and is having psychotic experiences on numerous medications, and now they go to see a psychiatrist who thinks they have bipolar. Hello! That doesn't make sense! Let's rule out

everything else [first]. I think it's societal change, even, you know, with the sort of instant gratification need to have an answer right away. You can order it on-line!

Her approach to treatment has changed in the direction of a focus on watching out for overmedication. But it has gone further; she finds herself not trusting the diagnoses with which patients come to her, explaining that "patients deserve a good look" at what may be happening to them; since a last diagnosis, "maybe something [has] changed for that patient, and now other things have declared themselves." Another effect has been that she finds herself standing up to managed care; however, she says,

well, and some of it's not even standing up as much as it's just - I guess in some ways playing along. You want me to do an evaluation in an hour, but I can't. So, it's going to be a suspended evaluation. Next time I see them it will be for another hour. And then bill it out for whatever you can bill it out for. But I'm not going to see this patient in half an hour because it's complicated. Multiple medical problems and other things.

So, what, then, did she think about the involvement of general medical practitioners in the management of client/patients' mental or emotional symptoms? "I have two reactions to that," she said. "One is to stay in business, and another part to say I couldn't live without them." She elaborated,

I really have a very paradoxical feeling about - you know, I think the primary cares do not receive adequate training in mental health. But I think as counselors, as support people - for some of the simple things I'm glad they're there. But they are being asked to overstep their - they're being asked because these medications are so safe these days. They are being asked to do things that they weren't asked

before when we had relatively more lethal medications such as the tricyclics. On the other hand, in [the town where] I work very closely with [some of the physicians] depending on the symptom . . . the doctors there have been very appreciative of my call-backs to them, and I've been very appreciative of the fact that they've taken care of emergencies, you know, situations.

As to the question of what psychotropic medications ultimately meant to her as a professional, I was once again surprised by her response, given her research background and respect for what biomedicine had to offer:

I think what they mean to me is that the science is poorly understood. Do I believe they work? With the right diagnosis, in the right condition, and the right ancillary treatment, they are adjunctive treatment. They are not the be-all and end-all. Absolutely necessary for some conditions like psychotic patients, or bipolar patients. ADHD, although ADHD can be modulated. How do they work? You know, we know how they work biochemically but that doesn't explain how they work physiologically or neurologically. So, we know that for sure. . . . As a biochemist, I did not want to get involved in any of this because when I did my - my dissertation, Ph.D., I adhered to the KISS principle: keep it simple, stupid. I asked very simple little questions that I knew I could answer. And I wanted to be able to tell a little story. So I experimented with that. These questions that psychiatrists and pharmaceuticals were asking are like that cartoon where the guy is going, A - here's how this works - A, and a bunch of question marks, and then, you know, and then something happens. That's kind of where we are with psychotropics. With a lot of psychotropics.

I expressed astonishment at this; could the understanding of pharmaceutical efficacy really still be so rudimentary? I found myself thinking about the splendors of the advertising. She continued,

Some of them are getting more targeting and better, you know. I think I have an understanding of the fact that brain state - brain stem neurochemistry - which is very primitive, does go off - we do know that serotonin is there. I mean, they have a lot to do with projections to other parts of the brain, but it's all that connection that we don't understand, just like, you know, the plasticity part involving dendritic pruning and shaping and stuff like that. We don't entirely understand that, but I think we're starting to see both ends get somewhat closer. [But] I don't know if it will ever happen in my lifetime.

We talked further about the research problem of getting at the significance of brain plasticity, given that one would have to delineate functional baselines, for example. This led her to express concern about the overuse of medication in children, given that it may involve an attempt to target pathways in the brain that are not even developed. Even worse in her mind, however, was the idea of psychologists gaining prescription privileges. Given the importance of, as she describes it, the "big picture" of biomedicine, practitioners without such a comprehensive background stand to inadvertently create serious problems: she describes how it can happen, when, for example, "the psychologists do the neuropsych assessment; pediatricians who were not trained in child psychiatry and development - some development - prescribing medications for ADHD. And we have - sometimes completely missing it, the diagnosis is not ADHD - it's autism. The psychologists missed it; now the pediatrician is perpetrating the error."

She finds that in the end perhaps it is a case of "you get what you pay for," explaining that she

would rather actually have a primary care physician consulting with me by phone than have a psychologist prescribing . . . because I've seen too many reports where psychologists have even put that in the recommendation. And I think, do you understand pharmacokinetics? Do you understand at all panic recirculation? Do you understand half-life? Do you understand volume-of-distribution? Do you understand interactions with people in their fifties? Do you understand any of this? Because if you don't - and a lot of physicians don't - on the level that I wished they were - that's why we even have specialists trained in psychopharmacology, fellowships in that.

Furthermore, in her experience too much prescribing of children seemed to be based on mistaken notions about behavior control, which, however, because of the potential for toxicity, becomes a moral issue. Referring to the Peabody paper again, she described herself as perhaps less interested in technicality than in "the first law of medicine: physicians, do no harm."

I felt that with this psychiatrist I had been in the presence of perhaps the best of biomedicine, in the form of the kind of thinking that takes into account not only the human physical condition, as well as the challenges of medical practice under the auspices of structures that do not hold patient wellbeing as central, but also remains open to the mysteries of being human, including the immeasurables. However, there was also a palpable message in this encounter: the medicalization of psychotherapy may already have become compromised medical practice.

LOWER THAN ANGELS

*There is not a subject-observer and an object observed; there is the world as a dream
swarming with signs and symbols, a field of interaction
where multiple forces and influences meet.*

(Jodorowsky 2004:102)

INTRODUCTION

Psychotherapists claim to be professionals. But what is it that they profess? A general answer would seem to include expertise in relation to states of mind and behavior; in German, a psychiatrist was known as a *Seelen Arzt*, a doctor of the *soul*. But the field of mental health no longer believes in the soul. Today, to be a respectable practitioner, one must engage in the language of brain and neurotransmitters; one must be conversant with a sea of psychopharmaceutical agents foisted onto the general public through the trance medium of advertising. And, if one is to make a middle-class living out of this profession, one must acquiesce to the constraining demands of the insurance industry that shapes medical practice in this society, since mental health practice is no longer a stand-alone profession. Psychotherapy has sold its soul.

In the meantime, it appears that mental health specialists who have aligned themselves with the biomedical model of practice have had no more substantial impact on emotional and mental well-being in this society than in times past; I would argue that indeed the useful role of psychotherapy has declined. At the same time, the ready availability of mind-altering pharmaceutical agents does not appear to have reduced any of the serious personal or social problems of our time. The United States is the most violent society in the West, anxiety and depression are rampant, and millions of children are now also medicated to control their restless behavior. We are a society characterized by widespread suffering which does not, however, appear to be healed by the most popular intervention of our time: drugs.

MAKING MEANING OUT OF MADNESS

But what would constitute healing? What characterizes the healing attempts of the mental health practitioners I interviewed? First, keeping in mind the contingencies of practice, it could be said that these practitioners are constantly involved in a parallel process: that of complying with professional, structural demands, such as writing treatment plans and case notes; attending case management and supervision meetings; going to conferences and on-going training; and spending time with client/patients. The structural demands can feel overwhelming, as can the nature of the issues that client/patients bring with them. To survive practice, let alone become proficient and find satisfaction in the work, mental health practitioners require a supportive environment; it can also be argued that they must live an effective or functional life themselves, one which is balanced and seems meaningful to them, in order to counteract the extraordinary stress of working continuously with others' emotions. A practitioner also benefits highly personally and professionally from on-going attempts to understand him- or herself; this protects both the practitioner and the client/patient from what are technically known as *transference/countertransference* issues, in the course of which the client/patient may have great difficulty perceiving accurately the role of the psychotherapist, and the psychotherapist inadvertently reacts to the client/patient's misperception. Of course, this can happen the other way around, too, which is why, ideally, practitioners have also undergone psychotherapy themselves.

It is difficult to imagine a more complex professional life than one that requires both inner and outer or subjective/objective understanding and management - that of self and context of practice - and then, by definition, seeks to understand others and their lived experience, and be instrumental in their healing. There is a constant flow of change in meanings, demands, and relationships that compels the practitioner to discover a way to maintain sure-footedness. One cannot constantly change theoretical orientations or

methodology and remain a stable practitioner personally and professionally; at the same time, flexibility may be described as a key to maintaining balance. There is, then, paradox at the heart of this profession.

There is a madness which arises for the practitioner, however, a raw and ragged feeling, when he or she is required to work at odds with fundamental training, such as to be done with a client/patient's grief or terror within a certain number of sessions; when client/patients expect their drugs to heal them and discount relationship; when writing treatment plans entails converting divulged inner worlds into empirical units of behavior. The fictions become even more prolific when the practitioner is supposed to prophesy the onset of wellness although having learned early that perhaps nothing in the world is more complex and unpredictable than human thought and behavior. At times it can appear that there is more distortion in the constrained practice of psychotherapy currently than in the minds of client/patients; in other words, the locus of madness is systemic, not invariably individual. Indeed, the thinking and behavior of client/patients is generally remarkably internally coherent.

Secondly, there is today a preoccupation with the chemistry of the brain, and in the spirit of allopathy, the so-called chemical balance can be altered to comply with a more desirable state (see Healy 2004:254–283). However, the independently thinking psychotherapist recognizes such implications of brain research as that every thought and behavior affects the chemistry of the brain; in other words, the brain, as part of the body, is a reactive organism (see Kabat-Zinn 1990:185–198). It is ancient wisdom as well as modern science that changing one's behavior will change one's thoughts and feelings and lead to a different experience of life (see Yogi 1963:53). To be seduced by the claim that the chemistry of the brain determines one's behavior and thought is a willfully narrow view of the truth about the human condition: we are free, within the confines of a species-specific biology and perceived societal constraints and conditioning, to attempt to create a life worth living.

Psychotherapy client/patients bring such complex emotions as shame, embarrassment, and confusion to sessions as part of anxiety and depression; can we honestly believe that these are mere chemical imbalances that ensued randomly, like a comet falling or exposure to a virus? Long-term practitioners come to see vast patterns in people's lives which reveal that thought and behavior and the form of life and feelings that client/patients experience are deeply interrelated. People make choices within their perceived frame of reference; they also dream of possibilities and take creative steps to make something happen, or by degrees they decide to give up pursuing a joyful or otherwise meaningful experience of life. The body and the brain react exquisitely to each type of perspective and decision; life is experienced and felt on the basis of an immense orchestration of chemistry, then, organized into feedback loops, which follow from the focus of one's awareness and perception.

But the madness of the perspective that pronounces chemistry as causal comes to a head in the situation of psychologists functioning as diagnosticians in addiction treatment programs. There, patients are supposed to be engaged in weaning themselves off exogenous chemical substances; these may be legal or illegal. Today they may include prescription drugs, such as pain killers, and benzodiazepines, old stand-bys in the management of anxiety. At the same time, however, most of these patients will be ingesting legally prescribed drugs which they will have obtained mainly through their general medical practitioners but also through psychiatrists. And the treatment program may also use other legal drugs, sometimes in the form of agonists, designed to counteract the effects of ingesting the designated undesirable chemicals such as alcohol. Meanwhile, during breaks from diagnosis and treatment, staff may be found outside smoking their legal drug, nicotine.

The practitioners in these work environments must somehow sift through this sea of chemistry in a meaningful way. Clearly there are issues of legality versus illegality;

more subtly, however, there is the question of “insight” - whether a patient appears capable of benefiting from talk therapy, which is philosophically predicated on the belief that changing one’s thinking can lead to freedom of action in the world. By extension, today a psychotherapist might logically also be tempted to frame psychotherapeutic efficacy in terms of freedom from addiction to one’s own chemistry, including that which leads people to become addicted to exogenous chemicals! But the goal would remain the same: the induction into a less chemically dominated way of life, although prescription drugs are deemed just fine.

Third, it is commonly accepted that medical conditions may affect one mentally and emotionally, but the reverse is not at all a given, namely, that physicians, for example, espouse and teach patients that their thinking is capable of disturbing their physiological functioning. On the contrary, in practice the materialist biomedical perspective tends to reduce the mind to the brain such that patients today believe that their prescriptions for psychotropic medication will fix the supposed chemical imbalance of their brains. This is maddening to psychotherapists who are in the position daily of witnessing the impact of thought and behavior on client/patients’ physiology: there are times when they slump and weep or arouse to anger; they may blush and fidget or turn stony and defensive. Their very posture can reveal years of habitual thought and defensiveness or the tendency towards a more relaxed attitude towards life (see Lowen 1958). Their thinking becomes their way of living, which includes the development of chronic health problems such as heart disease (see Ornish 2005), and yet it is rare for a physician to consult with a psychological practitioner.

Finally, it is axiomatic in the training of mental health practitioners to understand human development and its inexorable conclusion: a human being is socially constructed, even down to physiological responsiveness (see Moss 2007:103–104; and Montagu 1971). Indeed, the complexity of the relationship between biology and nurture

is such that it does not appear any lines will ever be drawn clearly as to where one begins and the other ends. Conception itself appears to be influenced by psychological factors, fetuses are suspected of being affected long-term by the mother's emotional state during pregnancy, and culture intrudes into the formation of behavior at every level from the moment of birth onwards (Crooks and Baur 2008:297, 312–313). Whether one studies neural pathways or cultural arrangements, the conclusion is the same: interpersonal relationships matter; they are indeed formative, and in their absence there may be disorder, distortion, or lack of development.

Yet, the cultural message client/patients have come to believe, supported by industrialized medical practice and pharmaceutical advertising, is that relationships are of no particular salience to the health of the mind or the brain. This appears like madness to psychotherapists given their understanding of the importance in terms of the healing potential of supportive, nurturing and respectful interpersonal relationships. Moreover, the discounting of relationship has led logically to the undermining of psychotherapy because it can appear redundant and even fraudulent (see for example Langs 1982).

Healing moves

Against this background, the mental health practitioner still attempts to heal his or her client/patients. The word “heal” has the same origin as the word “whole” and denotes restoration to wellness, to a natural and normal ability to function. Very generally, psychotherapy is predicated on the idea that when people are free to speak about what is troubling them and perceive themselves as being heard, their inner being is restored to wholeness; they experience healing as they come home to themselves, so to speak, and to the truth of their situation (Rogers 1961:35; and Karasu 2001:249–277). Most recently, beginning with Freud, this form of healing practice has been called “the talking cure.” Clients gain clarity about their situation, their own thinking, and their feelings, which effects a kind of inner relaxation. Over the course of the last one hundred years, at least

two hundred and fifty forms of psychotherapy have been invented, many of which no longer consist only of listening on the part of the psychotherapist (Corsini 1989:1–2, 9). Indeed, today mental health practitioners of every kind are under pressure constantly to intervene, to make something happen in the minds and lives of client/patients. I would argue that this is in line with an allopathic approach to the human condition, and that it is part of the stress induced by the context of practice. In this way, moreover, psychotherapy has become much like the practice of biomedicine.

Whether practitioners are highly aware of it or not, there will have been a specific underlying philosophy of healing to which their training introduced them; there is a perspective on the information about disorder and well-being to which they will have been exposed during their education and supervision. The practitioners I interviewed seemed generally quite conscious of what they were trying to accomplish and on what basis, even though they had difficulty describing the source of the madness in practice. In other words, they were clear about what they thought needed to be done for and with client/patients, although they could not so readily describe the philosophical underpinnings of the context of practice. What follows is a description of these philosophies as they seemed to reveal themselves on the basis of the interviews I conducted.

Holistic empiricism: Disease as largely of the body

As described in more detail in earlier chapters, the practitioners in this category make meaning in their practice using an *indexical* mode; that is, they ascribe naturalness to the phenomena of their focused awareness. From this perspective, they believe that the concept of “disease” is really attributable only to the body, and would therefore most likely constitute a natural or empirical phenomenon. At the same time, it is not the case that they reduce the mind to the body; they voice distinctions characteristic of the culturally pervasive *psyche/soma* split, but they suspect that mental illness is likely to

have somatic correlations if not even underpinnings. Thus, they also tend to favor treatments and interventions that take into account the whole condition of their client/patients.

Varying widely in terms of their training, from behavioral, educational, and cognitive psychology to clinical social work, general medicine and psychiatry, it seemed to me that the best in terms of healing potential of what might be described as holistic empiricism was represented in the interview with one of the psychiatrists from this group. He is an independent practitioner who has recently established a program he describes in terms of “resiliency” training, combining education in lifestyle changes with training in meditation and mindfulness. Patients come to this program with the hope of recovery from chronic depression and dependence on psychotropic medication, and many have been able to achieve their goal. The work for the patients is not easy or fast, and their lives are certainly changed, but in the direction of fitness, nutrition that matches their biological constitution, and a meditation practice and approach to mindfulness based on psychological type.

This psychiatrist is committed to integrative medicine, a position I would describe as enlightened physicalism. He has come to believe that aspects of the oldest and great medical traditions of world culture could be usefully combined with some Western approaches to provide more effective and individualized treatment for illness of all kinds. He was also exposed to the early findings of psychoneuroimmunology in his psychiatry training, which has become the foundation in the meantime of what is now known as mind-body medicine, and thinks that this is what makes neuroscience so fascinating at this time: “It’s validating what certain traditions have known for centuries,” he said, alluding to the impact of thought on physiology. He also agreed with my own assertion that the more recent form of scientific inquiry has impeded progress in terms of integrating findings; describing himself as primarily a clinician, as well as a healer and a

teacher, he added that he was himself, however, also a certain kind of scientist: “I just try to do - use - whatever I think works, whatever really helps people. Very pragmatic. If there’s scientific validation for it, so much the better. . . . I really do recognize that for a lot of people, they really need that scientific validation.”

He describes his understanding of the relationship between the mind and disease in the following way:

I feel as though we use words to separate ourselves into different areas and we need to do that to be able to talk about and understand it but I don’t feel that actually there is any separation between mind and the body. And so I honestly believe that a thought will directly impact your brain chemistry or your body’s chemistry. And vice versa. If you can change your body’s chemistry or brain chemistry, you can change your thoughts. And so I also consider mind to be more than the thinking part of oneself; I consider it to be - to include the observing self. It can watch the thinking process. . . . So in other words, I feel as though the whole - the mind-body-spirit conceptualization is just a way of talking about things that are actually much, much more unified than our vocabulary would suggest. So depression is a good example of an illness that I feel affects every domain of who a person is, and so in my way of thinking it should be addressed in every possible domain, rather than just serotonin reuptake inhibitors.

As to the question of what the term mental illness means to him, this psychiatrist said,

Well, you know, given my training and background, working as a clinical psychiatrist, when we have to - you have to label people in order for their insurance to cover, so I would consider mental illness to be really an agreed-upon definition that we use for purposes like that of giving labels and using insurance

and all. So it's really - I think it really is just a descriptor, it's just a set of descriptors that are - there are only so many ways that people can express mental and emotional suffering, and we've got them lumped into categories which, you know, makes some sense on the surface, but I consider mental illness to involve - there's just a wide spectrum of severity, and I do believe that for some people it is mostly biologically based, and for other people it is mostly psychologically or spiritually based. And then there's this whole mingling of them in the middle of that spectrum. But as a pragmatic definition I would consider it to include some element of not being able to function properly in some major role in life.

He finds that "inability to function properly" applies to physicians themselves, who perceive "medicine-as-usual unsatisfying right now," because,

I think the crux of it is that people feel over stressed and burned out by too many time pressures, productivity pressures. And it is a structural thing. But I think people see in - in holistic medicine, or integrative medicine - they see people having more time with their patients. For one - you know, that's probably the fundamental thing - and being able to treat people in a more broad, comprehensive way, which is what most people came to the field for in the first place, and then they just found themselves in a structure that didn't allow that. So, I think there's some interest too in just looking at things more holistically. But I think part of it at least is driven by a holistic or integrative treatment by definition it can't be overly pressured or rushed. You've got to allow time for it. So when I do these consultations for example I spend usually an hour and a quarter to an hour and a half with people which is almost unheard of. And it feels like a great gift to me.

He believes that taking time is itself healing because then

people feel heard in a deeper way. Heard and seen in a deeper way than they usually do, and just to have - I mean, people usually leave that session feeling

some hope, which they didn't have before, and it's nothing really that spectacular or out-of-the-ordinary, I don't think. I think it is that they finally feel like they had a chance to relate, tell their story, and have it heard and understood.

Hope is realistic, according to this psychiatrist, on the basis of the fact of being a living organism, which he elaborated on in the following way:

You know, some people who have struggled with depression their whole lives, they really have lost hope, and so often they've tried almost every medication available, and nothing has worked. A lot of people have tried really hard to do good self-care, too. But I really have to believe this in order to be effective and I do believe that no matter how long it's been there, the capacity is always there for the body to correct itself, for people to heal. . . . I think that if people really are in an advanced decline, that would not be as feasible, but people well into early elderly. . . . I think the capacity for the body to regenerate and to be resilient is really always there. One of the mindfulness principles I learned which I think is just so important to hold on to is the idea that as long as you are alive, there's more right with you than wrong with you. . . . And the capacity for things even to improve further are always there, as long as you're breathing basically. Unless there's been some really severe brain damage or something, you know. There are things that can't be corrected, but

What, then, did he believe was the cause of all the depression and anxiety that seems to characterize our society? In his opinion,

For the most part I believe that the reason we see so much depression these days is because those who have the genetics for depression the genes gets activated, or turned on, usually because of some environmental factors. It might be stress, it might be nutrition, might be not sleeping well, or getting enough rest, not

exercising. But it gets activated. And that's where people get stuck. What they don't realize is that those genes can be deactivated as well, you know; we used to have the notion - I had it too - that if you have the gene, you were out of luck. . . . But - but I believe now and I think science is bearing this out that you may have the gene and you can turn it off again. . . . So, I try to convey some sense of hope to people that there's something that happened to activate this for you, sometimes we can find the reason for that, and other times we can't. Usually we can. Usually there's some pretty apparent reason. . . . Either a stress, a stressful situation or I think very, very often the thing that can turn genes on and off is nutrition, and I think that nutrition has a huge amount to do with genes being activated and then deactivated again.

He cited the example of the mental and emotional condition of children in the United States in comparison to such societies as Norway, seeing "the rise of childhood depression as being almost completely aligned with the rise of childhood diabetes and obesity and with the advent of high fructose corn syrup." Further, he said, "I believe that the sweeteners in diet drinks are neurotoxic, I really do. And people drink so many of those. Very, very hard for the brain to function well."

He related this to the impact on the brain of psychotropic medications:

And people who have been on medications for long periods of time, it is very, very hard for them to get off of them. . . . It has become part of the way things are, homeostasis, you know. That's their new homeostasis, and then you take it away, and the brain complains greatly. So, people who have been on meds for five or ten or twenty years, it's going to be very hard for them to come off of it. I see people now - I treat college students - and I see a lot of people who have been on medications for five to eight years already. Coming - entering college. . . . That's a huge, huge problem. It's actually very, very hard to do. It's hard to get

off, and you know I consider myself really knowledgeable about helping people get off those medications, and there are times where I don't think it's going to happen. . . . If you look at how many people in this country are on these medications, and, you know, I should point out I'm not against using medications. . . . I even think it's appropriate when someone has an adjustment disorder that's really knocked them off their feet and they can't - they just can't improve with other measures. However, I - what I see happening is people like that staying on the medications for long periods of time, and then they can't get off of them. That's what I think is inappropriate.

He alluded to the congressional hearings about three years ago in relation to the use of serotonin reuptake inhibitors by children and teen-agers as prescribed by physicians. Some countries in Europe had pulled the use of this class of psychotropic medication for young people because it appeared to aggravate suicidality. He went on to say that,

I think they can cause bipolar symptoms, too. . . . But in the U.S. there's a warning, but they have not been pulled from use with teens. Anyway, during these hearings there were people on both sides of the argument, of course, and there were parents whose children killed themselves after using - after starting an anti-depressant - and then there were other parents whose children were suicidal and were greatly improved after they got on the medication, so it goes both ways. But there was a psychiatrist, a child psychiatrist, who was pleading with the congressman not to - he says, "we have nothing else to offer these children, please don't take this away." And I understand that statement because I - I do understand the dilemma physicians are in, and clearly wanting to have something to offer that's helpful. But at another level, the notion that we don't have anything else we can do for this is really tragic!

I asked him whether this is where nutrition might enter in to treatment, and he continued,

“Nutrition and some physical movement and self-awareness; and maybe some mindfulness or cognitive strategies. And bringing in more support, working with families. I mean, there are so many things that could be helpful!”

In his role as a continuing education teacher for other physicians, he said he also likes to quote a study about the length of time it takes to get a prescription:

Family doctors prescribe eighty percent of anti-depressants - it's not psychiatrists mostly So they had actors go in and give symptoms of depression in the course of the interview. It took - the average amount of time from the first mention of depression to having a prescription in hand - was about four-and-half minutes! You don't get any chance to talk about anything else! . . . So, we're in the midst of a huge experiment, without controls and without really good outcomes. Where there are so many people being medicated with these medications; they appear to a lot of people to be so benign and simple to use, but they're not, you know.

Returning to the subject of bipolar disorder, he stated that it had increased by twenty times as a diagnosis among teen-agers “just in the last few years”; when I asked him what he thought was driving that, he gave another essentially cultural answer:

I think there are at least two things, maybe three things. I think one is the use of antidepressants. I see it all the time, antidepressants in certain people are prone to cause agitation and bipolar type symptoms, so, you know, going back to the constitutional types, it's the pitta type [an ayurvedic constitutional type] who are the - it's the agitated depression who gets into trouble with this, and then it causes more behavioral problems and more sleep disturbance and sometimes real impulsiveness and sometimes self-injury. So I think that the - particularly the SSRIs - for the susceptible person - it causes bipolar-like symptoms. That's one thing. I think the second thing is that this is a societal, cultural-based diagnosis.

We're now diagnosing people with behavioral disturbances as bipolar whereas before we wouldn't have done that. And then I think that the third thing is, there's - it's sort of a fashionable thing. There's been so much written and talked about it now, and books about teenage bipolar, and so a lot of people are really cued into it, and seeing it where they didn't see it before.

And he sees the pharmaceutical industry as having a direct hand in creating the situation as it exists now, based on personal experience:

A few years ago I was hired by a pharmaceutical company to do training for family physicians about how to recognize and treat depression. And I mean I know that they have done a very, very effective job of swinging the pendulum. When I started psychiatry eighteen years ago, at least here in the Midwest, psychotherapists were relatively reluctant to refer people for medications, you know. They wanted them to work harder, to have some incentive not to take away their emotions too quickly. And then in the subsequent ten years have completely changed. And - and I feel like everyone bought into that, the psychotherapists as well as family docs and administrators. We have all this - employers - "we have all this untreated depression, we have to do a better job of recognizing and treating it." And that still is out there. And there is some truth to it. . . .

But the way we're going about it is not going to help us in the long run. . . . And physicians are influenced by the drug companies' advertising and their giveaways, they are.

This psychiatrist believes that treatment success involves relationship, collaboration, and effort, which he described in the following way,

I think the best way to go about that is for the [practitioner] to have a legitimate partnership with whoever they're treating, so that they're really in it together.

They - it's a shared responsibility, so the patients - they do need to have some motivation for change. They have to be ready for change to some extent. And they have to put some effort into it. So whether that be psychotherapy or learning about their mind and how it contributes, to various learning about good emotional regulation and emotional health.

He also believes that introspection, in the form of observing and becoming aware of one's thoughts and feelings, is a necessity, although this does not mean that everyone needs to undergo intense psychotherapy:

You know, I think that both children and adults in our country don't have much emotional awareness or skill, and the skills that would be needed are not that complicated. Or hard to learn. I used to not realize that 'cause it just seemed so big and complicated and not having studied and worked with mindfulness therapy for a while and then tried to consolidate it into a eight-week group format and worked with people who have real struggles, I realize now that the fundamentals for really good emotional health are not that complicated. . . . I don't think that one has to be too introspective to get the skill base. They do have to be willing to learn to work with their thoughts, and in that sense I guess that's introspection, but I don't think that they have to understand all of their inner motivations.

This psychiatrist is also a proponent of "more natural ways to adjust the body and the chemistry, the physiology, rather than the heavy hitting medications," which he defines in the following way,

What I'm thinking is something that's more aligned with how the body is supposed to work. So, it could be a chemical; it could be a man-made chemical like GABA, for example. People can use GABA - GABA is a neurotransmitter. You can take man-made GABA as a supplement and it can be calming, just like

natural neurotransmitters, but that's a more natural way to get at that than it is to take Valium, which interacts with those receptors and then causes all kinds of other problems. And same with serotonin. Some things like 5HTP, which is still chemically derived from plants, but it's a precursor to serotonin so it raises serotonin levels like your body is supposed to do if it was working well. Instead of using something to block the natural amount, recycling of serotonin. What medications do is, they block - normally a brain is supposed to recycle, just because it's more efficient. . . . It brings - yeah, conservation - so it doesn't have to keep producing more serotonin. It reuses it, and the drugs block that from happening. So, it seems really great at first, but over time because you're not able to recycle and reuse, you've got to produce more. Or you get even more depleted. I think that's what - where people run into real problems sometimes. . . . I mean, if you're working with patients you will see that so frequently, where they do really great for a few months, and then it peters out and you have to increase the medication, and that peters out. . . . And I believe - this is my speculation, but I believe it changes those receptors over a long period of time and then you've depleted your stores of serotonin even further because your body can't recycle it. . . . And so . . . I think it's helpful to try to understand how the body is meant to work, and then find ways to align with that.

This psychiatrist finds many of the changes during the last ten to fifteen years to be unhelpful to patients and worse:

Many of the changes have not been good, you know. The things we were talking about earlier like the quickness of prescribing medication, the prevalence of it; I think psychotherapy has in many ways kind of lost its standing as maybe first or primary treatment. When I started, even in the HMO at the time, people would

suggest first doing at least several sessions of psychotherapy before prescribing medication and now it's - therapy - is seldom done. Medication is first and often the only thing done.

As to the involvement of general medical practitioners who, as already mentioned, are the major source of prescriptions for psychotropic medication today,

I think a lot of the time it is very appropriate, and they do a very good job. My concern, really - my biggest concern - is that they don't get people off the medications in a timely fashion. And so, there's no way that psychiatrists could treat all the depression in this country. There's just no way, it's never going to happen. So, it has to be relied upon, and family practitioners if they know their patients well they can do a really good job with this. But I see people with their very first prescription getting eleven refills! So they get a year's worth of medication, the very first time. And they, after one year - they are going to have a hard time getting off it. So, if it's appropriate, fine, but, you know, I just think so often we're creating dependency on these meds. That's my biggest issue with it.

Finally, he summarized the meaning of these medications to him in the following way: "they're sometimes really helpful and supportive of a person's mood during difficult periods. They're overused, they're sometimes dangerous, poorly understood; I think they're really misused."

Dualism: Disease as applicable to mind

The semiotic process in which the practitioners in this category engage tends to be characterized by two modes, *indexical* and *symbolic*. They do this on the basis of suspecting somatic underpinnings to any disease state, which is *indexical* in the sense of attributing *naturalness* to such phenomena, but they insist that mind can be primary in the formation and maintenance of disease. Indeed, they focus on the role of mind in relation to disease, and in that sense use the *symbolic* or *conventional* mode in relation to

discussing psychotherapy. Moreover, in reifying mind, they actively inhabit the cultural *psyche/soma* split, and may therefore be described as true *dualists*, which, again, had been conventional in the world of psychotherapy.

This group of practitioners represented a wide range of training from case management to psychiatry, including a nurse practitioner, a psychiatric nurse, behavioral psychologists, and a ph.d.-level psychologist who specializes in neurolinguistic programming (NLP), arguably perhaps the most rigorous analytical system applicable to mind and its power of representation. It seems to me that the approach of this NLP practitioner stands out in this group in terms of the healing potential of the investigation of mental structures and habits and their relationship to a person's experience of the world and of life.

This psychologist has been in practice for over forty years and considers the term "disease" to apply to strictly physical conditions. He pointed out that the DSM does not even use the word "disease" but rather "disorder," and that much of what is described as "disease" in so-called scientific literature about psychology is based on a conflation of the terms "disease" and "disorder." He described the relationship between the mind and "disease" in the following way: If you mean by bona fide medical condition that [has been] confirmed by drug or by laboratory studies, and a knowledge of the etiology, then the mind has influence but doesn't cause the disease. Influences the disease, at least indirectly, the disease process, let's put it that way. . . . If you look at a medical definition, it has to have etiology, it has to have laboratory studies that confirm and validate the diagnosis, etcetera.

"Mental illness," then, according to this practitioner, is "some place between mental disorder and a disease," although he is aware that "they sometimes describe physical causes to those."

I asked him what he thought about that, given his long time in practice, and he responded in the following way:

Well, they've used that word for years. And it [mental illness] generally meant - it was interchangeable with mental disorders. But now since it's gone into medicalization, as you know, since it's become medicalized so much, then it gets mixed up with disease, which is for most mental illnesses there's no laboratory study that meets the criteria of a medical disease. So medicalization is - my understanding is - taking a medical model and applying it to personal problems which may be called mental or psychological disorders, and then forgetting that it's a model and start treating it as if it is real. So, it's actually only a model.

I asked him whether I understood correctly that he was saying that a medical model is being imposed upon something else, and he said, "Yeah. Problems of living, mental or psychological and emotional disorders."

This psychologist believes that mental health practitioners are working with something of a different order of reality than the physical, when it comes to explaining how people are able to change, for example:

OK, this is going to be different because this is not an accepted - not the usual: by a change in the person's internal representations of their reality. What I mean by that is, therapists I believe work with how a person represents their reality to themselves, with images and words and all that, symbols, whatever; that's what changes. That is, the map they have that guides them to this world which is internal representations, alright? That's what changes.

I asked him how this understanding might be reconciled with science or empiricism, to which he responded,

Well, empirical . . . depends how you mean by science; if you use the usual statistical studies, which is what science does, that's all about group averages. NLP is about each person as an individual; you have a model, we've got to apply a theory. One of the differences is that all these other things you're talking about -

the medicalization, psychodynamics - all of those have a theory of what reality is, right? And maybe you already know this, because you know NLP, but NLP says we don't know anything about reality, we can't even hear half the sounds that dogs hear. We have too many filters, so NLP is a model, and the model is not claiming to be anything true or real, it just says if you do this, you'll get these results. . . . And so, it's empirical. . . . Anything is what works, and what works is not measured with group things, although you could - you can do some experiments, but the NLP person who is doing some experiments, if you find five people that don't get it done, we want to know how far did that work that they didn't get it. . . . Did they really follow the procedure? One example is spelling; NLP basically goes finds people who are extraordinarily good at what they do, finds out how they do it, and teaches other people. All good spellers [for example] spell visually. But that's not the way we're taught. . . . We're taught phonetically, which you can't even spell phonetically!

My question as to the changes he had witnessed in his years of practice gave this psychologist an opportunity to elaborate on his views as well as to provide a living memory of psychotherapy's progressive reduction to material, biomedical interventions:

Well, when I started, medication - there wasn't near - there were only two or three medications that were used, specially when I started my training when I got out; of course, that was five years later, but and [psychotherapy] was barely getting started, so almost everything was psychodynamic, including what the psychiatrist did, and the medications that were used primarily were used in state hospitals to control people, and that's all. So then the changes came when several things came together including the insurance companies wanting to see some kind of results, and they're not just going to pay for ten years of psychotherapy. At the same time

my understanding from a lot of reading is, and to stick with my experience, that psychiatrists have always wanted to be real doctors and they got teased and they were low man on the totem pole - they weren't real doctors because there wasn't a physical thing. Well, a group of psychiatrists wanted to be real doctors, so the more of these medications came out that seemed to help, the more money then pharmaceutical companies poured into that kind of research, not other kinds of research. You put those together - the insurance companies - psychiatrists were switching over to medicalizing everything and looking for physical and biological causes, and as that happened, I noticed for example now, when I was going through training, the status people were psychiatrists. Now, the younger psychiatrists mostly - they don't even know how to do psychotherapy. They get no training whatsoever in psychotherapy. So, as I think you mentioned someplace, it's become that, although therapists don't like to admit it, the primary treatment modality is medication. The psychotherapists are auxiliary in effect.

At this point, I mentioned that my perception of this change was what had inspired my own research, that, specifically, it seemed as though about two-thirds of psychotherapy clients were already on medication by the time they sought out a psychotherapist, and he continued in the following way, "You're right, because that's the other thing that happened. That had never happened before, but now if you get a pharmaceutical company comes in with the Beck [a depression symptom inventory], and you give it to a G.P., he can give that and he thinks he knows, and oh, here's a pill for it." He mentioned that psychologists even used to look at anthropological data for help in understanding human nature, but, he said, "that's when it was all psychological; there were no physical causes."

Rather, this psychologist's belief in regard to human nature is,

that they have a dark horse, that most of the time the psychological mind influences and produces the chemical changes as much or more than the other way around. . . . Think about how medicine knows the mind influences the body in all kinds of ways; you hypnotize somebody and you can give them surgery, for crying out loud! But then they turn around and think it can't. I get mad and my blood pressure changes; you meditate and your blood chemistry changes. There's all kind of evidence that the mind influences the body. They never take that into consideration.

Instead, in his considered opinion, the medical profession's "use of neuroleptics with severely disturbed people has increased the amount of mental illness and the length of the disability. . . . It medicalizes problems in living; turns them into disease. The idea is it's a disease, which then all kinds of people don't want to have it, so they'll go get a pill for it." All in all, he finds this turn in treatment "dehumanizing," with only the pharmaceutical companies gaining on the basis of a philosophy of "the body is just a machine we don't have a human problem, we have a disease."

As a result of the changes he has witnessed, this psychologist finds himself thinking much more critically about "the so-called research of whatever they're saying is the disease model, or disease; they don't even say model. They say disease." He learns as much as he can about "the psychological, sociological, anthropological, and spiritual dimensions of so-called mental illness," as he puts it, and as a result, asks, "Why don't they see a neurologist if it's a brain disease?" But he himself admits that there is "so much peer pressure," which he described aptly in the following way:

I work at a clinic part-time, I really like the people, I've been there over ten years, I know enough, I can get away with being this silly zealot or whatever, because they know where I stand, but it is so strong in there; they sit there and talk about diagnosis . . . that's all they talk about! What's the diagnosis, and I really got

them going a month ago: I said, so how will you know what the real diagnosis is? And they couldn't answer, because they don't know that I know there's no reliability studies for diagnosis whatsoever, that say you did it. And even they were getting that point, they were getting it, but they couldn't really get it - their belief structure was so trained, and even the director's - he's a very bright guy - after we went through all of this, and one gal I like, she said, 'but if we didn't do this, what would we talk about?' And I said, how about how to help people better

Recalling this made him laugh. Then he continued by quoting Whittaker, the groundbreaking experiential psychotherapist whose work became part of the foundation of the specialty practice of marriage and family psychotherapy in relation to what he sees as the essential impossibility of reducing human problems of living to neurology: "Carl Whittaker said one time, 'gossip is the case conference of amateurs,' and they gossip! We were just doing a gossip thing."

I concurred that if we were going to get away from medicalization we would be back to talking about how people engage in relationships, including ourselves as practitioners. He said,

Think about it; medicalization - a relationship has nothing to do with medicine. The definition doesn't but there is a family therapist - I saw them go through what we went through. When I was going through [training], well, the head of our clinical program had to go to the state and take on the medical profession to be able to do psychotherapy. Then - this is long before I lived here - I watched psychology go through getting a license, which is mostly so that you get insurance, then I watched social workers do the same thing. Whoever is next on the pecking order in status; then I watched marriage and family therapists do the same thing, and now they got a heck of a problem, because they're dealing with relationships all the time.

As to the involvement, then, of general medical practitioners, this practitioner believes that “if they’re looking for medical causes so they can find the right medication, they’re overinvolved. If they’re looking for a holistic way of looking at their client as a whole person, they’re sometimes underinvolved.” In line with his perspective on the significance of mental representation as primary, he has come to the conclusion that the current problems of psychological practice come from a collective forgetting about the nature of medical practice, which he describes as being based simply on a reified *model*:

They made a medical model and they forget it was a model; it’s like taking a metaphor, which is a way of talking about something that helps people understand. In NLP it’s called ‘losing quotes’; if you say something in quotes, people will know this isn’t something exactly what I’m saying, right? And so it’s understood differently. So, people - they’ll talk about the medical model, but when you talk about it, they’re not talking - a model is a way to talk about something It doesn’t say what it is, it’s just a way of talking about it. But they lost the distinction between the model or metaphor and what’s supposedly real. They’ve lost that distinction, so that the - that’s how it got medicalized. The other - the influence of the pharmacological industry - is just so strong in doing this.

Reductionism: Behavioral health

The practitioners that comprise this group of interviewees make meaning according to a strictly *indexical* mode; as described previously, this means that they ascribe *naturalness* to the phenomena that they identify. However, they also tend to actively espouse *reductionism* in relation to the human condition, reducing the mind to the body on the basis of scientific materialism, which uses the closure principle to assert that nonempirical perceptual phenomena or subjective states are not admissible to scientific investigation. As a result, they generally do not concern themselves with the

inner states of their client/patients, focusing instead on behavior and language. Interventions consist of biomedical approaches, with medication management given top priority. When psychotherapy is used, it generally consists of cognitive behaviorism, with an accent on behavior. However, from this reductionist perspective, cognition also becomes behavior on the basis of the use of language. Moreover, both behavior and language, then, are seen as governed by feedback loops that may be reinforced by one's social environment, rather than as expressions of volitional being in the world.

Psychological practitioners with this approach appear to experience less philosophical conflict in their work environments than practitioners of other persuasions perhaps because they are conforming with the current locus of power within the health care delivery system; they also experience less cognitive dissonance of their own in relation to the writing of treatment plans, for example, and client/patients' desire for the efficient removal of symptoms. Indeed, the management or removal of symptoms through the use of medication is accorded the highest respect.

Healing moves from this perspective can be highly nuanced; practitioners who are in a position to prescribe medication may specialize in refining dosages such that they meet the needs of patients very precisely, and may pride themselves on this skill. When this is combined with psychotherapy, patients may perceive themselves as benefiting greatly, especially short-term if they are in crisis. An example of such a practitioner is a psychiatrist from this aggregate who practices as a consultant and professor of medicine in psychiatry at a renowned regional medical treatment and research center in the Midwest. Board certified in several specialties including psychosomatics, many of his patients are other physicians and medical students. Although having experienced training in perspectives that are predicated on the notion of the existence of the unconscious, including the collective as well as the personal, he sees himself as "somewhere in the middle" between what he describes as the current "movement towards sort of biological

reductionism” and what he defined as the “psychoanalytic reductionism” of forty years ago. His great attraction is to, in his words, the “art of medicine versus the science of it,” and his personal experience includes having attempted to inhabit distinct worlds of artistic expression and scientific research. Today, he brings these approaches to reality together in his practice on the basis of what may be described as a postmodern sensibility that is acutely aware of how language structures experience.

The following quote by this psychiatrist in answer to my question about his perception of the relationship between the “mind” and “disease” seems to summarize his synthesis of humanistic principles with biomedicine:

Well, I don't think it's terribly helpful to think of the mind and the disease as being separate. Nor do I think it's terribly helpful to think of the mind and the brain as being separate. Nor do I think it's terribly helpful to speak of the body as having disease and the head having something else. So, I find those sorts of dichotomies to be artificial and not very helpful. I prefer to think that we have a variety of metaphors that can be adapted to a given situation and we can work within that metaphor. The key thing in any encounter in my opinion medically is to be consistent, and to be - and sometimes I work in more than one metaphor, but if I'm treating someone with medication, I need to have a biological metaphor for explaining what I'm trying to do. If I'm combining it with psychotherapy I have to have some way of linking the two. But the notion of sitting around and thinking about the mind separate from the brain or separate from disease or separate from biological interventions strikes me as crazy as sitting around thinking about humans beings as a bag of chemicals - it doesn't work.

“Doesn't give the whole story of what's going on here,” I interjected at this point, to which he replied,

No, and I think we need to be clear that at any given time we're looking at a situation together from a particular perspective, and what - what language we adopt is presumably going to flow from the request, the situation. I'll often say to patients, you know, I hope by using these medications I hope we can adjust the thermostat, so you can do your therapy work in a less stressed way.

Given that this psychiatrist had some neurological titles on his bookshelf, I pressed him to say more about his perception of the nature of mind. Did he believe that perhaps it was an emergent feature of the brain? How did he define "mind"?

I think I probably see the mind as a construct of humans trying to make sense of their interactions. I mean the model that I use in my work - I also teach and do group psychotherapy - is intrapsychic versus interpersonal, but by definition any connection is going to be interpersonal in some way. But the mind as a separate entity - I don't think so. Emergent - maybe another way to think of it would be something that flows - well, I like the triangular model where there is a patient, a therapist, and the observing alliance, which strikes me as maybe the mind, or the connection, or something. But mind is too static a concept. It's rather like masturbation in a way. I mean, it's something that has - it's not connecting to anyone else, it's very self-absorbed.

"So, when you say mind as a construct it sounds to me as though this is beyond metaphor, it's almost a product of interaction. Not just literary metaphor, but a product of interaction," I said at this point, and he continued, saying,

Yes, and also - what I mentioned - the product is also grounded in the producers. So it's a bit like, you know, Heisenberg's uncertainty principle: how do you tell motion - how do you separate motion from the object? How do you separate mind from interaction? I don't know. Mindfulness as I understand it is about being

more self-aware, both inside of yourself but also inside of yourself in relation to the perturbations of the world around you.

What is the meaning of mental illness from this perspective? This psychiatrist put it in the following way:

Well, I don't - first of all, I think I'd have to say that I was a dimensional thinker, not a categorical thinker. I - and certainly since I was trained in a tradition - an existential tradition - that favors empathy, I have to locate my own mental illness as it were; when someone is mentally ill, very rarely can I not find of myself and my own experience in someone, no matter what the matter is. I prefer to think that patients come to me or are sent to me because they have some kind of distress. And the distress - we need to clarify what it is and figure out how to intervene. If it's a hallucination, then we might try medication to get rid of the hallucination. If it's a hallucination that hasn't responded to medication, we might figure out how you manage these irritating intrusions. If it's a hallucination only comes on when you're with your mother, we might have to talk about what that's about! What does mental illness mean? It's a - I think for me it's a fluid term. And I don't have much use for DSM. But I do find the notion that in order to have a diagnosis at all you have to prove that there is a problem that's a social or a work problem very useful. So if someone comes to me and they're just an odd person, I say well, what's the problem with you being odd? And [if] they don't have any problem with being odd, and nobody else does either, then there's not a mental illness.

This practitioner believes many kinds of interventions may be helpful to people in psychological distress, although it is clear that he likes to remain in charge of the process:

Now, I do get pretty uppity if they're getting drugs from more than one doctor. I don't like that. I don't really have a lot of use for large amounts of over-the-counter herbals, and I have a very difficult time with people who insist that what they're taking is pure, and what I'm offering is contaminated somehow. But I'm assuming people will use what they can to - to - I guess I'm assuming - I say to people that, you know, why wouldn't you take a medication to make you feel better? Would you not eat because - you say you don't want to put anything into your body. Well, do you eat and drink? Do you - you know, if it would help, maybe we should try a little experiment and see. If meditation is useful, if yoga is useful, if acupuncture is useful, if saunas, jacuzzies, massage is useful - of course, by all means, do it!

He did not seem to be saying that psychotropic medication is the ultimate answer, then, which he put this way when I expressed mild surprise that he was willing to endorse strategies other than biomedical: "Well, if we proceed from the assumption that a medication doesn't fix you, that it is an adjunct or something that might be useful, that might help you do what you need to do to help yourself . . ." I mentioned that it appeared that the general public seems to believe that psychotropic medications do indeed fix things, to which he replied,

Yep. Well, I disavow them of that notion rapidly if they're going to work with me! . . . Someone comes in and says to me, 'my life sucks, give me a pill,' and I say, well, I give pills for target symptoms. What are your target symptoms? The gentleman that I mentioned to you who had all these personality traits was quite striking to the residents as well as to me because he didn't endorse any depressive symptoms. He said, 'I'm depressed,' but then he wasn't depressed. . . . so in that sense the DSM might provide us with lists of targets. . . . the reason you have targets as well is to see if your medication is doing anything. So, I don't want to

hear about how your wife is a bitch, I want to hear about whether you're sleeping better, or whether you're eating better, or whether you're less anxious. And I think that's helpful because then patients don't overvalue the medication, and they're getting the message at least from me very rapidly that you've got to *do* something. I can help you maybe be better equipped to manage your life and your world, but medication - Prozac isn't going to make you get along with your wife. It may make it easier for you to work out your marital mess, or to leave, but it's not going to fix the problem.

This psychiatrist, who is also aware of recent studies demonstrating that changing one's thinking and behavior also alters brain chemistry believes that it is important to "try to figure out what modality a person wants to use," and he "does not hesitate to say I don't think medication will fix your bad personality." In his experience, sometimes patients are even helped simply by being given a name for their condition, as in this example:

I once had a physician I gave DSM all the personality disorders to, and I was thinking you're a narcissistic jerk from hell, and he came back and he said, 'I read your stuff. I think I'm probably narcissistic, but I'm also dependent and borderline.' He was right. And then we got on really well. Because he - he'd picked his diagnosis.

It is interesting to note, however, that despite the creativity of thought that this psychiatrist himself displayed, he does not attribute healing to patients' internal or subjective dimensions of being. In a manner that I found typical of most of the physicians I interviewed, he kept coming back to an interventionist approach dependent on his own skills, even as he noted interpersonal connections as somehow significant, as in the

following example: “So, if I can model that, that physicianhood or therapyhood gives you the right to ask anything, in an inquisitive and pleasant way, then what I’m doing that seems so death defying is actually just asking things that polite people don’t ask. Which are often key to what’s going on.” Most psychotherapists would agree with him in general in regard to the significance of thoughtful, relevant questions, but the philosophical underpinnings motivating the questioning are quite different. Whereas psychotherapists rely upon the existence of an inner or subjective dimension to human nature, one that has a potential efficacy in terms of agency in the world and personal healing, biomedicine has largely left such concepts behind. Some psychiatrists are in the strange position, then, of finding it personally necessary to formulate their own sometimes unique and artful syntheses or dance of metaphors to engage with the perceptions and conduct of their patients, given that they are indeed more than mere bodies.

In the end, however, this psychiatrist is willing to lay his own artfulness aside in tribute to a biomedical approach, as was revealed in the context of my question about the involvement of general medical practitioners in the mental and emotional issues of patients:

Are the psychotherapists exercising - are the psychotherapists in any position to decide whether a patient should be on medication? . . . You know, in most settings that would be considered practicing outside of your - your licensed area of expertise. I mean it’s trickier than that, of course. Ideally the best situations are where a physician and a psychotherapist have a collaborative relationship, but that assumes of course that the psychotherapist is ready to take patients for consultations and not have closed practices, that the patients can be seen rapidly when they’re in distress, so the decision can be made right now. But I - I’ll stick to my M.D. roots and say that psychologists are by and large not equipped ‘til

they've had a lot of training, essentially the same training I have, to be prescribing.

At this point I asked him whether he was aware of the movement to let psychologists prescribe, to which he responded,

Oh, I'm well aware, I'm well aware. But what I resent about that is then when it all goes badly, then I'll get a consultation. And you know I - it's a whole other issue. . . . But my point really here is that sure, I think medication is used excessively, I often take people off medication. I think it's used reflexively, it's certainly easier to use in some ways, it - it's cheaper for insurance companies to have people on medication, but I would consider

I asked him whether he was sure about his last point or whether it was just an hypothesis, to which he responded,

Oh, there are debates about it, there are debates about it. I mean, that's what the insurance companies will say. The systems go around about it. It is a hypothesis, I agree. But what I would also say is that once again, the patients that are referred to psychotherapy often are medication plus patients, you know, and I - I think it's - one should have a certain humility about that, because equally I will refer patients who I have treated successfully with medication for what I can do but I - they need more. Or they need different. Or they need plus. And often - you know, I - I often take people off medication to see if anything changes, and sometimes it does. And sometimes they go back and say, I really need to be on that whatever it was, because it really did help with x , y , and z . And I say, great! But that's your medical practice.

I mentioned that I too had run into many people who say that they want to be on medication because it makes them feel better. But how, then, I asked, was this different from walking around with a flask in one's back pocket? To which he simply replied, "It isn't."

As to how he actually understood medication to work, here was another psychiatrist who was willing to admit that things are not what they may appear to be or what consumers are being led to believe:

I don't think we know. And again in a nutshell our knowledge of these modalities is based on hypotheses that are tested with populations where certain symptoms are followed, and if they remit in a greater proportion than with *placebo* then we have more data for the wall we are trying to construct to understand. . . . So if I - you know, it's also where the objective meets the subjective because if someone comes back to me and says, 'I love my pill,' I'm not going to take it away, because I've read some study that says the *placebo* effect is a bad thing, you know? I mean, it's not up to anyone - if there's objective evidence that so-and-so is better on their pill, or even subjective evidence, then who is it for anyone else to tell them that they shouldn't be - now I sound like a libertarian, but in that respect I don't think it's helpful. I also think it's a misuse of the literature. I mean, one of the things that - a paper I find fascinating - it's written by Zimmerman, M. Zimmerman, American [medical] Journal a few years ago, about his practice in Rhode Island where he looked at a hundred patients - I think it was a hundred, some number of patients who were depressed - and found that I believe twelve percent would have made it into the group company studies that validated the use of the drug they were on for their depression. So eighty-eight percent we're flying by the seat of our pants or we're doing artistic creative work.

This creative work, he said, sometimes included deliberately using the *placebo* effect.

Consciousness: Disease as unease

The practitioners in this group predicate their practices on the perception of states of *being* in their client/patients; they begin with the recognition of *consciousness* as an attribute of being human and proceed from there, also taking note of their own state in

any interaction. Traditionally, this mode of working in psychotherapy was described as *symbolic* or *conventional*, given its past association with some religious perspectives, but I submit that it could be described as *indexical* on the basis of the insistence by these practitioners and others like them, many recognized historically, that consciousness is a characteristic of life itself. To acknowledge this would be to see consciousness as part of the natural order, which would move it epistemologically into *indexical* meaning making.

Most of the practitioners in this group are licensed psychologists, but two of them work in a medical capacity, one as a psychiatrist and the other as a nurse practitioner. All of them are aware of swimming upstream in the sense that their perspective on the human condition and its psychological practice implications are not currently dominant in the medicalized setting of much of the practice of psychotherapy. Several of them made a deliberate break with conventional methods at some point in their careers in order to practice with a greater sense of personal integrity and relief from cognitive dissonance.

Healing methods from the perspective of the overt acknowledgement of the existence of consciousness differ radically from other methods in that, most importantly, the practitioner does not seek to necessarily intervene; indeed, the foundational philosophical assumption or perception is that there exists an underlying wholeness in the natural order to which human beings have access on the basis of their own existence as living beings. A major implication of this is that the practitioner, in order to function as helpful in the lives of others, must him- or herself be working on their own relationship to this order. Ideally, they become *a healing presence*, in relationship to which help-seeking individuals relax into wholeness, meaning that health reasserts itself as the normal condition of life. Disease is seen as distortion, blockage, or contraction in the flow of the force-like dimensions of organic and psychological life; at the same time, these practitioners are not involved in the dualistic thinking that separates mind and body. Rather, they tend to see the natural world, including living beings, as energetic

expressions, perhaps of an ungraspable higher order. This, then, is not conventional religious thinking, but a focus on the dynamic quality of nature and the perception of health as its normal condition.

This perspective tends to undercut pathologizing; the client/patient is seen as experiencing something like a fluctuation in their state of being, rather than as having become a victim of a static condition. The role of the helper becomes that of walking with the client/patient, as a certain type of friend or companion on the road to wellness and restored health. The helper does not have the last word on what this wellness or condition of health ought to look like, since it is an ever-changing and ultimately personal matter. However, this is also not to say that such practitioners “do nothing”; they have generally trained rigorously in such methods as meditation or in expressive therapies such as the use of artwork but they offer to teach methods like these only at the point of the client/patient’s own indication of already moving in the direction of dynamic health or personal growth.

A practitioner who stands out in this group in terms of embodying all of these characteristics is a licensed psychologist and yoga and meditation practitioner. When I asked him how he would describe his official role with his client/patients, he responded with the following:

Disturber of the peace; breaker up of the stereotypes, routines, preconceived notions, limitations, and hopefully gaining mental health! . . . They come in thinking that I’m going to do certain things, which I may do, but during the whole process of therapy it’s an unexpected kind of change or revelation for them, so that a lot of the things that are happening they don’t expect, because part of the therapeutic change has to do with being caught off guard so that you can be vulnerable and safe at the same time, and that works pretty well. So I just wait for the right moment, and spring into action when there’s that learning - you know,

that learning, whatever you call it - point. That impressionable moment when something can be said that will make a difference for that person. Or if I ask the right question in the process that can create a learning moment because the question will put them into a frame of mind where they become vulnerable and into that very moment, and then the next thing can be said that will make a difference.

I said to him that he sounded like a trickster, to which he said,

Yuh, that's true, it is. There's no methodology in that; it's completely intuitive. There's no preconceived notions except that I'm going to do something But I don't have a sense of what needs to be done with each person when they walk in the door, and each day they walk in is a new day, a different day, and so I don't carry with me - after they leave at the end of the day, I don't carry any of that with me at all; it's done.

Given that he not appear to have any qualms about appearing unconventional, I asked this psychologist to describe how he had learned his therapeutic approach:

Again, I didn't learn a technique. I think that most of my understanding of human nature and the process of change, and how to implement or facilitate that, has come from the result in part of many different things. One of them was - would be - looking at the personal changes that I went through in my own life and having grasped those changes thoroughly, and developmentally having to do with my own mental/emotional/spiritual make-up. The relationship with my parents, my sister, friends, my own personality make-up in terms of how it actually didn't match; relationships with women and those that succeeded [or] failed over time; and finally getting married. But the depth, the greatest depth of my understanding of human nature came as a result of becoming involved in meditation and yoga. . .

. And studying with a teacher who was pretty much the epitome of my preconceived notions of what a yogi should be like, and all the reading I had done previous to meeting him. So I either fell into his lap or he fell into mine, and you know, back in 1973 - it's pretty much history from there. And with varying degrees of personal practice of meditation and teaching it - all those kinds of things - I just became an observer at realizing the process that people go through in order to achieve what they want to. So as far as a technique goes, I don't see it, I don't really see a technique in what I do, but maybe others do, I'm not sure.

His response to the question of his understanding of the relationship between the mind and disease was also telling in terms of his underlying philosophy:

Well, first you dissect the word 'disease,' and it becomes 'dis-ease,' and so by taking that dis-ease and applying it to where you are able to observe and perceive where a person is feeling out of balance, and so disease is being out of balance. So, my entire therapeutic role is to teach people how to find their own balance, and then the disease disappears. So, however that works for each person is very different Three- or four-year-old kids up to eighty-year-old people dying in a nursing home, I mean there's all kinds of - you have to be really flexible, mentally/emotionally flexible to do that. As a therapist.

I mentioned that I was not hearing him make a distinction between the mind and disease, however, so he elaborated on this in the following way, laughing:

Well, I don't really like disease because it goes along with, I think, at least to some degree, your purpose of having this interview, and that's the medicalization of mental health, and I think that's really a distortion of what mental health is really all about, so you focus on disease and that gets to be a problem. But rather than teaching people how to be mentally healthy we focus in on mental health and

balance. The disease model talks nothing - only about - disease, and it doesn't talk about the other stuff, and so I really ditched Westernized theory all together. I just don't buy it anymore, and I haven't for years, and I don't see any value to it, other than getting people engaged in a process of therapy. At the outset we sit and talk in our intake interview about all their dis-ease [sic], but then we proceed from there to how are we going to discover what your mental health is. And that's not a disease model. It's not productive [to focus on disease]. You spend too much time whining about the past when there's nothing you can do about it. . . . Not that people don't have legitimate things to whine about. . . . I don't want to minimize that, because people have been through terrible things, traumas, but focusing on them and trying to figure them out doesn't solve the problem.

I asked him specifically at this point whether the *perception* of something as distressing might be part of his definition of disease, but he reiterated that,

No, it would count for out of balance. . . . Or that there's a balance that they haven't been able to achieve, and if they haven't - if they're continually confronted with a certain kind of challenge that they can't find balance with then that imbalance becomes habitual, and then they have difficulty finding their way through it because whatever level of mental/emotional skill or talent they have in order to solve that problem isn't working, and subsequent to that people become - they fit into those little DSM IV categories of depression, or anxiety, or stress, or OCD, and all that stuff, but that isn't what I focus on when I'm talking to them. I just have to have that stuff for the insurance companies; makes people feel good though because they have a label on something, though.

There was, then, a pervasive coherency to his point of view which seems to rest on health as immanent.

His response to the question of the nature of mental illness was equally telling.

Laughing again, he said,

Somebody made it up . . . and maybe that's still part of that paradigm from centuries ago when they used to tie people to walls with chains and pour water on to them! It didn't seem to work; you've got to wonder who was mentally ill! But, so it's just a made-up word, you know, 'mental illness.' I mean, it's nice and it's convenient but maybe it works for insurance companies, but I'm fairly skeptical about the value of focusing on mental illness, so to speak. I mean, there are people who are schizophrenic and psychotic - and if there was anything that would be a 'mental illness' to me, that would be it. Anything short of that would be just a sense of being off balance, because my understanding of the severity of those psychoses is that they are organic in nature, and they haven't been able to figure that out yet. They haven't been able to solve that except by giving medications to subdue those uncontrolled impulses or functions of the brain that aren't being modified by the amygdala or whatever else is going on in there.

Was he saying that he would categorize only those disorders that involve a delusional component as brain-related illnesses somehow different from the other kinds of things that people manifest?

No. You know, delusional - I mean, most of us are delusional! So I'm not sure that - I think that at least ninety-nine percent of us are delusional. We live with the delusion, not in a strict sense, but we live in this delusion that life should be a certain way. It isn't the way we want it, we'd like it to be different, and we try to find a way for it. Every moment that we're alive, from the time we leave our parents' house, 'til we die, we're always looking for something better, or how to make it great. And that's the delusion, because the world out here is not going to change; it's the world within that has to change, and that's the difficulty. The impaired delusion is that somehow we're going to change what's going on out here! . . . Everybody says that and that's why we have wars; if we can't change those people, well, we'll kill them! They don't do what we want. It doesn't work.

I asked him whether he was questioning the very nature of what a delusion might be, and he said, “Oh, well, yeah! Who defined that? Who made up that word? . . . A lot of made-up words. Everything is made up!” But wasn’t it the case that we could hardly help creating meaning constantly, I asked. Refining his point then, he said, “We look for meaning. We often don’t use words that really clearly define something; it just simplifies it into a stereotype, and then it tends to lack any kind of poignancy at all. It just keeps us all delusional and we give up.” He seemed to be alluding to the Buddhist insight that the mind can distort consciousness through its own ceaseless activity.

From the consciousness perspective, it is the client who drives the course and the pace of psychotherapy, which emerges in this psychologist’s response to the question of how he would define treatment success:

What seems to happen is that people start feeling so good that they don’t think they need to come back, so I just let it go at that. It doesn’t necessarily mean that there isn’t more to do; everybody has to figure that out, you know, if they’ve had enough or not. Now, some people leave before they should. But that’s not really what I’m talking about. But most of the time I can tell [when] people are coming in, there’s not a lot of stress, if they feel balanced out to me, their tone of voice has improved, their expression on their face has resolved, and they’re not as anxious or painful. Their demeanor has changed, they’re obviously more relaxed. You can see their mental-emotional-physical changes and improvements, and we talk about that, and I ask them questions about it to see if they are also observing them in themselves, and then we look at that every so often, like, how do you think you have changed? How do you think that this is making a difference for you? If it isn’t, let’s try something else.

And he attributes success to the following largely subjective dimensions of being that clients bring to the encounter, including their own growing ability in the course of

treatment to step back from what they are experiencing in such a way that they essentially learn to observe themselves :

It's widely variable. Some people come in so desperate that they're willing to do anything. . . . They have to be motivated enough to see the value of experimenting with possible differences and changes of behavior and attitudes and so on. There are people who come in who aren't ready for that yet, so part of the therapy initially is therapeutically designed or intended to help people to get to the point where they're ready to change. Sometimes that takes a long time, because some people just aren't ready for change, even though they know they're miserable. They don't really know that it's them, or they attribute their problems to physical issues or they're blaming it on other people or they come in with a lot of trauma, post traumatic stress disorder, and that kind of stuff. . . . But they're so wrapped up into their problems mentally that they are not able to step back and make the observation of the mental and emotional process, so you have to teach that first. . . . And then they get to the point where they're willing and able to make changes, and then it comes a lot easier.

Specific techniques which he uses himself and teaches to clients when they appear to be ready include the following:

Letting emotions ride - learning how to ride the wave of emotions, rather than stuffing [them]. Journaling, practicing relaxation/breathing techniques; some people come in who are interested in Eastern philosophies, and I teach meditation and work with them on philosophies, the psychologies of Eastern thought. That's always refreshing because it's even easier to do therapy with people, even though it can get more complicated in a way, but I do a lot of work with parents on parenting - I work with their kids, and so on. A lot of it is education. . . . Therapy is really a teaching thing in a big way. So you're teaching people a lot of different

things depending upon whether it's how to talk, how to think, how to process.

They're involved in the examination of the process that they're experiencing, and through that [it] can teach them something that will help them through that.

Finally, a practitioner such as this psychologist does not necessarily believe that there is no role for general medical practitioners in the management of client/patients' mental or emotional health problems; however, as this psychologist put it, "If a doctor is going to be responsible, everybody that they give an antidepressant to, has to be required to see a therapist. . . . Otherwise they're doing a disservice; they are creating an illusion that the pill is the solution, and that creates dependency on the doctor and the pill to solve problems." He bases his opinion on his perception of psychotropic medication as a "temporary aid," with a "proven efficacy . . . less than twenty-five percent."

What emerged, then, on the basis of the interviews I conducted, were four different healing strategies which, in terms of semiotic philosophy, seem to be based on what I am calling *holistic empiricism*, *dualism*, *reductionism*, and awareness of *consciousness*. Of these strategies, reductionism in the form of biomedicine exerts the most power to frame the context of practice, tied as it is to the insurance and pharmaceutical industries. Client/patients from this perspective are regarded as necessarily dependent on biomedically trained physicians and mood-altering prescription drugs; they are, in other words, disempowered on the basis of a disavowal of an immanent potential for physical health and a disregard for the mental efficacy inherent in consciousness.

POWERS THAT BE

The mental health practitioners that I interviewed were all aware of the locus of power in the current climate of practice; in terms of this context, they see it as residing very obviously within the biomedical domain with which most of them have affiliated

themselves. To the chagrin of a significant number of them, making a living in the mental health field has required them to buy into the implicit reductionism of biomedicine which in practice denies the reality of another source of power, that of human conscious awareness. However, the field of psychotherapy can be seen as built on the recognition of this phenomenon, and the study of it, albeit often in derivative forms, still constitutes the bulk of theoretical and practical training in that field (see Corsini 1989:9).

An unholy alliance

A segment of the work of one of the behavioral psychologists I interviewed seems to demonstrate exquisitely the nature of the encounter, engagement, and cooptation of conscious awareness that occurs when psychology becomes involved with biomedicine. The work in question consists of the assessment of clients as to their likely ability to benefit from bariatric surgery, a class of elective procedures that make it more difficult to eat the quantities of food necessary to maintain severe obesity. From a biomedical perspective, a bariatric surgery may be recommended for people who have failed at diet and exercise regimens. But from a psychodynamic perspective, people who struggle with severe obesity may be suffering from a form of addiction, a complex phenomenon that can eventually involve self-destructive metabolic processes. Psychotherapeutic treatment would generally include the exploration of antecedent experiences, thinking, and behavior, as well as of current patterns of thought and behavior that maintain the destructive pattern. Ideally, the client gains *insight* into his or her own motivations for the problematic behavior, and can, on the basis of an understanding and encouraging relationship with the psychotherapist, grow out of and leave behind the thinking and behavior that maintains the problem.

Careful psychotherapy of this type, predicated on the recognition of human behavior and thinking as motivated, has traditionally encouraged self-reflection and -

understanding; it has also served to help people grasp the impact on them of their social environment, including all of their relationships, and has enabled many people to create positive change in their attitude towards themselves and others. In terms of the call to conscious awareness, then, which I would describe as the best that psychotherapy has to offer, it has been a powerful force for good which has included beneficial social change.

How, then, have psychologists come to be involved in assessments for an elective surgery related to a psychological problem? How has it become possible for people to have the choice of a surgery for a behavioral problem? What of the irony of choosing surgery rather than different behavior, assuming that surgery is meant to do away with the problem of lack of personal control? Is choosing surgery an attempt by individuals to continue to be able to eat foods of their choice and habitual quantity with an externally imposed constraint on them? There is a television commercial in which a woman claims that her stomach growled for food all the time, “like a lion.” At this point, a lion actually appears on the scene, but she says that her problem is gone now because she has had lap-band surgery, a bariatric procedure. A psychodynamic or even cognitive behavioral psychotherapist would try to discover with the woman what ingesting more food than her body actually requires means to her; what the behavior does for her; how and under what conditions she learned to do this. Again, the assumption with this form of intervention is that such knowledge gives people the opportunity, if they care to choose it, to change the nature of their relationships, in this case including to food. It is also understood today that thinking and behavior is capable of changing metabolic processes; in other words, it is a highly questionable proposition that behaviors involving choice may be uncontrollable.

But elective surgery is profitable business in biomedicine. And psychologists seek practice opportunities. However, it would appear that when psychotherapy encounters biomedicine, it is psychotherapy that acculturates, and that in the course of

this engagement, the human being is objectified, meaning that he or she is reduced philosophically to a mechanism devoid of volition and self-efficacy. In this way, then, psychotherapy undercuts itself and squanders the greatest gift it has to offer, conscious awareness.

The “last resort”

Another psychotherapist I encountered, a psychologist who does specialize in mindfulness techniques, admitted that she would refer her more “complex cases” to a psychiatrist for medication management. It would appear that when all is said and done, this psychotherapist, like most today, despite her formal allegiance to a philosophy of practice explicitly based on the power of awareness, does not ultimately trust the human capacity for engagement in a deeply caring and supportive relationship for its capacity to realign consciousness to counter chaotic and self-destructive tendencies in a troubled client. To me, this signals the extent to which psychotherapy has been coopted by biomedicine, when even a mindfulness-based practitioner would deflect into drug management of existential suffering.

At the North American Society of Adlerian Psychology’s fifty-seventh annual conference, held during June of 2009 in Tucson, Arizona, I was present when Dr. Peter Breggin poignantly asked psychotherapists to think about what they consider to be their “last resort”; despite years of training in careful and empathic listening, recognition of developmental stages, understanding of the etiology of distress, and proven methods of questioning designed to shift awareness, is it drug management? Is the human condition such that the invention of chemical remedies was inevitable and is in truth a godsend, given the terrible fate of being alive? What has happened to our perception of our capacity for functional engagement with life? Is it a hopeless undertaking after all in which we are doomed to misery unless we can medicate ourselves?

Perhaps more pragmatically, is rapprochement between biomedicine and mental health practice based on holism, conscious awareness, and other integrated perspectives even possible? What kind of institutional changes could reasonably be made, given the current context of practice? How could practitioners, including biomedically oriented physicians, as well as client/patients be accommodated in mutually empowering and healing relationships using existing institutional arrangements? These were the questions that began to cross my mind as I encountered the deep frustration of many of the mental health practitioners. Eventually, I met a practitioner who has indeed been attempting to create such a bridge.

A case of hope

Ken has been practicing psychotherapy in one form or another for almost thirty years. During this time, he has become increasingly aware of what appears to him to be a connection between client/patients' stress level and the amount of physical discomfort and pain that they report. He has come to suspect that stress is probably the basis of much if not most disease, especially as seen daily by physicians in their practices. In recognition of this, he has methodically sought to cooperate with local general medical practitioners, cultivating them as a source of clients whose issues are obviously related to highly stressful life events, but also attempting to educate them about the connection between illness and stress when the opportunity has seemed to present itself.

He cites a National Institute of Mental Health finding that between thirty and thirty-three percent of the patients who visit a physician could actually benefit from mental health services. If, as he estimates in the case of the rural settings in which he practices, local physician contacts number approximately ten thousand per month, then more than three thousand of these same patients could be benefiting from a relationship with a psychotherapist, by implication perhaps more than with a physician whose main recourse is generally medication only. Even if one halved the number of contacts to rule

out repeat visits by patients, many of whom are likely to be elderly, the number who could benefit would be enormous, he says. However, despite his consistent efforts, which include a high level of efficiency in terms of documentation and paperwork turn-around, he feels fortunate if he receives two or three referrals per week, even though the two office locations between which he shuttles have been located within medical practice buildings directly associated with two different hospitals in two different communities.

Ken's description of his services includes the following paragraph: "We know that mental health problems can begin when psychological or emotional stress (such as the loss of a loved one) triggers chemical changes in the brain. While some people can withstand more stress than others, sometimes we need help and that's okay." The order of the words in the first sentence was striking to me since these ideas are usually presented in reverse by pharmaceutical advertising, creating the impression that chemical changes in the brain give rise to the mental health problems. When I asked Ken about this, he acknowledged that this perception is at the heart of the very real disdain he has encountered over the years at the hands of physicians, especially of older generations, who, he says, dismiss psychotherapy out of hand on the basis of two main assumptions. The first one is that psychotherapists do not do anything different than the physician does, only more of it, this being an allusion to listening and assuming a caring attitude. The second assumption he has encountered is that psychotherapy is beyond science because supposedly it is not evidence based, and that therefore it does not deserve medical respect.

To counter these impressions, Ken has over the years encouraged client/patients who have benefited from psychotherapy sessions to report the fact to their physicians. It has been in this way that he has built his practice and his relationship with local physicians, although he is hardly overwhelmed in terms of numbers of client/patients. But to Ken, his is an important practice because it is in line with a dream which he

characterizes in this way: “integration, integration, integration.” He asks, “Why can’t this be more holistic? That’s what I would love to see. But because ultimately if we’re focused on what helps people, and stop the pooh-poohing of the disciplines like chiropractic, like psychology, if you have experienced people doing that stuff, things can happen that are fairly substantial. They [the positive effects] go way beyond their own medicine.”

Ken also identifies problems with *a* medical model that seems preoccupied with illness instead of wellness; he says, “we’re not looking to have people be overall healthy, we’re looking to have people be sick and then fixing them. . . . empowering people to be healthy - there is no money in that.” Moreover, especially in the case of physicians he describes as “established,” “just giving - handing out prescriptions - clearly that’s an easier process versus trying to convince someone they need to do counseling.” To him, then, “the whole model becomes frankly suspect.” However, given the apparent reality that medical practitioners are the first helpers distressed client/patients turn to, it seems obvious that if psychotherapists are going to continue to have a role in the helping professions, then they need to create some sort of relationship with physicians.

But this can be a daunting challenge. In Ken’s case, one of the hospitals with which he has been associated for more than a decade moved to a new location in town, and despite his long-term relationship with the physicians, no office space was assigned to him. When I interviewed him the first time, he was still located in his old space, which was attached to the then partially demolished remains of the old hospital building. I asked him at the time whether he thought this situation was related to the status of psychology in the eyes of the physicians, and laughing ruefully he acknowledged this, saying, “Oh, very much so. I mean, they needed more office space, exam rooms, so there was no discussion about that; it was just - whatever!”

Ken gave numerous examples of client/patients who had benefited greatly from psychotherapy with him in the form of the resolution of emotional issues often in under ten sessions; in some cases, the client/patients had been taking prescribed medication for years with no impact other than emotional numbing. So, although the so-called evidence-based philosophy of biomedical practice may logically create distrust of psychotherapy, the well-being of client/patients could be cited as a worthy motivation for integration. Ken suggests that, “Why not every time you have an antidepressant coming to the surface, why are we not offering counseling simultaneously? I do see some of that happening, but it’s always going to be physician driven. Why is it always physician driven? Why not have integration of physician and psychologist?” In what Ken also describes as “wrap-around” practice, physicians could be useful to psychologists in helping to rule out physical issues that impact client/patients’ sense of well-being.

Such an integration, however, should not rest only on cognitive behavioral interventions, according to Ken, since this would be to leave out emotional integration. What seems to effect healing, in his experience, is for client/patients to wake up to their own core beliefs, which are made up of emotionally significant perspectives on how the world appears to work. Getting at these does indeed require time and patience, two components of healing that appear to be in short supply in medical practice, but for which psychotherapists are trained. Physicians are also not generally trained to use their own countertransference reactions, which can, however, be invaluable in diagnosis, as when the practitioner notices his own tension in relation to a client/patient, as Ken describes in this example: “I can feel tension right at this level; do you feel that? ‘Yes.’ In your stomach right now? ‘Yes.’” Psychotherapists, then, are often in a position to potentially discern a wide range of possible sources of distress that could also constitute the ground for useful collaboration between themselves and physicians.

Ken also gives management reasons as to why physician practices perhaps even ought to include some psychotherapists as when employees associated with the practice find themselves experiencing difficulties in the work setting; “who,” he asks, for example, “is providing the medication to handle the depression of the employees who are being oppressed by the physicians?” Medical practices are understood to be notorious for their power-based hierarchies, which is an attitude that emerged in many of the interviews I conducted.

Implicit throughout Ken’s thinking seems to be that perhaps psychology could move biomedicine to focus on wellness; he kept coming back to the idea that medicine could be focusing on health, using its position of powerful influence to educate the general public in a way that many psychologists have now taken on, encouraging people to make lifestyle changes well-understood to support health. Here he includes “the whole broader sense of spirituality,” or, alternatively, “people seeing themselves in the context of the larger Whole, and how do I fit in the universe? Or, how do I see myself in relation to others?”

In a follow-up interview, Ken was excited to describe the local hospital’s involvement in a new statewide medical initiative, named DIAMOND, for “Depression Improvement Across Minnesota: Offering a New Direction.” Designed to treat depression more efficiently, meaning more cost effectively as I was soon informed, it also happens to be more effective in terms of outcomes for patients. I had also attended an informational session to which local psychotherapists had been invited, designed to introduce the initiative to the community, and had spoken informally to a physician afterwards. When I asked her why she personally thought this initiative would be a good idea, she replied, “Because it is the right thing to do,” obviously referring to the improved treatment outcomes for patients. However, management at the new hospital, comprised of the doctors themselves, had still not provided Ken with any professional practice space, despite his on-going presence at the initiative implementation meetings.

The PowerPoint presentation given to the community psychotherapists by two of the physicians very early one morning at the new hospital had consisted largely of truncated lists of diagnostic criteria from the DSM, such as the PHQ-9 [a patient health questionnaire], designed for use by general medical practitioners, and statistical findings in relation to the use of various psychotropic medications used to treat mental and emotional disturbance. Ostensibly, the medical community was soliciting the cooperation of psychotherapists, but only two of the slides used in the presentation even alluded to psychotherapy, and there was no public endorsement of it as such by the presenting physicians. The term “psychotherapy” appeared under the heading of “Best Treatment,” as an alternative to the use of antidepressants, and “cognitive therapy” was mentioned as an alternative to adding a second drug to one already being used, but there was no discussion about this. Much of the presentation, to which the local physicians had also been invited, consisted merely of comparative drug treatment findings, and the thrust of the presentation seemed to be an exhortation aimed at the physicians to use more refined criteria when making mental health diagnoses.

Unlike Ken, I was not inspired by the presentation of the new initiative; I failed to see how anything was going to change substantially. In fact, there was every indication that mental health diagnoses by general medical practitioners would increase and that psychotherapy would continue to lose salience as a treatment option. A major point made in the presentation, under the heading of “Depression Care As It Was,” referred to “the ‘black hole’ of behavioral health.” I asked Ken what he thought this had meant, and he said that it had seemed like a reference to a lack of cooperation of psychotherapists with physicians. Again, I found no reason for much optimism, since it had become clear during the presentation that the insurance industry had begun to deny payment for general diagnostic categories such as “311 NOS,” “depression not otherwise specified.” In other words, although more consistent treatment of depression would obviously be a good

thing for patients, physicians would also lose money if they persisted in meting out diagnoses lacking in specificity. From this perspective, then, the only reason to refer a patient to a psychotherapist would be if a physician thought that he or she could not find the “correct” diagnosis, a concern that came to light when one of the physicians asked whether he would be able to get help with “the extra little numbers.”

Ken admitted that the DIAMOND model is “a little limited,” but continues to hope for more holistic medical practice to emerge on the basis of efforts such as those being made by a few of the local physicians who, according to him, want to adopt a “*health* model” but find themselves “stuck” in the medical model. This appears to be an allusion on their part to the economic structure of medical practice which, however, Ken continues to believe could be shifted ideologically.

Like Maslow, I would argue that basic needs must be met before one can realistically entertain (self) actualization; that is, given the economic structure of medical practice in the United States, shaped and constrained as it is by an insurance industry seeking constantly to contain cost, physicians, like psychotherapists, often find themselves at odds with the basic tenets of their training yet must maintain economically viable practices. They know they are in a position of influence and power in the lives of their patients, and today they do have basic knowledge about the relationship between lifestyle and health (see Creagan and Wendel 2003). But to make a living, mental health practitioners who include a reluctant physician population must seek and find illness. It would appear that promoting wellness would help to contain cost, but, strangely, the insurance industry does not reimburse for education in wellness.

Psychotherapists are still trained in and expected to teach functional thinking and behavior, but they too find themselves continuously under pressure now to justify the time they spend with client/patients, which translates into identifying disease, and, increasingly, adhering to so-called “best practices” formulated by insurers and physicians

in line with the aims of the pharmaceutical industry. In other words, the economic structure of medical and psychological treatment in the United States increasingly dictates the use of medical diagnosis and the prescription of pharmaceutical agents only. It would appear, then, that hope for change in the direction of the promotion of wellness would have to begin with changes in the economic structure of medical practice.

Consciousness and conscious awareness: Past, present, and future

Whether or not the economic structure of medical practice changes in the United States in the foreseeable future, the reality of the existence of human conscious awareness in some form and its potential for development remains ever present. Despite age-old philosophical debates in the West and modern neurological studies that argue back and forth about the nature of consciousness, human beings predicate the conduct of their lives on its existence. The modern Western perspective evolved from Greek notions of awareness as impelled by the gods to the Medieval philosophical reification of soul to modern biological reductionism, which, until very recently left us with consciousness as emergent and no more than a biological byproduct. Meanwhile, philosophies of the East, some of which are at least four thousand years old, developed vast and complex semiotic systems for managing conscious awareness, never doubting its reality or salience to human affairs. Many American psychotherapists are turning to these systems now in the search for more effective ways of helping client/patients who are being failed by biomedically condoned pharmaceutical pipe dreams.

Today it is increasingly understood in the West that the state of one's consciousness can affect one's immune system and metabolic processes on the basis of neurotransmitter responses. This is now a branch of holistic medical inquiry called psychoneuroimmunology (PNI) which can be argued to have made the Western *psyche/soma* split outmoded (Pert 2000). When one meditates, for example, or engages in biofeedback training, neurological and metabolic processes have the opportunity to

return to baseline or steady states, recovering from the fight-or-flight chemical upheaval induced by thoughts and emotions (Kabat-Zinn 1990). These beneficial effects are not unlike those facilitated by deep sleep. To become aware of one's thoughts and emotions as they arise, moreover, and especially of those which are habitual, is to become aware of how one's state of awareness or lack thereof is involved in one's health, and to drop habitual entrapment in thoughts and emotions is to let the body return, then, to a natural state, meaning one that is relaxed, efficient, and whole again.

The human body is subject to both conscious and unconscious regulation; it now appears that habitual attitudes to which the body accommodates itself muscularly also create an habituated chemical environment within, which in turn affects one's perception of one's emotional state (see Moss 2007:199). Breathing is an example of a physical function which is readily observable in terms of both conscious and unconscious regulation; blood pressure is in this category too in that consciously relaxing one's breathing, for example, can lower it (Rama, Ballentine and Ajaya 1976:25–27). The chemistry of the blood is, in turn, affected by one's breathing style. An ordinary example of this interrelationship and its effects is the fact observed by psychotherapists that people who suffer from anxiety disorders tend to hold their breath (see Rama, Ballentine and Ajaya 1976:27). It is precisely in the untangling of these kinds of relationships which involve the physical body and the state of consciousness that psychotherapists and physicians could be working together to assist client/patients in experiencing greater well-being, all without the cost, side-effects, and dependencies created by a reliance on pharmaceutical agents and the rituals of prescription.

Of all the different forms of psychotherapy that exist, biomedicine, under the name of "behavioral health," has increasingly come to accept cognitive behaviorism, which is remarkable and does indicate progress in the direction of the practice of more holistic medicine if indeed the true nature of human behavior is reducible to chemical

fluctuation, rather than the other way around: that cognition and behavior significantly organize the chemistry of the body and the brain. The importance of understanding this lies in the logical and practical consequences of one's point of view on the issue; if chemistry is the ultimate source of behavior, then the licensing of psychologists and other mental health practitioners for the purpose of talk therapy is indeed redundant, if not absurd. If, conversely, thinking matters, then training and possibly licensing in talk therapy would seem to be very important if not vital, given that one may be invading "where angels fear to tread," which is to say into the domain of an organizing force, that of human mind and conscious awareness.

Returning to dignity and an alternative future

Billboards visible from freeways proclaim a "public health" message: "Prevent suicide. See your doctor." No one argues that suicide should not be prevented, or that suffering should go untreated. But the question is how. To see a biomedical practitioner for psychological distress in the current climate of practice is generally to be medicated only; in all likelihood, the patient will not receive psychotherapy, will not be invited into a healing relationship, and will not be encouraged to call upon his or her own latent inner resources to reestablish psychological balance and a sense of wellness. On the contrary, he or she will be inducted into drug dependency and a childlike abdication of personal efficacy. He or she will most likely be seduced into a feeling of powerlessness over his or her own physiology and emotional state, and will remain entranced by the idea that human suffering is unnatural and to be avoided at all costs. Nothing would essentially change.

Conscious awareness, on the other hand, is the daily bread of psychotherapy and is the gift it has to give; it is even what permits its own deconstruction, and can be seen, as I argue, as a feature of the natural order. Speaking semiotically, it behooves us to *indexicalize* it, not in opposition to empirical reality but as a complementary feature, so

that neither impelled by gods nor overcome by soul nor subsumed by materiality the honor and dignity as well as strength of being human, such as it is, is restored.

I believe that the time has come for psychotherapy to return to sobriety by moving out from under the influence of pharmaceutically dominated biomedicine. The time has come for it to reclaim its unique place in the healing arts: the healing of consciousness. This would restore wellness to practitioners and help-seeking individuals alike who struggle to maintain balance and find meaning in life. This could be the alternative future.

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APPENDIX

INTERVIEW PROTOCOL

1. a.) What is your professional title?
b.) What is your licensure?
c.) What is your official role with your client/patients?
d.) How long have you been working in this role?
2. Which types of health related issues were you trained to assess?
3. What is your understanding of the relationship between the mind and disease?
4. What does the term *mental illness* mean to you?
5. a.) Which of the following types of symptoms do you see in your practice:
 - depression
 - anxiety
 - mood disorder
 - delusional
 - systemic
 - addiction
 - self-mutilation
 - attention problems
 - hypochondriasis
 - eating disorder
 - otherb.) Are you aware of your client/patients using other forms of treatment concurrently with what you provide for these types of symptoms? If so, what kinds?
6. a.) How do you *define* treatment *success* with your client/patients?

- b.) To what do you *attribute* success with your client/patients?
- 7. a.) Please describe the treatment modalities you tend to use:
 - b.) Please describe your rationale for the use of your preferred treatment modalities:
- 8. a.) Have you seen changes in the treatment of mental or emotional symptoms by professionals since you began practicing? If so, what kind?
 - b.) To what do you attribute any changes?
 - c.) What is your opinion of any changes you have witnessed?
 - d.) Have changes in treatment impacted your own methods? If so, how?
 - e.) What do you think about the involvement of general medical practitioners in the management of client/patients' mental or emotional symptoms?
- 9. a.) What do psychotropic medications mean to you as a professional?
 - b.) Briefly describe your basic understanding of how psychotropic medications work.
 - c.) How did you gain this understanding?
 - d.) For psychotherapists: What proportion of your clients would you estimate are already on psychotropic medication when they first come to see you?
- 10. Is there any other information or idea you would like to share with me that you believe might be relevant to this project?